

Date: 12/1/21

*Virtual Meeting
(in lieu of meeting at the 2021 Fall National Meeting)*

RESTRUCTURING MECHANISMS (E) WORKING GROUP

Monday, December 6, 2021

3:30 – 4:30 p.m. ET / 2:30 – 3:30 p.m. CT / 1:30 – 2:30 p.m. MT / 12:30 – 1:30 p.m. PT

ROLL CALL

Elizabeth Kelleher Dwyer, Co-Chair	Rhode Island	Marlene Caride	New Jersey
Glen Mulready, Co-Chair	Oklahoma	My Chi To	New York
Russ Galbraith	Arkansas	Kimberly Rankin/Melissa Greiner	Pennsylvania
Michael Conway	Colorado	Raymond G. Farmer	South Carolina
Kathy Belfi	Connecticut	Amy Garcia	Texas
Kevin Fry	Illinois	David Provost	Vermont
Judy Weaver	Michigan	Scott A. White	Virginia
Fred Andersen	Minnesota	Steve Drutz	Washington
John Rehagen	Missouri	Amy Malm/Richard Wicka	Wisconsin
Lindsey Crawford	Nebraska		

NAIC Support Staff: Dan Daveline/Casey McGraw

AGENDA

1. Consider Comments on Co-Chair Exposed White Paper—*Superintendent Elizabeth Kelleher Dwyer (RI)*
 - *Bob Wake (ME)-Page 109*
 - *Luann Petrellis-Page 215*
 - *Enstar-Page 219*
 - *Scott White (VA)-Page 221*
 - *ALCI-Page 229*
 - *Swiss Reinsurance-Page 223*
 - *Joint Comment Letter (NWM, NY Life, MassMutual, W&S)-Page 235*
 - *ProTucket-Page 251*
 - *NOLHGA & NCIGF-Page 261*
 - *National Workers Compensation Reinsurance Association-Page 351*
2. Discuss Any Other Matters Brought Before the Working Group
—*Commissioner Glenn Mulready (OK)*
3. Adjournment



[Dec 6 Restructuring Agenda.docx](#)



Restructuring Mechanisms

An NAIC White Paper

October 22, 2021

Created by the
Restructuring Mechanisms (E) Working Group
of the
Financial Condition (E) Committee

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A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period requiring insurers to record a liability for these incurred but not reported claims. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer's business model and left to slowly runoff. For some insurance companies, runoff business¹ remains embedded with the core business without the ability to segregate the runoff business. There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers or individual policy novation. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remain with the original insurer. The only way to transfer a block of business with finality is an individual policy novation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled "Liability-Based Restructuring White Paper." (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off "material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities"² from current insurer operations. The white paper achieves this focus by inclusion of various section on related topics as well as multiple appendixes. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled "Alternative Mechanisms for Troubled Companies." (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States ("US") at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendixes.

¹ For purposes of this paper "runoff business" is defined as a block of insurance business that is no longer being actively written by an insurance company and no premiums are being collected, except where required to in accordance with contractual or regulatory obligations, and where the existing or assumed group of insurance policies or contracts are managed through their termination. This definition was developed based on comments received by the Restructuring Mechanism Subgroup from both regulators and industry interested parties; however, this definition has not yet been adopted by the subgroup.

² Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper (1997).

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be broken down into two categories generally referred to as insurance business transfer (“IBT”) and corporate division (“CD”). Several states, including Arkansas, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes while other states such as Arizona, Connecticut, Illinois, Iowa, Arkansas, Pennsylvania, and Michigan have enacted CD statutes. The stated intent of all these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the United Kingdom (“UK”) are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, better allocate specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsureds and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as redirect regulatory focus away from the insurer’s on-going business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.

Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such as mass tort, asbestos, environmental and general liability risks. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business.³ With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities.⁴ One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; 2) finality of economic transfer and 3) operational efficiencies.⁵

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulator Concerns with Restructuring Plans

While restructuring may provide value to the insurer, regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that provides less capital than is needed to satisfy the insurer's obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to

³ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁴ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁵ David Scasbrook (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.

approve the restructuring plan. Regulators have utilized procedures to ensure the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

Section 2: History of Restructuring in the United Kingdom

A. Part VII Transfers in the United Kingdom

IBT and CD laws and regulations are relatively new in the US, but the legal mechanism for the transfer of insurance business has been implemented and operational in the UK for over twenty years. Part VII of the Financial Services and Markets Act of 2000⁶ (“Part VII” and “FSMA”) enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 300⁷ successful Part VII transfers have taken place in the UK providing guidance to American insurers on how this process could continue to unfold in the US.

A Part VII transfer is a regulatory mechanism, governed by sections 104–116 within Part VII of the FSMA. This act allows an insurer or reinsurer to transfer long-term as well as general insurance business from one legal entity to another, subject to approval of a court. Many insurers use the procedure to give effect to group reorganizations and consolidations. Part VII transfers have also been used extensively in response to Brexit.

In accordance with the FSMA, the Prudential Regulatory Authority (“PRA”) and the Financial Conduct Authority (“FCA”) maintain a Memorandum of Understanding which describes each regulator’s role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. Under the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

Section 110 of the FSMA allows both the PRA and the FCA to be heard in the proceedings. The Memorandum of Understanding confirms that both the PRA and the FCA may provide the court with written representations setting out their views on the proposed scheme, and the PRA may prepare a report regarding the IBT.

As set out in the Memorandum of Understanding, before nominating or approving an independent expert under section 109(2)(b) of FSMA . . . the PRA will first consult the FCA. Further, the PRA will consult appropriately with the FCA before approving the notices required under the Business Transfers Regulations.

⁶ Financial Services and Markets Act of 2000, 48 Eliz. 2, part 7 (Eng.). FOR CITATION TO ONLINE SOURCE USE: Financial Services and Markets Act of 2000, part 7 (Eng.), <https://www.legislation.gov.uk/ukpga/2000/8/contents>.

⁷ Comment letter from the IBT Coalition Interested Parties to the Restructuring Mechanisms (E) Subgroup dated July 22, 2019.

Part VII transfers require a “scheme report.” This report is similar to the independent expert report under US IBTs, however, because the word “scheme” has a different context in the US, the word “scheme” is not used. Under section 109(2) of FSMA an independent expert report may only be made by a person:

- (a) appearing to the PRA to have the skills necessary to enable him to make a proper report; and
- (b) nominated or approved by the PRA.

The regulators expect the independent expert making the report to be a neutral person, who:

- (a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and
- (b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group’s discussion of the Part VII transfers, consumer representatives raised the UK court’s decision in *Prudential v Rothesay*⁸ which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity

⁸ As noted by Birny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. Note this was overturned by *The Prudential Assurance Company Limited v. Rothesay Life PLC* [2020] EWCA Civ 1626.

transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals⁹ found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

- (1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.
- (2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries' capital.
- (3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.¹⁰

Despite this set of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of transferred. While such an arrangement may provide some of the same features as a Part VII transfer the solvent scheme does not continue the coverage with a new insurer the way a Part VII transfer does. Other differences may exist in law but are not deemed to be relevant to this specific white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. Those generally following the UK structure began with Rhode Island in 2002 adopting a statute titled Voluntary Restructuring of Solvent Insurers¹¹ patterned after Solvent Schemes of Arrangements. This type of process

⁹ *Prudential Assurance Company Ltd and Rothesay Life Plc, Re*, England and Wales Court of Appeal (Civil Division)(Dec. 2, 2020).

¹⁰ *Id.* at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15

¹¹ [R.I. Gen. Laws Chapter 27-14.5](#).

was renamed Commutation Plans and differs from the UK law in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.¹² Commutation Plans continue to be available under RI law.

In 2015 Rhode Island adopted an Insurance Business Transfer Plan regulation¹³ structured similar to the Part VII transfers. Again, in contrast to the UK, the regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments receives continues to believe that it meets the statutory requirement have been met, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act (“LIMA”).¹⁴ LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act¹⁵ modeled after UK’s Part IV regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed two IBTs in October 2020 and September 2021, involving a Rhode Island and Wisconsin insurer respectively, which are described below. Neither of the plans were challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act¹⁶ which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is made for an extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report

¹² [In re GTE Reinsurance Co., No. PB 10-3777, 2011 WL 7144917, at *5–6 \(R.I. Super. Ct. Apr. 25, 2011\)](#)

¹³ 230 RICR 20-45-6.

¹⁴ See Legacy Insurance Management Act, 2014 Vt. Acts & Resolves 93 (codified as amended at VT. STAT. ANN. tit. 8, §§ 7111–7121 (West 2017)).

¹⁵ Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 *et seq.*

¹⁶ As announced by the Arkansas Department of Insurance July 8, 2021, ACA §§ 23-69-501, *et seq.* (See Arkansas statute at <https://www.arkleg.state.ar.us/Bills/Detail?id=SB203&ddBienniumSession=2021%2F2021R>)

The National Council of Insurance Legislators has promulgated a model IBT law¹⁷ modeled after the Oklahoma IBT statutes, as well as a model CD law¹⁸. A number of states have adopted CD statutes, whether specific to insurance or based on the state's general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania¹⁹. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

A. Similarities and Differences between Statutes

Rhode Island's IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer's domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer plan on policyholders considering whether the security position of policyholders is materially adversely affected by the transfer. All states also require notification to all affected policyholders as well as the opportunity to be heard at a public hearing.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate runoff books of business from an insurer.

The Illinois' Domestic Stock Company Division Law²⁰ requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless the following characteristics exist:

- (1) policyholder/shareholder interest are not protected;
- (2) each insurer would not be eligible to receive a license in the state;
- (3) division violates the uniform fraudulent act;
- (4) division is made for the purpose of hindering, delaying, or defrauding other creditors;
- (5) any of the companies are insolvent after the division is complete.

¹⁷ Insurance Business Transfer Model Act (Nat'l Council of Ins. Legislators 2020).

¹⁸ Insurer Division Model Act (Nat'l Council of Ins. Legislators 2021).

¹⁹See A.R.S. §§ 29-2601, *et seq.*; C.G.S.A §§ 38a-146, *et seq.*; 215 ILCS 5/35B-1 *et seq.*; M.C.L.A. §§ 500.5500 *et seq.*; A.C.A. §§ 23-69-501, *et seq.*; 15 Pa.C.S. §§ 361 *et seq.*

²⁰ 215 ILL. COMP. STAT. 5 as found at <https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1249&ChapterID=22>.

The Connecticut CD statute²¹ creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the domestic insurer; (2) the resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing.

The Pennsylvania CD statute²² was enacted in 1990 and is the subject of the NAIC 1997 white paper on Liability Based Restructuring. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the states equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal experts.

B. Transactions Completed to Date

²¹ C.G.S.A §§ 38a-146, *et seq.*, Public Act No. 17-2 as found at <https://www.cga.ct.gov/2017/act/pa/pdf/2017PA-00002-R00SB-01502SS1-PA.pdf>

²² 15 PA. CONS. STAT. §§ 361 *et seq.*

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in announced that it had approved a transaction that transferred a book of business from one entity to another. This transaction is discussed within Attachment 1, which is the 1997 Liability-Based Restructuring White Paper, and is commonly referred to as “the Brandywine” transaction, but within the 1997 White Paper is discussed within Appendix 1 and relates to Cigna, where more information is available. During the Working Group’s discussions in 2019, the Pennsylvania Insurance Department, which is captured in the following paragraph.

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and immaterial to the policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re²³ completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision²⁴ on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company’s (“PWIC”) IBT plan.²⁵ The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company (“Sentry”), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for approval.²⁶ This IBT transfers a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2020. The transaction was a transfer of risks with distinct characteristics into a single insurer within a holding company structure. All the transfers originated and ended within the same holding company. The Illinois Department of Insurance has

²³ C.A. No. PB 10-3777 (R.I. Super. Apr. 25, 2011)

²⁴ State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777
<https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/decisions/10-3777.pdf>

²⁵ Judgment & Order of Approval & Implementation of the IBT Plan, In re Transfer and Novation of Insurance Policies from Province Wash. Ins. Co., et al., CJ-2019-6689 (D.Ct. Okla. Cnty Oct. 15, 2020) at
<https://www.oscn.net/dockets/GetCaseInformation.aspx?db=oklahoma&number=CJ-2019-6689&cmid=3831864>.

²⁶ Approval Order in Case No. 20-0582-IBT from Oklahoma Insurance Commissioner, filed on November 23, 2020, at
<https://www.oid.ok.gov/wp-content/uploads/2020/11/20-0582-IBT-SAW-Order-11-23-20.pdf>.

indicated that it will issue a detailed regulation as experience develops with CD plans proposed and completed under the statute.

Section 4: Impact of IBTs and CDs to Personal Lines

A. Guarantee Association Issues

An important issue for corporate restructuring is the availability of guaranty association coverage in the event of the insolvency of the restructured insurer. In order to uphold the stated declaration that restructuring should not materially adversely affect consumers, guaranty association coverage should not be reduced or eliminated by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine association coverage. Although most states pattern their laws after the NAIC model law, there could potentially be different results concerning guaranty association coverage depending on where the insured resides.

The Working Group received input from both the National Organization of Life and Health Insurance Guaranty Associations (“NOLHGA”) and the National Conference of Insurance Guaranty Funds (“NCIGF”). NOLHGA described how the concerns for insurance consumers of personal lines business is particularly pronounced.

NOLHGA indicated that for there to be guaranty association coverage in the event of an insurer insolvency, there are three conditions that must be present. Those conditions are:

- (1) The consumer seeking protection must be an eligible person under the statute; typically, this is achieved by being a resident of a state who has a guaranty association;
- (2) The product must be a covered policy; and
- (3) The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state or have been licensed in the state.

In most states, coverage can be provided for an “orphan” policyholder of the insurer when the coverage is issued but the policyholder has since moved to a state that is not a guarantee association member. Those policies are covered under the state in which the insolvent insurer is domiciled. This provision is designed to plug the gap in these rare situations. Orphan coverage was not designed to provide coverage to all policyholders regardless of domicile as might occur if the resulting insurer in an IBT does not meet the requirements for guarantee association coverage. These issues can be addressed in legislative and regulatory manners including maintaining a certificate of authority in each state, so the insurer is a guarantee association member insurer in each state. However, if an insurer is unwilling or unable to meet such requirements it could impede the ability to complete a restructure.

One interpretation of the NAIC Property and Casualty Insurance Guarantee Association Model Act (Model # 540)²⁷ is that based on the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claim Transaction” an orphan policyholder could not be covered by the state guarantee association.²⁸ Consequently, there is a concern that no guarantee association coverage would be provided if policies are transferred to a nonmember insurer. Many statutes require that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred. These limitations, however, are designed to avoid coverage being provided when the policy at issue did not “contribute” to the association, which would not exist in the case of an accessible policy later transferred to a nonmember insurer.

NCIGF’s position is that where there was guaranty association coverage before the IBT or CD, state regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate or in any way impact guaranty association coverage. An CD or IBT should not create, expand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states that have adopted the NAIC Property & Casualty Guaranty Association Model Act.²⁹ These gaps could include the definitions of Covered Claim, Member Insurer, Insolvent Insurer, and the Assumed Claims Transaction found in Section 5 of the model law.

Fulfilling this intent may require guaranty association statutes be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee’s work is discussed in the Recommendations section below.

B. Assumption Reinsurance

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholder with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, in situations where the solvency of the insurer might be at risk. There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.³⁰

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be affected. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

²⁷ Available at <https://content.naic.org/sites/default/files/inline-files/MDL-540.pdf>.

²⁸ See NOHLGA and NCIGF joint submission to NCOIL dated February 24, 2020 for more information. Available at <http://ncoil.org/wp-content/uploads/2020/02/2020-02-24-Comment-on-NCOIL-IBT-Model.pdf>.

²⁹ Property and Casualty Guaranty Association Model Act (Nat’l Ass’n of Ins. Comm’r’s 2009).

³⁰ Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act by implication prohibit an IBT or a CD. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholders express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper. The issue has not yet been addressed by any court nor raised in the proceedings on restructurings. Therefore, while it is raised here for informational purposes, resolution of the issue is left unanswered for now and for the courts to determine in the future.

C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the regulators willingness to consider the restructuring of certain lines of business. During the Working Group's discussion, it was noted by a number of regulators that restructuring of certain lines of business, such as long-term care, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care, is likely to be subject to a great deal of opposition and higher capital requirements for the insurers involved.

The nature of long-term care policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others,³¹ a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. The US Constitution includes the Full Faith and Credit Clause as well as the Privileges and Immunities Clause (also referred to as the doctrine of Comity)

³¹ Gendron, Matthew Esq. (2018) "Rhode Island's Voluntary Restructuring of Solvent Insurers Law and Similar Efforts in Other States," *Roger Williams University Law Review*: Vol. 23: Iss. 3, Article 3, available at: https://docs.rwu.edu/rwu_LR/vol23/iss3/3. That article briefly raises questions about whether full faith and credit or comity would apply to help insulate an IBT transaction from collateral challenge in a court outside the approving state.

in Article IV. These clauses create methods of extending the effect of a restructuring mechanism beyond the state that issued the judgment and giving that state's judgment effect in all other states in which the insurer does business.³²

Thus, the Privileges and Immunities Clause or the Full Faith and Credit Clause are two methods stemming from the US Constitution that provide for recognition of court orders from other states. We will briefly touch on both concepts but leave these non-core insurance topics to others to discuss in more depth.

The policyholder challenging the decision must first identify the property of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to the resulting insurer, but alleges no additional harm, may have difficulty identifying the property interest of which they have been deprived. The determination on full faith and credit will likely rely upon the issues raised and considered in the Court of the domestic state.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK.³³ This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis,³⁴ while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. *Narragansett Electric Co. v. American Home Assurance Co.* is one such case.³⁵ In *Narragansett Electric Co.*, the court

³² The same analysis does not apply to jurisdictions outside the United States and is not addressed in this white paper.

³³ See SIDLEY AUSTIN LLP, PART VII TRANSFERS EFFECTUATED PURSUANT TO THE UK FINANCIAL SERVICES AND MARKETS ACT 2000 (2017), <https://www.sidley.com/-/media/publications/part-vii-transfers.pdf>.

³⁴ See Jennifer D. Morton, Note, *Recognition of Cross-Border Insolvency Proceedings: An Evaluation of Solvent Schemes of Arrangement and Part VII Transfers under U.S. Chapter 15*, 29 FORDHAM INT'L L.J. 1312, 1314–15 (2006).

³⁵ See *Narragansett Elec. Co. v. Am. Home Assur. Co.*, No. 11 Civ. 8299(PKC), 2012 WL 4075171 (S.D.N.Y. Sept. 12, 2012).

reviewed claims by London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier.³⁶ Equitas argued that it had not assumed the obligations at issue. As the court summarized, “Equitas’s motion to dismiss raises the question whether this [Part VII] transfer of insurance obligations from Lloyd’s to Equitas is effective and enforceable under U.S. law.” First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent to US policyholders raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a UK’s independent expert’s report.³⁷ Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. *Allianz Insurance Co.* is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. *Allianz Insurance Co.* also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

Allianz Insurance Co. concerned General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared an ultimate parent company—Berkshire Hathaway.³⁸ At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in *Allianz Insurance Co.* seemed to be that the post-Part VII insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden’s potential asbestos claims.

There, a claim originating in Pawtucket, Rhode Island, but with waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co.*, 57 N.E.3d 18, 24 (Mass. App. Ct. 2016).

³⁶ See Steven E. Sigalow & Richard E. Stewart, *How Lloyd’s Saved Itself*, 37 THE INS. FORUM (2010), reprinted in JONES DAY, <http://www.jonesday.com/files/Publication/dae28676-d6c8-4de6-9cbb-c05aee419d4b/Presentation/PublicationAttachment/533860ba-d4f1-4056-85d9-78b84dc71af5/How%20Lloyd's%20Saved%20Itself.pdf> (last visited June 9, 2021).

³⁷ *Air & Liquid Sys. Corp. v. Allianz Ins. Co.*, No. 2:11-CV-00247-JFC, 2012 U.S. Dist. LEXIS 121553 (W.D.P.A. 2012).

³⁸ *Id.* at *12. This interrelated nature is not unusual and is referred to as an intra-company transaction.

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law.³⁹ The court determined that, given the location of the petitioner’s assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action.⁴⁰ The court in *Hopewell* also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.⁴¹

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The Working Group believes that trust in these mechanisms and protection of the policyholders who will be impacted by them, demands a standard set of financial principles under which to judge the transaction. As such, the Working Group created a subgroup to specifically address these financial issues.

The Restructuring Mechanism Subgroup (“Subgroup”) has been charged with the following initial work related to this White Paper:

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long- term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.⁴²

Members of the Subgroup have studied and acknowledge that UK Part VII procedures set forth robust processes and that setting similar requirements should be applied to IBT and CDs.

³⁹ *In re Bd. of Dirs. of Hopewell Int’l Ins. Ltd.*, 238 B.R. 25, 31–32 (Bankr. S.D.N.Y. 1999).

⁴⁰ Written by then the Chief United States bankruptcy judge in the Southern District of New York Tina Brozman, this decision detailed relevant history behind the Bermuda schemes of arrangement, including the different methods available to companies. One arrangement involved a cut-off scheme, developed in 1995, in which companies have no more than five years to submit additional claims prior to a bar date. This scheme greatly reduced the time for a run-off to wind down its business.

⁴¹ Citing to 11 U.S.C. § 101(23) (2012), The court applied a standard that “a foreign proceeding is a foreign judicial or administrative process whose end is to liquidate the foreign estate, adjust its debts or effectuate its reorganization.” *Id.* at 49 (internal quotations omitted).

⁴² Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).

As of the date of this paper, the charge related to best practices has not been completed. The Subgroup will continue its work with the goal of developing financial best practices. Those practices will be exposed for comment and discussion prior to referral to other groups.

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. A number of states—Connecticut, California, and Oklahoma—have enacted statutory solutions to these issues. In addition, NCIGF has provided proposed statutory language. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the guaranty association issues to assure that consumers are not harmed by the transaction.

C. Statutory Minimums

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

- (1) Requirement of court approval must be required for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.
- (2) Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.
- (3) Requirement of a notice to stakeholders, a public hearing, robust regulatory process, and an opportunity to submit written comments are necessary for all policyholders, reinsurers, and guaranty associations.

None of the restructuring mechanism are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes are different and drafted by the legislatures of the states which enacted the statutes. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transaction. Other transactions, however, may not need all of these provisions. For example, an intra holding company transaction may not need full faith and credit.

While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the

transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies have difficulty getting licensed in the various states either because of “seasoning” issues or because they are not writing ongoing business so the state may be hesitant to grant a license. Lack of licensure can provide a lack of regulatory control which can lead to actions which harm consumers. The Working Group, therefore, recommends that the appropriate committee look at licensing standards for runoff companies that states may wish to adopt.

DRAFT

Liability-Based Restructuring White Paper

**Liability-Based Restructuring Working Group of the
NAIC Financial Condition (EX4) Subcommittee
June 1997**

Adopted by Liability-Based Restructuring Working Group & EX4 in June 1997

by Executive Committee in September 1997
Adopted by Plenary in December 1997

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I. SCOPE

In general, restructurings can be effected through various forms and occur for different reasons: a parent company may divest itself of insurance operations by walling off and trying to sell certain operations, or making material changes to pooling arrangements in a way that, in effect, results in a corporate restructuring. Similarly, an insurance organization may spin-off some of its operations, possibly taking a private company public, may separate commercial and personal lines operations, or may create an off-shore entity to which problematic liabilities and/or assets are transferred due to favorable regulatory and tax environments. The most common specific examples of restructuring during the past several years have been liability-based restructurings (LBRs) of insurance operations into discontinued and on-going operations, primarily because of material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities. Policyholders, insurers, regulators and guaranty funds have expressed concerns about these transactions. Descriptions of some recent restructurings are summarized in Appendix 1.

Conceptually, an LBR is an extraordinary transaction, or series of transactions, in which one or more affiliated insurance companies wholly or partially, isolate their existing insurance obligations from their on-going insurance operations. The notion of isolation is one of substantive change that creates a legal separation, such that policyholders and other creditors holding the isolated existing insurance obligations have limited or no financial recourse for their direct satisfaction against the on-going insurance operations. The concept of an LBR does not, in the absence of such isolation, include restructurings to achieve capital allocation or business-mix decisions, such as changes in pooling percentages, changes of the primary insurance writer or the separation of on-going insurance operations from other on-going insurance operations.

The purpose of this paper is to identify and discuss regulatory, legal and public policy issues surrounding such LBRs of multistate property/casualty companies and their affiliates. Single-state insurers and their affiliates may undertake similar LBRs and many of the issues contained herein may apply; individual states may choose to utilize this paper as a resource in those transactions. While restructurings of life and health companies are known to have occurred, such transactions may present different issues and considerations and therefore are excluded from discussion in this paper.

This paper is not intended to establish a position either for or against LBRs since each case must be evaluated on its own merits by the regulatory authority. Furthermore, this paper is not intended to address every insurance company merger, acquisition, divestiture, withdrawal from one or more lines of business or states, or other corporate transaction which impacts a company's obligation to its policyholders or its ability to meet those obligations. These are typically addressed under other applicable statutes or regulations.

II. BUSINESS REASONS

A. Rating Considerations

One of the major considerations in recent LBRs has been the insurer's desire to maintain or obtain favorable financial and other rating designations from the private rating agencies. Ratings play a major role in determining whether an insurer can remain competitive in its target market and may

affect its ability to attract new capital. Insurers that have been subject to earnings drag due to the adverse development of APH or other liabilities may be faced with rating downgrades. By separating problem liabilities from on-going operations, the insurer may improve or maintain its rating. In turn, this may allow the insurer to more effectively take advantage of business opportunities, potentially achieve higher returns on its capital, and become more attractive to the financial markets.

B. Solvency Issues

Through an assessment of its APH or other liability exposures, an insurer may realize that recognition of probable ultimate liabilities in these areas will have a material impact on its financial condition. By separating these liabilities from the on-going operations, the insurer can dedicate surplus to support the restructured operations and eliminate the drag on earnings in its on-going operations and avoid further commitment of capital for pre-existing liabilities.

It should be recognized that an LBR, by itself, does not create resources from which claims can be paid. Accurately establishing adequate reserves to meet probable ultimate liabilities may eliminate the drag on earnings. If the establishment of such reserves materially weakens the insurer's financial condition, it is unlikely that it will be able to dedicate appropriate surplus to support both the restructured and on-going operations without additional capital. In these circumstances, if additional capital is not forthcoming, the regulatory authority should take appropriate action.

C. Other

Other reasons an insurer may consider restructuring include, but are not limited to, the need to raise capital or a desire to exit a line of business. In some cases, restructuring may be considered as a method to exit the insurance business or to camouflage financial and other problems.

III. ADVANTAGES AND DISADVANTAGES

LBRs may result in a more effective use of existing capital, a more competitive on-going insurance operation, more effective claims management, better management of ultimate liabilities related to problematic lines of business, and improvement of the availability and affordability of insurance coverage. In addition, an LBR may result in the attraction of additional capital and the enhancement of shareholder value.

On the other hand, underfunded LBRs may reduce the likelihood certain policyholder claims will be paid by the insurer. In addition, LBRs may be difficult to structure equitably due to the uncertainty associated with estimating APH liabilities, may pose questions related to policyholder participation and guaranty fund coverage in the event a restructured entity fails, and may have a negative impact on the public trust in the property and casualty insurance industry and the effectiveness of insurance regulation.

Each LBR will present certain advantages and disadvantages. An advantage to future policyholders (availability and affordability) may arise from a disadvantage to existing and prior policyholders (reduced likelihood of having their claims paid). The regulatory process requires that these advantages and disadvantages be assessed in light of applicable law and the impact upon policyholders. A pre-approval checklist is attached at Appendix 2.

IV. FINANCIAL SOLVENCY ISSUES

A. General Solvency Considerations

Regardless of the nature of an LBR, a key responsibility of the regulatory authority in assessing whether to approve the transaction will be to analyze financial solvency issues. The regulatory authority must determine whether the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. To make this determination, the regulatory authority will need to assess reserve adequacy, collectibility of reinsurance balances, and the value and liquidity of assets. Before formulating a conclusion based on these assessments, the regulatory authority should also consider the adequacy of capital and surplus levels and whether financial support is available from the parent company or other affiliates.

The restructuring insurer should provide the regulatory authority a detailed analysis of business and operational aspects of the LBR, including a detailed business plan, historical, current and pro-forma financial statements, and a description of the transaction's tax consequences. The financial information provided should include a balance sheet of the insurer as if the restructuring plan were approved, and schedules detailing assets and liabilities to be reallocated as a part of the restructuring plan. Any special charges or write-downs that will be made as a result of the LBR should also be specifically identified. The detailed business plan should also include a discussion of how the LBR will impact obligations to policyholders and other creditors. In addition, a statement should be provided describing the consequences if the LBR is not approved.

The regulatory authority should consider the engagement of experts to provide opinions about the impact on obligations to policyholders and other creditors, solvency, and the financial condition of the companies affected by the LBR, both immediately before and after restructuring.

B. Reserve Adequacy

Determining a reasonable estimate for liabilities will be a key part of the regulatory review process. Long-tail liabilities, especially those related to APH exposure, are most difficult to estimate. Although it is acknowledged that there is a high degree of uncertainty related to estimation of APH reserves, some regulatory authorities have concluded that sufficient information and actuarial methodologies exist to assess and estimate these exposures. The regulatory authority should consider taking the following actions to thoroughly review the adequacy of reserve estimates:

First, the regulatory authority should engage a qualified actuarial firm to: a) review methodologies used by the insurer to estimate reserves; b) review the insurer's economic approach to funding the run-off liabilities, including reserve discounting, if any; c) determine whether the claims unit is adequately staffed with qualified professionals and that its approach to settling claims is consistent with industry "best practices"; d) opine on the adequacy of reserves on a gross and net of reinsurance basis, by accident year and line of business; and e) review the funding of the discount and the adequacy of reserves net of the discount, if reserve discounting will be permitted. Second, if liabilities include material exposures to APH liabilities, consideration should be given to performing a "ground-up" review of reserves to estimate known and incurred but not reported (IBNR) reserves. This review should include the evaluation of all known liabilities on a case-by-case, policy-by-policy basis, including IBNR reserves.

Third, the regulatory authority should consider requiring the development of a cash flow model stress test to evaluate the adequacy of assets, including reinsurance, to fund the liabilities. The ultimate liabilities, payment patterns and cash flow assumptions should be included in the review. The stress test should consider varying loss payment patterns and investment yields.

C. Reinsurance

1. Collectibility of Reinsurance Balances

The success of an LBR may depend, in large part, on the LBR's effect upon existing reinsurance agreements and the collectibility of reinsurance balances stemming from those agreements. Depending on the materiality of these balances, the regulatory authority should consider requiring an independent analysis of reinsurance recoverables including: a) a review of the process used to monitor, collect, and settle outstanding reinsurance recoverables; b) an analysis of existing and projected reinsurance balances, including the expected timing of cash flows; c) an analysis of the quality and financial condition of the reinsurers and prospects for recovery; d) a detailed description of write-offs or required reserves based on the independent analysis taken as a whole; e) disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes; and f) a discussion of the impact of the LBR on the collectibility of the reinsurance balances. The regulatory authority may also consider requiring a legal analysis of the effect a liquidation or rehabilitation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and the legal rights of reinsurers to claim offsets against such recoveries.

2. Reinsurance Coverage

LBRs may include reinsurance stop loss or excess of loss coverage as an integral part of the transaction. These treaties are often complex and may require the regulatory authority to retain qualified experts to ensure that coverage is adequate, and that the treaty will perform as anticipated. The treaty may be analyzed to determine how it will operate, how the reinsurance premium will be calculated and how it will be paid, and whether the quality and financial condition of the reinsurer(s) is adequate. The regulatory authority should determine whether the amount of coverage provided by the treaty, in combination with other resources, is sufficient to meet the obligations of the restructured entity.

In addition to a stop loss or excess of loss treaty, the LBR may involve new or amended quota-share or pooling agreements within the group. The regulatory authority should review the agreements and supporting documentation to understand the movement of business and to determine the financial impact of the changes on the run-off and on-going companies. The regulatory authority should also consider reviewing existing reinsurance programs to determine that provisions are consistent with other information provided and that adequate coverage exists for on-going operations.

D. Liquidity and Value of Assets

Although proper estimation of liabilities is critical to the success of an LBR, equally as important is the assessment of whether existing assets and future cash flow are sufficient to fund the liabilities.

Much of the work related to determining whether there is a proper matching can be achieved through an appropriate stress testing process. The asset assumptions used in the stress test should be evaluated by the regulatory authority, especially if assets have high volatility, liquidity uncertainties, material valuation issues or lack diversification.

Consideration should be given to obtaining current appraisals for any material real estate or mortgage holdings; and obtaining independent investment expertise to value limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other asset for which the regulatory authority has concerns about the carrying value.

The regulatory authority should also consider reviewing assumptions as to investment yield and determine how the reallocation of assets might impact historical yields. This review will be the key determination of allowable discount rates and the spreads to be required between investment yield and reserve discount.

Should the asset analysis indicate there are problems related to asset matching, the regulatory authority may consider requiring: a) reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk; b) parental guarantee of investment yields; c) collateralized parental guarantee of asset valuation; and d) disposition of assets prior to transaction approval.

E. Capital and Surplus Adequacy

One of the most difficult aspects of reviewing an LBR is determining what level of capital and surplus is adequate. In general, standard provisions of the NAIC's Risk-Based Capital (RBC) For Insurers Model Act (the Model Act) should apply.

Unlike an on-going insurance company, run-off entities do not compete for new or renewal business. There may be other differences in the risk profile of run-off entities that could indicate the need for reassessment of the applicability of the Model Act in individual circumstances. The reserve, underwriting, and investment factors generating the majority of required RBC were developed to measure risks retained by a run-off entity. The Model Act makes specific provision for exempting a property and casualty insurer from actions to be taken at the Mandatory Control Level if that insurer is writing no business and is running-off its existing business. Under such circumstances the insurer may be allowed to continue its run-off operations with the regulatory authority's oversight.

Other factors to consider in determining the adequacy of capital and surplus levels include

volatility and uncertainty related to reserve estimates, the quality of assets, and the degree of parental and affiliated support.

F. Support From Parents and Other Affiliates

As discussed in previous sections, support from parents or affiliates may play an integral part in the LBR and may be a significant factor in whether the transaction is approved. The regulatory authority should consider analyzing the change in organizational structure resulting from the LBR, placing special emphasis on the extent to which the resulting corporate structures have common ownership, overlapping management, substantial reinsurance arrangements, and on-going business ties. If the financial and marketing futures of the corporate structures are materially tied together, it may be less likely that any part of the organization will be abandoned.

If one of the resulting insurer structures is perceived to be weaker than another, the parent may show its intention of continued support through issuance of “cut-through” provisions for the benefit of policyholders of the “weaker” entity. These provisions give policyholders the legal right to file a claim against the entity issuing the cut-through should the insurer liable under the insurance contract (policy) be unable to meet its obligations. (Note: Some states have enacted laws prohibiting cut-through transactions.)

Stop loss and excess of loss reinsurance transactions have been discussed earlier in this report. The importance of these transactions, especially if with affiliated entities, should not be minimized. These transactions are often used to provide a cushion for the uncertainties related to asset and liability assumptions and can often be structured to strengthen the transaction. The regulatory authority should determine whether parental or affiliated support is available should the collectibility of reinsurance balances deteriorate.

The parent or affiliates should be encouraged to provide financial and managerial support to all entities. This support lends credibility to the LBR and provides an additional layer of security to policyholders.

V. LEGAL AND PUBLIC POLICY ISSUES

A. Applicable Laws

LBRs may implicate, directly or indirectly, a number of laws in the state of domicile including both general corporate statutes and insurance code provisions. A thorough review of all potentially applicable laws is necessary to fully understand the requirements and potential ramifications of an LBR. To the extent changes to an insurer’s corporate structure affect relationships with policyholders in other states, the laws of those jurisdictions may apply. Following is an overview of the principal laws that may need to be considered by the regulatory authority with regard to an LBR.

1. General Corporation Statutes

Corporate organization is governed by each state’s corporation law. Many states have

enacted the Revised Model Business Corporation Act (RMBCA)¹ or a similar law. In most states, the corporation law applies to insurers, unless stated otherwise. The state insurance codes supplement the corporate law with additional or different requirements for insurers.²

The general corporation law addresses the existence and internal governance of the corporation. Corporation laws set forth minimum requirements and procedures to be adhered to in connection with extraordinary transactions affecting corporate existence and structure such as reorganizations, mergers, exchanges, divisions,³ disposal of assets and dissolutions. Such extraordinary transactions may require the approval of shareholders in addition to that of the board of directors.

a. Mergers and Consolidations

State law governs consolidation and mergers of insurers. The procedures and requirements regarding changes to the corporate structure of an insurer are usually the same as those for other corporate entities. Insurers may be subject to more regulatory scrutiny than general business corporations. A merger occurs when one corporation absorbs the other and the identity of the absorbed corporation disappears. In consolidation, the separate corporate entities disappear and a new corporate entity emerges.

Statutes governing consolidations or mergers, for the most part, require that notice be given to all stockholders or members. Mergers or consolidations of stock insurers do not require the approval of policyholders but do require approval by the regulatory authority. Mergers or consolidations of mutual insurers must be approved by both the policyholders and the regulatory authority.

b. Divisions

Division statutes have recently been enacted by two jurisdictions. These statutes permit the division of a single corporation into two or more resulting corporations. In a division, assets and liabilities are allocated among the resulting corporations. An LBR that includes a division may also include other transactions such as changes to a pooling agreement that may require regulatory review in other jurisdictions.

2. Insurance Code Provisions

a. Insurance Holding Company Act⁴

¹ As of 1996, 22 states have enacted the current version of the RMBCA or substantially similar laws.

² Neb.Rev.Stat. § 44-301 (Reissue 1993) states in pertinent part: "...[T]he Nebraska Business Corporation Act except as otherwise provided... shall apply to all domestic incorporated insurance companies so far as the Act is applicable or pertinent to and not in conflict with other provisions of the law relating to such companies. "

³ 15 Pa.Cons.Stat. §§ 1951-1960 (1995), effective in 1989; Tex.Bus.Corp.Act § 5.01 *et seq.* (Vernon Supp. 1990), effective in 1989.

⁴ The Insurance Holding Company System Regulatory Act (Holding Company Act) adopted by the NAIC is enacted in some form in 48 states.

Certain aspects of an LBR may be subject to the Holding Company Act even though the act does not explicitly address LBRs. An LBR may be subject to review by the regulatory authority under the Holding Company Act if the insurer is a member of an insurance holding company system. For example, if an LBR results in a change of control⁵ of a domestic insurer, the transaction must be pre-approved by the regulatory authority in accordance with certain stated criteria.⁶

In addition, the Holding Company Act governs transactions between the domestic insurer and other members of the insurance holding company system even if there is no change in control.⁷ Some of these transactions trigger advance notification to the regulatory authority depending upon the nature and extent of the transaction. All of these transactions must be on terms that are fair and reasonable. An LBR will probably be subject to these requirements of the Holding Company Act if inter-company agreements such as management agreements, reinsurance agreements or tax allocation agreements are affected.

Finally, the Holding Company Act also governs dividends or distributions by a domestic insurer. For example, if an extraordinary dividend or distribution is part of an LBR, the prior approval of the regulatory authority may be required.⁸

b. Examination Law

All states have examination statutes that provide the authority and responsibility to conduct examinations of insurers to determine their financial condition and compliance with insurance laws and regulations. This authority includes targeted examinations triggered by a wide array of events such as deteriorating financial condition, risk-based capital results, financial analysis results, financial ratios and LBRs. Generally, a periodic examination of insurers is contemplated; however, the regulatory authority may also conduct an examination as often as deemed appropriate.⁹ The regulatory authority has the discretion within statutory confines to determine the scheduling, nature and scope of an examination. The regulatory authority is also granted examination powers under the Holding Company Act.¹⁰

Generally, the regulatory authority may retain attorneys, appraisers, actuaries, certified public accountants, loss-reserve specialists, investment bankers or other professionals and specialists at the cost of the insurer being examined.¹¹ Given the extraordinary nature and complexity of LBRs, it is essential that the regulatory

⁵ Control is presumed to exist with the power to vote 10% or more of the voting securities of an insurer.

⁶ Regulatory jurisdiction under the NAIC Insurance Holding Company System Regulatory Act is of domestic insurers, but some states assert jurisdiction over non-domestic insurers on the basis of the insurer being “commercially domiciled” in that jurisdiction due to the volume of business. *See* CAL. INS. CODE § 1215.4 (1993).

⁷ The NAIC Insurance Holding Company System Regulatory Act at Section 5A. Similar authority as to insurers that are not a part of an insurance holding company system can be found in the Disclosure of Material Transactions Model Act adopted by the NAIC.

⁸ *Id.* at Section 5B.

⁹ The Model Law on Examinations adopted by the NAIC has been enacted in 41 states, see Section 3A.

¹⁰ The NAIC Insurance Holding Company System Regulatory Act at Section 6A.

¹¹ The NAIC Model Law on Examination at Section 4D.

authority have the ability to contract for the services of all experts and specialists deemed necessary and to assess such costs to the insurer.

The examination statutes generally provide for the confidentiality of all workpapers, recorded information and documents obtained by, or disclosed to, the regulatory authority in the course of an examination and that these materials may not be made public, subject to some limited exceptions.¹² The examination authority under the Holding Company Act contains a similar provision regarding confidentiality of examination materials. These confidentiality provisions are necessary for the regulatory authority to conduct a thorough examination. The examination statutes provide the regulatory authority an important tool to evaluate LBRs, but the examination law prevents the regulatory authority from disclosing examination documents that might be of interest to policyholders. (See § 5(B)(4)).

c. Other Laws

Other insurance regulatory laws that may need to be considered regarding an LBR relate to the orderly withdrawal from insurance business in the state,¹³ demutualization, or redomestication¹⁴ of the insurer to another state. Issues regarding guaranty fund coverage and assumption reinsurance requirements deserve special consideration and are discussed in separate sections of this paper. Other insurance laws and regulations may need to be considered in connection with an LBR. Therefore, it is important to evaluate all the ramifications of an LBR and the component steps and transactions necessary to achieve the LBR. This may involve regulatory issues not identified in this paper.

B. Due Process

What do the concepts of due process and equal protection mean in the context of the review of an LBR by the regulatory authority? The requirements of due process and equal protection are triggered by action of the state through its authorized governmental agencies. The concept of due process includes both procedural and substantive aspects. Procedural due process concerns the right of interested parties to notice and the opportunity to be heard. Substantive due process requires that government action be based on legislation that is within the scope of legislative authority and reasonably related to the purpose of the legislation. Not every proposed LBR will affect private interests to the extent that the requirements of due process and equal protection will be applicable.

The regulatory authority should consider the persons whose interests are affected by a proposed LBR and who is entitled to notice and the opportunity to be heard. The regulatory authority should consider whether a public hearing concerning the LBR is required or should be held.¹⁵ The regulatory authority should consider whether interested parties should be allowed to present evidence, call witnesses and cross-examine the witnesses of other parties. The regulatory authority should consider whether policyholder consent is necessary.

¹² *Id.* at Section 5F (Six of the 41 states that have enacted the Model Law have not adopted the section on confidentiality).

¹³ See N.J. Stat. Ann. § 17:33 8-30 (1994).

¹⁴ The Redomestication Model Bill adopted by the NAIC is enacted in 37 states.

¹⁵ The United States Supreme Court has held that due process of law does not require a hearing in every case of government action. See 16A Am.Jur.2d 1054, citing *Boddie v. Connecticut*, 401 U.S. 371 (1971).

The regulatory authority should consider the information that should be disclosed and to whom disclosure should be made. The regulatory authority should consider the persons that may be aggrieved by its decision. These questions may well have their answers in general (*i.e.*, non-insurance) administrative and state and federal constitutional law. If not, local law may govern policyholder relationships and rights. Finally, the regulatory authority should consider whether the action to be taken is reasonable under all the attendant circumstances.

C. Assumption Reinsurance

Corporate restructurings may be subject to the assumption reinsurance transactions statutes. The Assumption Reinsurance Model Act was drafted by state insurance regulators and adopted by the NAIC Dec. 5, 1993. The model act establishes notice and disclosure requirements intended to protect consumers' rights in an assumption reinsurance transaction. Under these statutes, insurers must seek prior approval from the regulatory authority for a transfer of business as well as notify all policyholders affected by the transfer. Policyholders must be informed that they have the right to reject the transfer.

An assumption reinsurance agreement is any contract that both transfers insurance obligations and is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations and/or risks under the contracts are extinguished. If the laws of the domiciliary states of both the transferring and assuming insurer contain provisions substantially similar to the model act, the assumption reinsurance transaction is subject to prior approval by both states' regulatory authorities. If no substantially similar requirements exist, the transaction is subject to the prior approval of the regulatory authorities of the states in which affected policyholders reside. Policyholders receive a notice of transfer by mail and may reject or accept the transfer. If the policyholder does not respond, the policyholder will be deemed to have given implied consent and the novation of the contract will be effected.

The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. In addition, a domiciliary regulatory authority has the necessary discretion to effect a transfer and novation if an insurer is in hazardous financial condition and the transfer of its insurance contracts would be in the best interests of the policyholders. These statutes may also come into play if an insurer transfers business through bulk reinsurance or a contract of bulk reinsurance. Bulk reinsurance or a contract of bulk reinsurance is an agreement whereby one insurer cedes by an assumption reinsurance agreement a certain percentage of its business to another insurer. The transaction must be filed with and approved by the regulatory authority of the insurer's state of domicile.

D. Policyholder Consent

When a new agreement replaces an existing agreement, a novation has occurred.¹⁶ Because the

¹⁶ See, e.g., *Black's Law Dictionary* 1064 (6th ed. 1990) which defines "novation" as, in part: "A type of substituted contract that has the effect of adding a party, either as obligor or obligee, who was not a party to the original duty. Substitution of a new contract, debt, or

Assumption Reinsurance Model Act specifically states that it is intended to provide for the regulation of assumption reinsurance transactions as novations of contracts,¹⁷ general rules of contract law apply to any disputes arising under the assumption reinsurance agreements.

Many courts have found that the type of implied consent required by the Assumption Reinsurance Model Act is legally sufficient. For example, in *State Dept. of Public Welfare v. Central Standard Life Ins. Co.*,¹⁸ the Supreme Court of Wisconsin found implied consent to an assumption agreement where the policyholder retained the original policy, was silent after receiving a certificate of assumption and subsequently paid 15 premiums to the assuming insurer.

Furthermore, in *Sawyer v. Sunset Mutual Life Insurance Co.*,¹⁹ the Supreme Court of California held that when an insured's beneficiaries sued the insurer that had assumed the insured's life insurance policy, "the bringing of suit is sufficient evidence of assent on the part of respondents to said agreement and undertaking."

However, other courts have required express consent by the policyholder to an assumption reinsurance transaction. For example, in *Security Benefit Life Ins. Co. v. Federal Deposit Insurance Corp.*,²⁰ the U.S. District Court for the District of Kansas found that where a series of assumption reinsurance agreements was executed, the agreements were not enforceable without proof that the policyholder or at least one of its successors in interest consented to the novation. Acquiescence to the transaction did not constitute policyholder consent to the assumption reinsurance transaction.

In *Travelers Indemnity Company v. Gillespie*,²¹ the Supreme Court of California stated that even when an insurer obtained reinsurance and assumption agreements pursuant to the state's withdrawal statute, policyholder consent to the transaction was still required.

In *Prucha v. Guarantee Reserve Life Ins. Co.*,²² the policyholder wrote to his insurer and said he did not consent to the transfer of his policy to another insurer through an assumption reinsurance agreement, but he paid premiums to the new company. The Court of Appeal of Florida, Third District, found that the policyholder's payment of premiums did not constitute implied consent to the novation because the policyholder had no opportunity to consent and his premium payments were merely an effort to protect his investment.

E. Rights of Other Interested Parties

What persons have an interest in a proposed LBR in addition to policyholders and insurance regulators in non-domiciliary states? Guaranty funds have an interest in the approval of LBRs because they may be called upon to step in and pay claims if the restructured entity is subsequently

obligation for an existing one, between the same or different parties.... A novation substitutes a new party and discharges one of the original parties to a contract by agreement of all parties...."

¹⁷ NAIC Assumption Reinsurance Model Act § 1 (1993).

¹⁸ *State Dept. of Public Welfare v. Central Standard Life Ins. Co.*, 120 N.W.2d 687 (Wis. 1963).

¹⁹ *Sawyer v. Sunset Mutual Life Insurance Co.*, 66 P.2d 641 (Cal. 1937).

²⁰ *Security Benefit Life Ins. Co. v. Federal Deposit Insurance Corp.*, 804 F.Supp. 217 (D.Kan. 1992).

²¹ *Travelers Indemnity Company v. Gillespie*, 785 P.2d 500 (Cal. 1990).

²² *Prucha v. Guarantee Reserve Life Ins. Co.*, 358 So.2d. 1155 (Fla. App. 1978).

found to be insolvent. Third parties having pending claims against an insured of the restructuring insurer may also be interested persons. Other interested persons, depending upon the circumstances in each case, may include reinsurers, ceding insurers, general creditors, shareholders, if the restructuring insurer is a stock company, and the public.

The regulatory authority should consider the type of notice to be given to interested persons. The regulatory authority should also consider whether certain persons should be afforded the opportunity to intervene in the proceedings concerning an LBR. Finally, the regulatory authority must consider the fiscal impact of giving notice to a large number of interested persons and the participation of those persons in the approval process.

F. Disclosure of Information

In an LBR the regulatory authority should consider the extent to which financial information about the insurer involved must be disclosed to interested persons or the public. Applicable state laws may require the regulatory authority to disclose certain information. However, most of the states have enacted laws that provide for maintaining the confidentiality of sensitive information acquired by the regulatory authority during an examination of an insurer or in the course of certain other regulatory activities. Use of the examination law to evaluate an LBR may prevent the regulatory authority from disclosing materials that the regulatory authority would prefer to release to interested persons or the public.

The regulatory authority should determine whether disclosure requirements or confidentiality provisions are applicable to the review of an LBR. In the absence of explicit statutory guidance, the regulatory authority should balance due process considerations and the public's right to know with the need to protect sensitive or proprietary information.

G. Guaranty Fund Coverage

An important issue for the regulatory authority with regard to an LBR is the availability of guaranty fund coverage in the event of the insolvency of the restructured insurer. From the viewpoint of the insurance consumer, absent express consent, guaranty fund coverage should not be reduced or eliminated by an LBR.

1. Overview of Guaranty Fund System

Each state has a guaranty fund, created by statute, to provide a safety net for policyholders and third party liability claimants in the event of the insolvency of an insurer writing property and liability lines of insurance. Although the majority of state guaranty fund statutes are based upon the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act, there are variations from state to state that should be taken into account by the regulatory authority when reviewing a proposed LBR. First, the lines of business covered may differ. Also, the amount of coverage provided per claim varies. Although the Model Act and many state statutes provide for payment of covered claims of up to \$300,000, some state laws provide more or less coverage. Several states have enacted net worth provisions that exclude from coverage the claims of persons whose net worth

exceeds a certain benchmark, the rationale being that such persons are sophisticated purchasers and can afford to absorb some loss.²³

Since each state guaranty fund is a separate entity, each fund makes its own determination with respect to coverage. Therefore, potentially, the guaranty funds in some states may determine that claims arising from the policies of the restructured insurer are covered, while other guaranty funds may reach a different conclusion.

Finally, although the regulatory authority reviewing an LBR should consider the potential availability of guaranty fund coverage as one of many factors in deciding whether to approve the LBR, it is important to note that the existence of guaranty fund coverage can only be conclusively determined if and when the insurer becomes insolvent.

2. The Availability of Guaranty Fund Coverage May Depend Upon the Form of Restructuring

Whether guaranty fund coverage is available to policyholders, claimants, and creditors of an insurer involved in an LBR may depend upon the form of the restructuring. The regulatory authority should determine the effect of an LBR on the availability of guaranty fund coverage in the event the restructured insurer subsequently becomes insolvent. Issues to be considered include:

- a. Whether an unlicensed insurer is involved in the LBR;
- b. Whether the restructured insurer that could become insolvent is the insurer that issued the policy;
- c. Whether the restructured insurer that could become insolvent was the insurer at the time the insured event occurred;
- d. Whether the guaranty fund coverage in other states varies from the coverage available in the regulatory authority's jurisdiction.

3. Conclusion

Guaranty fund coverage and the provisions for triggering the guaranty fund vary by state. Regulators involved in the approval of an LBR should determine the effect of the LBR on the availability of guaranty fund coverage for policyholders in the event the restructured insurer subsequently becomes insolvent. If it is concluded that an LBR places the availability of guaranty fund coverage in serious question, the structure of the proposed transaction or questionable component should be modified before approval.

VI. ON-GOING REGULATORY OVERSIGHT

²³ It might be questioned whether such exclusions are appropriate if policies are transferred to a restructured entity without the insured's consent.

A. General

The responsibility of the regulatory authority does not end with the approval of an LBR. Subsequent to the completion of the transaction there will be one or more insurers with obligations to policyholders and other creditors. These insurers will continue to require regulatory oversight. Because of the existence of obligations to policyholders and other creditors, the insurance laws of the state of domicile should continue to apply to the restructured insurer. However, the LBR may also result in the need for additional regulatory oversight. As an LBR can take many forms, the exact nature of the oversight is dependent on the risks created by an individual restructuring. To the extent that these risks can be identified prior to the approval of the LBR, the regulatory authority should consider incorporating any additional regulatory requirements in the order approving the transaction.

This section assumes that the restructured insurer remains domiciled in the United States. If this is not the case, most of this section will not apply, as the regulatory authorities approving the transaction will no longer have jurisdiction over the restructured insurer. This should be considered prior to approving the LBR.

In the end, any LBR will be judged on the reorganized insurer's ability to meet its obligations to policyholders and other creditors. If approved, the regulatory authority has the responsibility to identify new risks created by the LBR, and institute appropriate regulatory safe-guards to help ensure that all obligations to policyholders and other creditors will be met. An outline of a program for on-going regulatory oversight is attached at Appendix 3.

B. Oversight

One of the primary areas of concern regarding a restructured insurer is the availability of sufficient resources to meet all of its obligations to policyholders and other creditors. Although the restructured insurer would still be subject to the domiciliary state's examination law, additional oversight may be required to help mitigate additional risks created by the LBR. For instance, if a dedicated pool of assets is created to meet obligations to policyholders the regulatory authority should consider additional oversight measures designed to ensure the assets will be available to pay policyholder claims. See Appendix 3 for examples of conditions and requirements for on-going regulatory oversight of an LBR.

One of the factors that will be analyzed prior to approving an LBR is future corporate affiliations. In cases where there are continuing affiliations, the regulatory authority's oversight would most likely include monitoring compliance with agreements between the resulting insurers. For example, the regulatory authority should consider on-going evaluations of statutory compliance with any capital maintenance agreement, and review of management or administrative agreements or other inter-company agreements or transactions. In addition, the regulatory authority should review compliance with the requirements set forth in the order approving the LBR.

Where there is common management and/or ownership of on-going and run-off operations of a restructured insurer, the regulatory authority needs to be aware of any potential conflicts of interest between the two entities. This may lead to inappropriate influence by the on-going entity of the run-off entity's operations. For example, it might be in the interest of the on-going entity for the run-off

entity to settle claims of current on-going entity customers on a preferential basis. This could have the effect of jeopardizing whether the run-off entity will have sufficient assets to settle other policyholders claims. A similar conflict exists if there is a block of policies whose obligations revert to the on-going entity upon the insolvency of the run-off entity. If such conflicts exist the regulatory authority should consider an examination of the claim settlement patterns of the run-off entity as part of its regular examination process.

If an LBR results in one or more insurers that have no on-going operations, the regulatory authority should consider requiring regulatory approval before the run-off entity can begin or resume on-going operations. Prior to approving the reactivation of operations, the regulatory authority should consider the financial and operational resources available to the restructured insurer, and be able to determine that such a reactivation will not place existing policyholders at any additional risk.

The regulatory authority should evaluate residual market obligations before approval of an LBR. Consideration should be given to requiring that these types of obligations be assumed by the on-going entity.

VII. CONCLUSIONS AND RECOMMENDATIONS

The Liability-Based Restructuring Working Group concludes and recommends as follows:

- LBRs present both advantages and disadvantages, and therefore, LBRs should not be prohibited per se, but each should be evaluated on its own merits by the regulatory authority.
- LBRs are extraordinary transactions that vary widely in form, method and circumstances, and therefore, a “one size fits all” stand alone model law approach is not recommended at this time. Insurance regulatory authorities must have adequate statutory authority with sufficient flexibility and discretion to respond to the situation presented. The Working Group believes that existing regulatory authority is generally adequate, but recommends that the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, the Assumption Reinsurance Model Act, and the Insurance Holding Company System Regulatory Act be revisited to consider whether amendments may be appropriate in light of LBRs.²⁴
- An LBR should be subject to approval or disapproval by the domestic regulatory authority(ies) on the basis of a comprehensive and thorough review. The regulatory authority should have the ability to engage all experts necessary to assist in the review at the expense of the LBR applicant.
- The LBR applicant has the burden of justifying the LBR to the regulatory authority. The regulatory authority should not approve a proposed LBR if the transaction is likely to jeopardize the financial stability of the insurers, prejudice the interests of policyholders or be unfair or unreasonable to policyholders. An LBR is not an acceptable alternative to appropriate regulatory action, such as the rehabilitation or

²⁴ More specifically: the working group recommends that; (1) the NAIC review its Post-Assessment Property and Liability Insurance Guaranty Association Model Act to consider whether the definitions of “covered claim” and “insolvent insurer” should be amended to make it clear that coverage continues when there has been a division; (2) that the Assumption Reinsurance Model Act be reviewed to consider whether to clarify that a division transaction is subject to all the requirements of that Act; and (3) that the Insurance Holding Company System Regulatory Act be reviewed to consider whether any of the filing requirements should be amended in order to more fully address LBR transactions.

liquidation of insurers in hazardous financial condition, unless the hazardous financial condition is corrected in association with the LBR.

- If the effect of the LBR is intended to extinguish an insurer's obligation to its policyholders, consent of the policyholders should be required. Such transactions result in a novation or have the same effect on policyholders as a novation and therefore should satisfy the procedural and legal requirements of a novation. States should consider adopting the Assumption Reinsurance Model Act or other legislation that will safeguard the interests of policyholders.²⁵
- Public confidence in insurance and the integrity of the regulatory process requires that regulatory authorities strive to respond to LBRs as consistently as possible. Consideration should be given to developing a standardized regulatory review process through filing requirements, guidelines, protocols and best practices. The Pre-approval Checklist, Appendix 2, and On-going Regulation Oversight, Appendix 3, are examples of such regulatory guidelines.
- Interstate cooperation and communication are especially important. LBRs are likely to trigger the regulatory jurisdiction of more than one state and will be of interest to all states where affected policyholders reside. The domiciliary state of the parent or largest insurer involved in the LBR should coordinate activities among the states having jurisdiction over some aspect of the LBR, make basic information available to non-domiciliary states and respond to specific inquiries from non-domiciliary states as necessary.
- Policyholders should have an opportunity for direct participation in the LBR approval process. At a minimum, this should include notice to policyholders of the proposed LBR with an explanation of the LBR and its effect on policyholders, meaningful access to information about the LBR, and a public hearing that affords policyholders an opportunity to be heard. Meaningful access to information necessarily requires that policyholders be given access to information that may be sensitive and proprietary. The competing interests of the policyholders and the insurer in this regard should be balanced with appropriate measures such as protective orders or confidentiality agreements to allow policyholders access to such information while protecting the insurer's interests, in accordance with applicable public information laws.
- The review of all financial aspects of a proposed LBR culminate in a determination of the adequacy of capital and surplus. It should be demonstrated that each insurer in the group will have adequate capital and surplus to support its own liabilities and plan of operation. The capital facilities at the holding company level also should be reviewed for adequacy should a member of the group require additional capital infusions, guarantees or other support measures.
- A key regulatory consideration in evaluating an LBR is whether there will be an on-going parental or affiliate involvement with the restructured insurer after the completion of the LBR. This involvement may take many forms, including, but not limited to, overlapping management, capital and surplus guarantees, reinsurance agreements, cut-through provisions and investment yield guarantees. The form and extent of the involvement or support will depend on the structure of the LBR and the entities involved.
- Material exposures to asbestos, pollution and health hazard claims (APH) have been the motivating factor in recent noteworthy LBRs. The Working Group recommends that the NAIC request that the

²⁵ Arizona recently enacted Title 20, chapter 4, article 1, section 20-736 which requires policyholder consent or approval by the Director of Insurance of transfer or assignment of an insurer's direct obligations under insurance contracts covering Arizona residents.

Casualty Actuarial (Technical) Task Force consider documenting and evaluating the analytical techniques in use to estimate such long-tail exposures.

- The major LBRs that have generated concern and raised issues are a fairly recent development. The nature of future LBRs and their frequency remains to be seen. The NAIC should consider monitoring the evolution of these transactions in order to determine whether additional regulatory responses are necessary.

APPENDIX 1**Case Studies****Cigna Corporation Property and Casualty Division**

An intercompany reinsurance pooling arrangement existed between a substantial portion of the property and casualty insurance companies of Cigna Corporation. The lead company in the pool was the Insurance Company of North America (INA), a Pennsylvania-domiciled insurer.

For some years the pool's loss reserves experienced adverse development mainly from its 1986 and prior general liability policies which included APH and other long-tail liabilities. During 1994, A.M. Best downgraded the rating of the companies within the pool to B++. After a mini-restructuring in 1994 that created two separate intercompany reinsurance pooling arrangements, A.M. Best gave the pools two separate ratings, one being A- with developing implications, the other a B+ with negative implications.

To alleviate A.M. Best's and market concerns over the operations of Cigna, a second restructuring proposal was submitted to the Pennsylvania Insurance Department in October 1995. The restructuring plan called for the use of the Pennsylvania Business Corporation Law's division statute to divide INA into two companies. The two companies resulting from the division would be controlled by two separate holding companies. Simultaneously with the division, Cigna would amend its two pooling arrangements. The effect would be that the one resulting insurer, CCI (which would then be merged into Century Indemnity), would receive the 1986 and prior liabilities along with certain assets and be placed in run-off. The other resulting insurer, INA, would receive the remaining liabilities and assets, continue to write business and enter into a new intercompany reinsurance pooling arrangement with a substantial portion of the Cigna companies (active companies). As part of the restructuring, a capital infusion of \$500 million was contributed by Cigna Corporation to Century Indemnity. In addition, the active companies supported Century Indemnity through an \$800 million excess of loss reinsurance agreement and a \$50 million dividend retention fund.

The Pennsylvania Insurance Commissioner approved the division and changes to the intercompany reinsurance pooling arrangements. Seven other states, Texas, Ohio, Indiana, Illinois, California, New Jersey and Connecticut, approved changes in the intercompany reinsurance pooling arrangements and a change of control of certain insurers. The reorganization became effective on Dec. 31, 1995.

Restructuring of the Crum and Forster Group

Prior to the 1993 restructuring, the Crum and Forster Group, ultimately owned by Xerox Corporation, included 21 property and casualty insurance companies, five of which directly participated in an inter-affiliate pool. The lead company of the pool was United States Fire, which, along with affiliates Westchester Fire and Constitution Reinsurance, was domiciled in New York. International Insurance Company was the sole Illinois domestic participant in the inter-affiliate pool. International Surplus Lines, an Illinois domestic, ceded 100% of its business to International Insurance Company, so it was an indirect participant in the pool.

Following a preliminary restructuring in 1990 which included exiting from the standard personal lines market and other market-related action to improve on-going operational results, Xerox announced plans to

exit the financial services business. During the latter part of 1992, in preparation for the LBR, the group greatly strengthened loss reserves, after having suffered significant losses from Hurricanes Andrew and Iniki. Although the LBR was intended to enhance the salability of the insurance operations, an immediate goal was to realign the business into stand-alone company groups. Each group was to be dedicated to a particular purpose with greater management accountability and better focus.

The initial step of the LBR was to de-pool the group's operations. Seven separate operating groups were created: (1) Constitution Reinsurance – treaty and facultative reinsurance; (2) Coregis – professional liability, public entity and other property and casualty programs; (3) Crum & Forster Insurance – commercial property and casualty insurance through a select network of independent agents; (4) Industrial Indemnity – workers' compensation coverage and services; (5) The Resolution Group – reinsurance collection services and management of run-off businesses; (6) Viking – non-standard personal auto; and (7) Westchester Specialty Group – umbrella, excess casualty and specialty property business. To this end, various assumptive and indemnity reinsurance contracts were executed among the affiliates, and a stop loss contract was entered with Ridge Re, an affiliated reinsurer funded by the group's direct parent, Xerox Financial Services. Additional capital constituting \$235 million in cash and \$100 million in notes was contributed to the group.

The LBR received approval in the 15 states in which the 21 property and casualty insurance companies were domiciled. The primary states were New York, Illinois, California, and New Jersey. Initial discussions with the states began during the first part of 1993, and approval from all states was received by September 7 of that year. Regulators granted approvals to Form A exemptions, restatement of unassigned funds/quasi-reorganization, various reinsurance agreements, the merger of International Surplus Lines into International Insurance Company, various service agreements, and assumption certificates.

ITT Corporation

In 1992, the Connecticut Insurance Department approved a series of transactions through which ITT Corporation restructured its insurance business into discontinued and on-going operations. Effective Sept. 30, 1992, First State Insurance Company (FSIC) redomesticated from Delaware to Connecticut. Ownership of FSIC and its Connecticut domiciled subsidiaries, New England Insurance Company and New England Reinsurance Company, collectively referred to as the First State Companies, was transferred from Hartford Fire Insurance Company (HFIC) to ITT Corporation through an extraordinary dividend. Since Connecticut was domicile to FSIC and its subsidiaries, no other state was required to approve the transaction. All approvals were made pursuant to Connecticut's holding company act and notification was made to all states requiring notice regarding the discontinuation of writing new and renewal business.

The Home Insurance Group

Prior to mid-1995, the Home Insurance Company and five of its seven property/casualty insurance subsidiaries operated under a pooling agreement for the writing of commercial business. Following several years of losses, the Home's upstream parents, Home Holdings, Inc. and Trygg Hansa AB, entered into an agreement in principle in December 1994 with the Zurich Insurance Group to sell the Home Companies. The agreement virtually put the Home and its subsidiaries into run-off. The issues surrounding the acquisition and related transactions involved adequacy and funding of reserves, including asbestos and environmental, reinsurance, mergers and redomestications, and placement of renewal business. In addition, Home Holdings, Inc. had outstanding public shareholders and public bondholders.

New Hampshire, the domiciliary regulatory authority for the Home Insurance Company, coordinated a multistate review. Provisions of the modified agreement included a guaranteed investment rate of 7.5%, excess of loss reinsurance coverage of up to \$1.3 billion, deferral of servicing fees over cost, policyholder access to a Zurich company for new and renewal business, renewal fees paid by Zurich to fund interest on public debt, and the buyout of Home Holdings' publicly held capital stock. The states of New Hampshire, New York, New Jersey, Illinois, Indiana, California and Texas participated in approving all or part of the transaction, and all insurance subsidiaries except U.S. International Reinsurance Company were eventually merged into the Home Insurance Company in run-off. New Hampshire has maintained continual regulatory oversight since the transaction was approved in June 1995.

APPENDIX 2**Pre-Approval Checklist**

Following is a list of information and data that, if not included in the original filing, should be requested by the regulatory authority and considered in the review of an insurer's proposed LBR. This list should be used as general guidance and is not intended to be all inclusive. An LBR may be effected through various forms. The regulatory authority may find it necessary to request additional information, dependent upon the complexity of the proposal, the level of regulatory oversight warranted and other circumstances specific to the proposal or the insurer.

1. Narrative

A general written summary of the proposed LBR, explaining:

- a. Reasons for undertaking the LBR;
- b. All steps necessary to accomplish the LBR, including legal and regulatory requirements and the timetable for completing such requirements;
- c. The effect of the LBR on the insurer's financial condition;
- d. The effect of the LBR on the insurer's policyholders;
- e. The consequences if the LBR is not approved.

2. Business Plan

- a. On-going Operations
 - i. A listing of the insurer's major markets/products.
 - ii. A description of the insurer's strategy covering major markets/products and customers and the critical success factors for achieving these strategies.
 - iii. A description of the insurer's competitive positioning for each of its major markets/products and a discussion of growth potential, profit potential and trends for each.
 - iv. Identification and a discussion of the significant trends in the insurer's major markets/products, *e.g.*, demographic changes, alternative markets, distribution methods, *etc.*
 - v. Identification of the largest risk exposures of the insurer, *e.g.*, financial market volatility, environmental exposures, geographic distribution, *etc.*
 - vi. A description of the major business risks of the insurer, *e.g.*, sales practices, data integrity, service delivery, technology, customer satisfaction, *etc.*
- b. Run-off Operations
 - i. A description of all plans regarding any run-off operations.

3. Financial Information

- a. Historical financial statements, including the most recently filed annual and quarterly statutory statements.
- b. Financial statements (in a spreadsheet format) detailing the accounting of the proposed LBR including:
 - i. Schedules detailing assets and liabilities to be reallocated as part of the LBR.
 - ii. An accounting of any special charges, reevaluations, or write-downs to be made as part of the LBR.
- c. Pro-forma financial statements of the insurer(s) as if the LBR were approved including an explanation of the underlying assumptions.
- d. Financial projections for three years (assuming the LBR is approved) for both the run-off and on-going entities and an explanation of the assumptions upon which the projections are based.
- e. A description of any tax consequences of the LBR.

4. Analysis of Reserves

Retain qualified independent actuarial experts.

- a. The actuarial expert should perform a “ground-up” actuarial review of case and incurred but not reported reserves for asbestos, pollution, health hazard and other long-tail claims.
- b. The actuarial expert should also opine on:
 - i. Methodologies used by the insurer to estimate reserves.
 - ii. The adequacy of reserves on a gross and net of reinsurance basis.
 - iii. The adequacy of the expertise of the insurer’s claims unit.
 - iv. The insurer’s economic approach to funding the run-off liabilities, including cash flow model stress tests.
 - v. If reserve discounting is permitted, funding of the discount and the adequacy of reserves net of discount.

5. Analysis of Reinsurance

- a. An analysis of reinsurance recoverables by a qualified expert including:
 - i. A review of the process used to monitor, collect and settle outstanding reinsurance recoverables.
 - ii. An analysis of existing and projected reinsurance balances including the expected timing of cash flows.
 - iii. An analysis of the quality and financial condition of the reinsurers and prospects

- for recovery.
 - iv. A detailed description of write-offs or required reserves based on the independent analysis taken as a whole.
 - v. Disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes.
 - vi. A discussion of the impact of the LBR on the collectibility of reinsurance balances.
- b. A legal analysis of the effect that a rehabilitation or liquidation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and on the legal rights of the reinsurers to claim setoffs against such recoveries.
 - c. If reinsurance stop loss or excess of loss coverage is an integral part of the transaction, a copy of such agreement and a written opinion from a qualified expert as to:
 - i. The adequacy of coverage;
 - ii. The ability of the treaty to perform as anticipated and be unaffected by delinquency proceedings;
 - iii. The practical operation of the treaty;
 - iv. The timing and method of payment of reinsurance premium;
 - v. The financial condition of reinsurers;
 - vi. The sufficiency of coverage and other resources.
 - d. A discussion of existing or proposed reinsurance programs, whether with affiliates or other reinsurers, to assist the regulatory authority in determining that provisions are consistent with other information provided and that adequate coverage exists for both on-going and run-off operations.
 - e. Any proposed amended, cancelled, or new pooling agreements, including explanations of significant differences before and after the restructuring, flowcharts to demonstrate the proposed movement of business, and the anticipated financial impact upon the affected companies.

6. Analysis of Liabilities Other Than Reserves

An analysis of material liabilities other than reserves, including a discussion about any reallocations or dispositions as part of the LBR, especially as they relate to reinsurance agreements and inter-company cost and tax-sharing agreements. The analysis should include all non-reserve related accruals and outstanding debt line items found on the Property/Casualty Annual Statement (page 3) for liabilities, including write-ins.

7. Analysis of Assets

An analysis should be performed to determine if existing assets and future cash flows are sufficient to fund liabilities. This analysis should include:

- a. Disclosure of assumptions regarding the assets of the insurer(s) involved in the LBR,

especially those assets with high volatility, liquidity uncertainties, material valuation issues, or representing a material percentage of the invested asset portfolio.

- b. Current appraisals of any material real estate or mortgage holdings, independent valuation of limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other assets of concern.
- c. A list of assumptions used by the insurer(s) as to investment yield, and disclosure of the effect that the reallocation of assets will have on historical investment yields.
- d. If the asset analysis performed by the insurer indicates a potential asset/liability matching problem, documentation that the insurer plans to take action such as:
 - i. Reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk.
 - ii. Securing a parental guarantee of investment yield.
 - iii. Securing a parental guarantee of asset valuation or a parental agreement to substitute the insurer's assets.
 - iv. Disposing of assets prior to approval of the LBR.

8. Parental Support

- a. The plan should provide for the provision of financial and managerial support by the parent company to all entities.
- b. The plan should provide for a commitment of parental support to run-off operations in the event of:
 - i. Inadequacy of reserves;
 - ii. Asset deterioration;
 - iii. Deterioration in the collectibility of reinsurance recoverables.

9. Organizational Impact

- a. The plan should affirm that the restructured entity was either licensed or an approved surplus lines carrier in all jurisdictions in which it wrote business, and will be licensed in all jurisdictions where it takes on business as a result of the restructuring.
- b. Analysis of the change in organizational structure resulting from the transaction. Areas to emphasize include:
 - i. Ownership of the resulting corporate structures;
 - ii. relation between management of the resulting entities;
 - iii. Substantial reinsurance arrangements between resulting entities;
 - iv. Other on-going business ties between the resulting entities.

10. Analysis of Issues Affecting Policyholders

- a. Consider whether to require that “cut-through” provisions be put in place for policyholders of the weaker entity.
- b. Obtain a legal opinion that policyholders of restructured entities will not lose guaranty fund coverage as a result of the LBR.
- c. Hold discussions with affected guaranty funds and National Conference of Insurance Guaranty Funds (NCIGF) regarding any coverage issues.
- d. Consider whether to require that a mechanism be put in place to obtain policyholder consent regarding any novations.

APPENDIX 3 ON-GOING REGULATORY OVERSIGHT

The following are examples of conditions and requirements for on-going regulatory oversight of an LBR.

- Reporting
 - Require periodic operating reports.
 - Require financial statements and management reports more frequently than required by statute.
 - Require periodic reports on certain losses, including payments.
 - Require financial projections annually.
 - Require reports on actual results compared to plans.
- Balance Sheet Discipline
 - Require recurring actuarial reviews of reserves. This requirement could include departmental approval of the actuarial firm selected and the scope of the review.
 - Require periodic independent reviews of reinsurance recoverables.
 - Establish guidelines for future investments of inactive operations.
 - Limit discounting of reserves as allowed by law, so long as investment earnings continue to support the rate of discount.
- Specific Transactions
 - Prohibit dividends by inactive operations without prior approval.
 - Prohibit dividends by active operations for a set period of time.
 - Require creation of a dividend “sinking fund,” with contributions from inactive operations requiring regulatory approval and payments to be made from the principal amount. The fund would be maintained in a separate account and could not be terminated without prior written approval from the regulatory authority.
 - Require intercompany balances with the inactive operations be settled within 90 days of each quarter.
 - Require prior approval of affiliated transactions between inactive and active operations.
 - Require prior approval for inactive operations to establish security deposits with any

other jurisdictions except to the extent required by law.

- Communications
 - Require notice to all known policyholders and claimants affected by the transaction.
 - Require a written response to any inquiry regarding the LBR.
- General Monitoring
 - Require on-site monitoring facilities.
 - Require right to notice of and right to attend all Board of Directors meetings.

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Alternative Mechanisms for Troubled Companies

An NAIC White Paper

February 2010

**Created by the
NAIC Restructuring Mechanisms for Troubled Companies Subgroup
of the Financial Condition (E) Committee**

Drafting Note: This white paper is limited to situations where the legal entity is in a financially troubled condition that could potentially lead to an insolvency in the foreseeable future. It will not consider situations where the insurer is merely inconvenienced by a particular book of business.

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I. INTRODUCTION

A. BACKGROUND/PURPOSE

State insurance regulators have well-developed receivership statutes, practices, and procedures to handle impaired and insolvent insurers. These statutes, practices, and procedures serve, first and foremost, the goal of consumer protection. They are a critical and essential part of the Regulatory Solvency Framework. However, given improvements in regard to the early detection of financially troubled insurers and insureds' requirements for A-rated coverage, a new landscape has emerged with a growing number of troubled insurers seeking to engage in mechanisms of run-off or restructuring as an alternative to being placed in traditional receivership proceedings. For example, as of mid-year 2008 alone, there were approximately 129 active insurers in voluntary run-off domiciled in the United States with over \$36 billion in claims in progress. As a result of a changing landscape and the fact that the NAIC has little formal documentation available to regulators dealing with alternative mechanisms for winding-down troubled companies, the Receivership and Insolvency (E) Task Force during 2007 began drafting charges to undertake a study of alternative mechanisms and relative best practices. These charges were presented to the Financial Condition (E) Committee during the 2007 NAIC Winter National Meeting. The Committee members supported the charges, but felt the topic of active troubled insurers required the expertise and perspective of regulators involved in the active solvency monitoring process, as well as receivership process. Thus, a Restructuring Mechanisms for Troubled Insurers Subgroup was formed directly under the Committee with regulators representing both perspectives. The Subgroup's 2008 adopted charges were as follows:

Undertake a study of alternative mechanisms, such as solvent schemes of arrangement, solvent run-offs, and Part VII portfolio transfers (a transfer leaving no recourse to original contractual obligor/insurer) and any other similar mechanisms to gain an understanding of:

- i. How these mechanisms are utilized and implemented.
- ii. The potential effect on claims of domestic companies, including the consideration of preferential treatment within current laws.
- iii. How alien insurers (including off-shore reinsurers) who have utilized these mechanisms might affect the solvency of domestic companies.
- iv. Best practices for state insurance departments to consider if utilizing similar mechanisms in the United States and/or interacting with aliens who have implemented these mechanisms.

The study is documented in the form of this NAIC white paper. Additionally, the study was limited to situations where the legal entity was in a financially troubled condition that could have potentially led to an insolvency in the foreseeable future. The Subgroup did not consider situations where the insurer was merely inconvenienced by a particular book of business or wished to exit the insurance business for reasons unrelated to solvency.

B. AUTHORITY & APPLICABILITY

The information in this white paper is meant to provide guidance to state insurance regulators and be an advisory resource. It discusses approaches and concepts that are available within and outside the United States in order to assist regulators with assessing possible alternatives for handling troubled insurers. Mechanisms discussed in this white paper may not be available or applicable in all jurisdictions due to differences in statutes, regulations, and implementing tools and resources, as well

as changing market conditions. In fact, statutes and regulations that define the authority and duties of regulators may require, or provide for, specific procedures to be implemented in certain circumstances. In addition, although this white paper was intended to generally apply to all risk-assuming entities that are subject to the authority of the insurance department, the majority of the Subgroup's discussion was focused on property/casualty insurance companies. Due to their unique characteristics, the mechanisms mentioned in this white paper, may not be appropriate in the context of life, health, or other personal lines of insurance for which guaranty association protections are available, or for certain types of specialized risk-assuming entities (e.g., health maintenance organizations, syndicates, risk retention groups, chartered purchasing groups, chartered self-insured groups or pools, captives, insurance exchanges, etc.). Lastly, an appropriate mechanism for a particular troubled insurer will also depend on the specific circumstances of the situation.

C. OTHER CONSIDERATIONS

As state insurance regulators consider the relative advantages and disadvantages of these alternative mechanisms, they should do so in the context of the overall policy objectives behind each alternative. Different policy objectives will inevitably lead to very different results. The current system that utilizes liquidation and provides for guaranty fund protection for certain policyholder claims reflects a legislative policy that places the rights of policyholders and claimants above the interests of other creditors of the insolvent company. While these laws may vary somewhat from state to state, they share several key features. The interests of policyholders and claimants are granted priority over claims brought by other insurers, the government, and general creditors. The laws seek to preserve, to the greatest possible extent, the insurance protection that the policyholder believed he/she was getting when he/she purchased his/her policy from the now-insolvent insurer. The law treats all similarly situated claimants in the same manner, thereby prohibiting preferential treatment for certain favored individuals or entities. Finally, they preserve, in some meaningful form, the right of judicial review. These elements form the foundation of the existing system that exhibits a clear legislative choice to place the interests of consumers above the interests of investors and large institutions that are better equipped to withstand the losses resulting from insurer insolvency.

II. GENERAL ADVANTAGES AND DISADVANTAGES FOR UTILIZING ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

A. ADVANTAGES

- Alternative mechanisms can be useful tools for a troubled insurer's management and regulators, potentially leading to a quicker resolution than a traditional receivership.
- Alternative mechanisms typically allow for continuous claims payments, or at least orderly claims processing and partial claims payments without interruption.
- Alternative mechanisms can cost less than receiverships, thus resulting with maximum dollars paid out to policyholders/claimants.
- Alternative mechanisms may allow greater flexibility to achieve commercially acceptable results, such as freeing up capital.

B. DISADVANTAGES

- The inherent risk for consumer and claimant issues increases, requiring stronger regulatory monitoring and controls for protection. For some alternative mechanisms, there is no guarantee that appropriate fairness will take place.
- Alternative mechanisms for troubled insurers might become a tool for solvent carriers to transfer value away from policyholders.
- As to reinsurance, restructuring might affect the value of the future reinsurance claim or offset rights, arbitration rights, and reinsurance collateral.
- The cost of efficiency or company enticements may come at the expense of policyholders or insureds.
- Difficult decisions arise with a troubled insurer that is not clearly solvent or insolvent, and significant ramifications could follow with certain choices.
- Companies may seek to continue run-off or restructuring activities even after it becomes clear that the company is hopelessly insolvent, resulting in preferential payments made at the expense of outstanding claims.
- Compensation incentives may restrict future claims-paying ability.
- Voluntary restructuring schemes may deny policyholders and consumers the substantive and procedural safeguards otherwise available for their protection in court-supervised receivership proceedings.
- Run-off and restructuring schemes may be used to circumvent state priority and preference rules in order to discount claims at the expense of policyholders and other claimants. They may also be used to circumvent other consumer protection laws, including state receivership and guaranty association laws as well as commutation and assumption transfer laws.
- May allow the company to terminate coverage and extinguish liabilities over the objections of policyholders and other creditors by majority cram-down vote.
- Run-offs and restructuring schemes may result in substantially reduced payments to policyholders. State receivership laws typically require a showing that a rehabilitation plan is fair and equitable, complies with priority rules, and provides no less favorable treatment of claims than would occur in liquidation. Run-offs and alternative mechanisms, such as

those addressed herein, may have the ability to sidestep these equitable standards and permit broad discretion in discounting claim values. In fact, the success of a plan may be dependent on the ability to impose deep discounts on claims, and there may be no rules or mandatory standards in place to protect policyholders or claimants.

- There is a risk that similarly situated creditors will be treated differently or that they will receive payments that are less than they would receive in an insolvency proceeding.
- Alternative mechanisms adopted in any given state may not be enforceable across state lines, leaving the company at risk of further exposure, litigation, and ongoing collection activity that may disrupt efforts to implement a restructuring plan.
- Alternative mechanisms are not appropriate for compromising the claims of consumer policyholders due to lack of sophistication and the existence of extensive consumer protections built into insolvency laws.
- In the absence of strong regulatory involvement, there is a risk that policyholders and creditors will not receive adequate or accurate information on which to base their decisions.
- The interests of management may not be the same as the interests of policyholders and creditors.

III. TYPES OF ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

MECHANISMS AVAILABLE TO INSURERS WITHIN THE UNITED STATES AND RELATED TERRITORIES

A. RUN-OFF OF TROUBLED INSURER

1. DESCRIPTION

A troubled company run-off is usually a voluntary course of action where the insurer ceases writing new business on all lines of business, but continues collecting premiums and paying claims as they come due on existing business. Due to state cancellation laws, the insurer may be required to renew business, which can be particularly challenging for insurers running-off personal lines risks. The insurer may seek to run-off business in the traditional sense—paying claims in full in the ordinary course of business—or management of the insurer might seek to end or limit their exposure on insurance business before policy terms expire by utilizing reinsurance, assumption transfers, negotiated settlements, and/or voluntary policy commutations. These transactions should not have a negative impact on policyholders, as close regulatory monitoring is normally maintained throughout the process. The goal is to completely close operations while remaining solvent.

In order to succeed in run-off, assets and income must be maintained at sufficient levels to cover the remaining claims and administrative costs of handling those claims. However, solvent run-offs may have little revenue other than investment income, and run-offs may develop into insolvencies that could require receivership proceedings—for example, if the insurer is unable to collect reinsurance, makes errors in estimating recoverable assets, experiences a decline in asset values and investment income, and/or encounters other cash flow issues at any point in the process.

Although run-off mechanisms can generally be applied to property/casualty, life, health, title, or fraternal insurers, it is of general consensus that personal lines should not be included in any commutation plan incorporated as a component of any run-off plan.

a. STATUTORY BASIS FOR SUPERVISED RUN-OFF PLANS

Run-off of a troubled company may be subject to regulatory supervision under applicable state law. (See, e.g., NAIC Risk-Based Capital (RBC) For Insurers Model Act, Section 6.B(2).) Regulatory supervision of a troubled company run-off may be triggered in order to enhance the regulatory oversight and monitoring of the financial performance, consumer protections, and market conduct related to implementation of the run-off plan. Enhanced regulatory oversight may include increased financial and regulatory reporting requirements, regulatory approval of transactions and claim settlement practices, and on-site regulatory supervision. Supervision of the run-off plan is conducted in order to ensure that policyholders, consumers, and other creditors fare no worse under the run-off plan than in receivership.

For example, the Illinois Insurance Code, based on the NAIC Model Act, provides the Illinois Director of Insurance with a discretionary alternative mechanism for handling troubled property and casualty companies and health organizations whose RBC Reports indicate a mandatory control level event. Section 35A-30(c) of the Illinois Insurance Code, 215 ILCS 5/35A-30(c), provides:

In the case of a mandatory control level event with respect to a property and casualty insurer, the Director shall take the actions necessary to place the insurer in receivership under Article XIII or, **in the case of an insurer that is writing no business and that is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Director.** (Emphasis added)

A mandatory control level event is defined under the statute as an RBC Report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC. Under this statutory mechanism, if there is a mandatory control level event at a company that has ceased writing new business and the company is engaged in a voluntary run-off, the Director has the discretion to either seek a receivership order or to allow the company to continue its run-off under the Director's supervision.⁶⁸ In order to persuade the Director to exercise the supervised run-off option, the company must prepare and present a comprehensive run-off plan, including financial projections, that establishes that the plan is viable, that there is a high probability that the run-off can be conducted without putting policyholders at greater risk, and that all claim obligations will be satisfied.

The specific content of the run-off plan may vary depending upon the nature of the business being run-off and the financial circumstances of the troubled company. (See a sample outline for a run-off plan at VII. *Appendix C*.) However, the primary goals of the plan should include and achieve consumer protection, satisfaction of all policyholder obligations, and the maintenance of positive surplus and sufficient liquidity. Typically, the components of such a plan would include substantial cost-cutting measures, commutations of reinsurance agreements, collection of outstanding premium, recovery of statutory deposits, policy buy-backs, novations, and claim settlements.⁶⁹ A key element of such a plan would be a discussion of the benefits to the policyholders of a run-off rather than a receivership, including the impact of any state guaranty fund or guaranty association coverage.

The nature and scope of the Director's supervision may be delineated in a comprehensive corrective order, which would include and reference such things as the run-off plan, periodic reporting requirements, on-site monitoring, procedures relating to the approval of transactions, claim settlement practices, and other related matters. The corrective order, which may be amended from time to time, would likely be confidential under state law. Because the company is involved in a supervised run-off, it may be appropriate to negotiate certain adjustments (e.g., discount reserves, allow prepaid expenses, remove schedule F penalty) to its statutory financial statements, but, as adjusted, the financial statements should still comply with Generally Accepted Accounting Principles. Any such adjustments should be based upon credible forecasts and other available information.

⁶⁸ Section 35A-30(d), 215 ILCS 5/35A-30(d), of the Illinois Insurance Code provides the Director with a similar supervised run-off option with respect to troubled health organizations.

⁶⁹ In 2005, the Illinois voidable preference statute was amended to provide that in the case of a company involved in a supervised run-off, a transaction involving transfer of cash or other assets by the company (buy-back, settlements, etc.) that was approved by the Director in writing cannot later be found to constitute a voidable transfer, 215 ILCS 5/204 (m)(C). This provision provides policyholders and other parties to buy-back, novation, commutation and other approved transactions with protection from the voidable preference statute in the event that the company ultimately goes into liquidation. In the absence of this protection, policyholders and others may be reluctant to enter into such transactions.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Voluntary run-offs may enable commercial parties to achieve commercially acceptable results in arm's-length transactions that reflect customary market practice.
- Timely defense and payment of policyholder claims in full not otherwise always covered by guaranty funds or associations.
- Potentially more favorable environment for the negotiation of disengagement transactions and commutations with reinsurers.
- Continuity of management information systems.
- Some business entities may be willing to acquire insurance companies in run-off and inject additional capital or reduce overhead expense. This consolidation and management expertise could provide some efficiency for regulators in regard to their monitoring processes.
- Typically involve commutations and other solutions reflective of the consent of the contracting parties.
- There is evidence that it appears to be a robust method, given that there are accumulators of seasoned run-off companies.
- Strategic decisions can be made quickly and efficiently working with appropriate state regulators.

DISADVANTAGES

- Preferential treatment issues might arise when dealing with business-to-business structures, if both large and small policyholders exist, as deals tend to focus on settling with large carriers first. In addition, more complicated commutations may be structured in the run-off plan to be handled last.
- Preferential payments may arise with respect to creditors whose priority of payment in the event of liquidation would be classified below that of policyholder and consumer claims.
- Policyholders and consumers may be compelled to accept less than the fair value of their claims.
- Potential negative impact of adverse claim development.
- Attempts to commute or settle with policyholders (complete policy buy-backs) can result in reinsurers resisting payment.
- To the extent the estate assets are reduced by paying claims earlier, the estate assets remaining to pay remaining policyholder and guaranty association claims will be reduced, costing the industry more.
- Larger insureds may have better leverage to negotiate better settlements.
- Absent regulatory oversight—there is no guarantee that settlements will be at consistent or even fair levels.
- The absence of court oversight and mandatory rules and standards (such as priority rules and rehabilitation plan standards) increases the likelihood that policyholder claims will be sharply discounted and that bargained-for benefits and protections will be lost.
- Guaranty funds may be disadvantaged in a subsequent receivership if non-guaranteed creditors were paid more than the ultimate distribution from the receivership.

B. NEW YORK REGULATION 141

1. DESCRIPTION

In 1989, at the request of the New York Superintendent of Insurance, the New York Legislature enacted New York Insurance Law § 1321. Section 1321 authorized the Superintendent to permit an impaired or insolvent New York domestic insurer (or an impaired or insolvent United States branch of an alien insurer entered through New York) to commute reinsurance agreements to eliminate the company's impairment or insolvency.

Until the Legislature enacted NYIL § 1321, commutation agreements with troubled New York domestic insurers were subject to challenge as potential preferences pursuant to the Insurance Law's voidable transfer provisions. When the Legislature enacted Section 1321, it extended the voidable transfer period from four to 12 months (NYIL § 7425(a)). The Legislature also amended the insurance law to provide that commutation agreements executed pursuant to NYIL § 1321 "shall not be voidable as a preference" (NYIL § 7425(d)).

Section 1321 required that any commutation proposed under the new statute be approved by the Superintendent "in accordance with standards prescribed by regulation." In 1990, the acting New York Superintendent promulgated Regulation 141 (Regulation No. 141, Commutation of Reinsurance Agreements, N.Y. Compo Codes R. & Regs. tit. 11, Section 128 (1989) (11 NYCRR Section 128)). Regulation 141 sets out the "applicable standards that the superintendent will use in determining whether such commutations entered ... will be approved."

Regulation 141 applies to all New York-domiciled insurers (and U.S. branches) "other than a life insurance company" as defined in NYIL § 107(a)(2). However, the regulation excludes impaired or insolvent life insurers and solvent insurers. The Regulation sets out how a troubled insurer may propose and implement a Regulation 141 plan. Among other things, the Regulation's procedures add the requirement that any company seeking the benefits of Regulation 141 must stipulate that the troubled insurer will consent to an order of rehabilitation or liquidation if its proposed commutation plan does not restore policyholder surplus to the required minimum amounts (or such surplus as the Superintendent deems adequate).

The troubled insurer must provide the New York Department with a draft commutation agreement and a proposed commutation offer that will be extended to "each and every ceding insurer to which the impaired or insolvent insurer has obligations." The reinsurer must also provide a balance sheet showing both the insurer's impairment or insolvency as determined by the Superintendent and a pro forma balance sheet reflecting the troubled company's financial condition subsequent to the plan's implementations.

The proposed commutation offer must include an offer to pay a percentage of the cedent's losses. The impaired insurer must advise its cedents that the commutation offer remains subject to the Superintendent's determination that the total of all accepted commutation offers has restored policyholder surplus either to a statutory minimum or an amount that the Superintendent deems adequate.

Regulation 141 requires that offers to commute assumed reinsurance obligations be made to "each and every ceding insurer to which the impaired insurer or insolvent insurer has obligations." The Regulation broadly defines the term "obligations" to include paid losses, loss reserves, incurred but not reported (IBNR), all loss adjusting expenses (paid, case, and IBNR), reserves for unearned premiums, and "any

other balances due under the reinsurance agreements.” The terms of all proposed commutation agreements must be the same.

For example, the same discount must be offered to each cedent—e.g., 90% of paid losses, 60% of case reserves, and 30% of IBNR. No cedent may be favored with different discounts. Discounts for different lines of business may be proposed, but these discounts must be “reasonable, actuarially sound, and supported by documents justifying such a variance.” To date, none of the Regulation 141 plans approved by New York Superintendents of Insurance has incorporated different discounts by line of business.

Any proposed Regulation 141 plan submitted to the Superintendent must include an exhibit setting forth the obligations due each cedent to which the troubled company has obligations and the consideration (commutation offer) to be paid each cedent. Within 10 days of the plan’s approval, the troubled company must deliver its proposed commutation agreements to its cedents. No cedent may be compelled to commute its “obligations.” The terms of the proposed commutations and the amount offered “shall not be subject to negotiation.” Each cedent makes its own determination with respect to whether the cedent wishes to accept the proposed commutation or refuse to commute and run the risk that the Regulation 141 plan will not succeed.

The results of an approved plan must be returned to the Superintendent within a period specified by the Superintendent. The plan results must include: copies of all executed commutation agreements; copies of all rejected commutation agreements; “correspondence pertaining to all ... offers made to the ceding insurers”; a pro forma balance sheet showing the effect of the accepted/rejected offers; any other components of the plan to restore surplus to policyholders; and copies of any agreements that modify, commute, or assign any retrocession agreements.

If the Superintendent determines that the proposed commutation agreements and any other plan components sufficiently restore policyholder surplus, the commutation agreements take effect. The Superintendent may specify, when he or she approves the Regulation 141 plan, that cedents that agree to commute be paid within so many business days.

If the Superintendent determines that surplus has been restored, the Superintendent may proceed against the troubled company armed with the company’s stipulation consenting to entry of any order of rehabilitation or liquidation.

The primary procedural safeguards for an approved Regulation 141 plan include: the state regulator’s full discretion to accept, reject, or modify any proposed plan; explicit requirements that the same commutation terms be offered to every ceding company whose obligations appear on the troubled company’s books and records; the absence of any “cram down” provisions that would allow the Superintendent to approve the commutation of a cedent’s contracts over a cedent’s objections; time-frames for the submission of a plan and payment of agreed commutation amounts within days after the plan’s results have been approved; and provisions calling for the preservation and production of all communications between the troubled company and its cedents.

In addition, and as previously noted, the commutation agreements executed pursuant to an approved Regulation 141 plan will not take effect “unless ... the plan shall eliminate the insurer’s impairment or insolvency” and restore surplus to policyholders to levels required under the insurance law or an amount that the Superintendent deems “is adequate in relation to the insurer’s outstanding liabilities or financial needs.”

Although the troubled company’s directors must consent to an order of rehabilitation or liquidation if the company’s surplus has not been restored to the required minimum, the Superintendent need not consider any plan proposed pursuant to Regulation 141 “in lieu of taking any other action” against the company. This gives the Superintendent full discretion to decide whether to allow the troubled company to propose a plan or to take other action against the company, including supervision, rehabilitation, or liquidation.

Thus far, three professional reinsurers have successfully implemented New York Superintendent-approved commutation plans pursuant to Regulation 141: 1) Rochdale Insurance Company; 2) Paladin Reinsurance Company; and 3) Constellation Reinsurance Company. In addition, the Insurance Company of the State of New York (INSCORP) obtained the Superintendent’s approval for a Regulation 141 plan and submitted its commutation plan results to the Superintendent. However, as a result of the continued adverse development, INSCORP’s policyholder surplus could not be improved to an acceptable level, and INSCORP was placed in rehabilitation.

See *VII. Appendix D – Reference List of NAIC Model Laws and State Selected Related Statutes* for review of the Regulation.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- No cedent can be outvoted and compelled to accept a commutation offer.
- All communications to and from the ceding insurer must be preserved and provided to the regulator.
- Although the regulation was designed for professional reinsurers, the plan also works if the troubled insurer is engaged in assumed reinsurance and also wrote direct business.
- No court approval is required.
- The plan must show how the proposed commutations will affect its retrocessional program, thus reducing the risk that the commutation plan will bind or negatively affect retrocessionaires.
- The Superintendent has ultimate oversight, flexibility, and control, to the extent that the Superintendent may approve, disapprove, or modify a plan, and the Superintendent may also review all the communications exchanged relating to the offer to ensure that no unfair offsets were arranged or that offers to commute did not otherwise favor or disfavor particular cedents.
- Regulation 141 also allows for other components to be added to the plan to restore policyholder surplus, including surplus notes and capital contributions.

DISADVANTAGES

- As an offer under this regulation is based on the assuming reinsurer’s books at a given date, discrepancies between the ceding and assuming insurers’ books are likely to occur.
- Timing could become problematic if the regulator does not enforce strict deadlines regarding the consideration and execution of offers.
- Regulation 141 does not require an audited balance sheet to confirm the extent of the troubled insurer’s financial condition.
- Many subjective considerations must be used by the troubled insurer to determine in advance what percentage of approval is needed for the plan to work.

C. RHODE ISLAND STATUTE AND REGULATION FOR VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS

1. DESCRIPTION

Rhode Island's Title 27, Chapter 14.5⁷⁰ provides for voluntary restructuring of solvent insurers. The statute was intended to provide an alternative to a traditional run-off by bringing "solvent schemes of arrangement" (which are discussed further in the next section) to the United States. It allows solvent companies that are in run-off to reach a court-ordered (and department of insurance supervised) agreement with all of its creditors in order to accelerate completion of the run-off, bringing certainty of payment to creditors and reducing administrative costs often associated with lengthy run-offs.

The statute sets forth a structure for court-ordered review, approval and implementation of what the statute refers to as a "commutation plan." The process may only be utilized by reinsurers and commercial property and casualty insurers domiciled in Rhode Island and in run-off (R.I. Gen. Laws § 27-14.5-1(6)). In addition, the insurer must be solvent and adequately reserved in accordance with all applicable Rhode Island statutes and regulations, as well as in compliance with all other department solvency standards.

A company considering the process must first prepare and submit their proposed commutation plan to the insurance department for review⁷¹ (Insurance Regulation 68(4)(a)(i)). A commutation plan is very broadly defined as a plan for extinguishing the outstanding liabilities of a commercial run-off insurer. After the plan is reviewed by the department and all issues are resolved, the company may apply to the court for an order agreeing to classes of creditors and calling for a meeting of creditors (Insurance Regulation 68(4)(a)(iii)). At this point, the company is required to give notice of the application and proposed commutation plan to all parties pursuant to fairly broad requirements set forth in the statute (R.I. Gen. Laws §§ 27-14.5-3 and 27-14.5-4(b)(1)).

All creditors and interested parties (such as Guaranty Funds) are granted full access to the plan and all information related to the plan. Both creditors and interested parties are given an opportunity to file comments or objections to the plan with the court (R.I. Gen. Laws § 27-14.5-4(b)(3)). Ultimately, all creditors must be given an opportunity to vote on the commutation plan, and approval of the plan requires consent of at least i) 50% of each class of creditors, and ii) the holders of 75% in value of the liabilities owed to each class of creditors (R.I. Gen. Laws § 27-14.5-4(b)(4)). However, it is important to note that only the claims of creditors present or voting through proxy at the meeting of the creditors are counted toward determining whether the requisite majorities have been achieved. (See Insurance Regulation 684(e)(i).)

Upon approval of the commutation plan by the creditors, the company must petition the court to enter an order confirming the approval and allowing implementation of the plan (R.I. Gen. Laws § 27-14.5-4(c)(1)). The implementation order must enjoin all litigation in all jurisdictions between the applicant and creditors, as well as release the applicant of all obligations to its creditors upon payment

⁷⁰ The Rhode Island statute was adopted in 2002 and amended in 2007. See R.I. Gen. Laws § 27-14.5-1 *et seq.*, "Voluntary Restructuring of Solvent Insurers," and R.I. Insurance Regulation 68 (Commutation Plan regulations).

⁷¹ Plan approval is done by the court; however, the department has the statutory authority to intervene in any proceeding brought under this statute. According to the Rhode Island Division of Insurance Regulation, it is highly unlikely that the court would approve a plan over the Division's objection.

of the amounts specified in the plan (R.I. Gen. Laws § 27-14.5-4(c)(2)). The court may only issue an implementation order if it determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders (R.I. Gen. Laws § 27-14.5-(c)(1)(ii)). The court does have a responsibility to ensure that all policyholders and creditors have been treated fairly. Once the implementation order is entered, distribution to creditors may begin.

After implementation and upon completion of the commutation plan, the court can issue an order of discharge or dissolution. As a result of this order, the company is either i) dissolved or ii) discharged from the proceeding without any liabilities. At this point, any residual assets are distributed to the company owners (R.I. Gen. Laws § 27-14.5-4(d)).

One of the key aspects of the process is that the court's implementation order releases the insurer from all obligations to its creditors upon payment of the amounts specified in the commutation plan. This brings about a court-ordered finality to the run-off that would not be possible utilizing traditional run-off options. To this end, the order actually binds the insurer and all of its creditors and owners, whether or not a particular creditor or owner is affected by the plan or has accepted the plan, or whether or not the creditor or owner ultimately receives money under the plan. The order is also binding whether or not creditors had actual notice (R.I. Gen. Laws § 27-14.5-3(b)).

It is also important to note that because the restructuring mechanism provided for by the statute would not be appropriate or practical for companies with a large number of small creditors with very diverse interests, the statute is restricted to use by reinsurers and commercial property and casualty insurers. It includes express limitations on the lines of business that can be included in a commutation plan, and specifically excludes all life insurance, workers' compensation and personal lines (See R.I. Gen. Laws § 27-14.5-1(21)). However, in cases where a company does have excluded lines, the statute provides for a bifurcated process for disposing of all lines of business within the context of the run-off scheme. Commercial lines would be included in the commutation plan, and, if possible, excluded lines would be transferred to an eligible insurer through court-ordered and department-sanctioned assumption reinsurance (See R.I. Gen. Laws § 27-14.5-1(6) and R.I. Gen. Laws § 27-14.5-4(d)(2)(ii)). Again, the process is available only to solvent companies—the theory being that the restructuring would permit all liabilities to be paid in full.

The definition of "Commercial Run-off Insurer" under the statute was expanded by amendment in 2007 to include companies newly formed or re-activated under Rhode Island law solely for the purpose of accepting transferred business for restructuring pursuant to the statute (See R.I. Gen. Laws § 27-14.5-1(6)). The purpose of this amendment was to expand the population of insurers that might qualify for the process. The amendment permits an insurer to transfer some or all of its commercial liabilities (a very controversial process) to a newly formed run-off entity for the sole purpose of implementing a commutation plan pursuant to the statute. The original insurer would be allowed to continue writing business with no further obligations under the transferred policies. Any such transfer would require prior approval of the department.

Since the statute's enactment in 2002, no insurer has availed itself of the statute, and no other U.S. state has adopted a similar law.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Might provide a better solution for policyholders and investors than traditional run-off options (creditor democracy).
- Provides certainty of payment to creditors of present and future claims.
- Avoidance of a lengthy run-off with the associated ongoing administrative costs, adverse claim development and deteriorating reinsurance collections.
- Provides certainty of payment by reinsurers.
- Accelerated release of capital to shareholders at the conclusion of the process, allowing for more efficient deployment of capital to non-run-off operations.
- Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism for these companies will create an active market for investment in run-off companies.

DISADVANTAGES

- Permits an insurer to terminate coverage and extinguish liabilities over the objections of policyholders and creditors who are in the minority.
- Creditors are bound by the plan whether they had notice or not, and only those present or voting through proxy are counted toward establishing the requisite majority, which may create incentives to manipulate notice (though the department and court could take steps to prevent such manipulation).
- Although the process is limited to solvent insurers and the intent therefore is that full value will be paid to all creditors, there are no guarantees that all policyholders will receive full value, or even present value for their claims (especially those with IBNR claims).
- There is no reference to segregating and preserving reserve assets for excluded lines, or any explanation as to how policies and claims would be administered and paid during the interim period prior to completion of the plan.
- Questions concerning the enforceability of any such plan across state lines may leave companies exposed to further risk, litigation and disruption or termination of a plan—i.e., even if the Rhode Island court did approve the plan, it is possible that policyholder or claimant actions could arise in other states' courts, (or perhaps federal courts), resulting in enforcement and implementation issues for the company attempting the restructuring.⁷²
- Although the Rhode Island plan is available only to commercial insurers and reinsurers in run-off, the plan is not exclusively limited to “troubled” companies; thus, any commercial run-off insurer could conceivably use this mechanism to cease operations and eliminate ongoing claims payment liability.
- Despite the fact that there is significant statutorily delineated regulatory guidance included in the Rhode Island framework (unlike UK solvent schemes), parties may view Rhode Island’s “commutation plan” statute as simply a domestic version of the UK’s solvent schemes and attribute all of the disadvantages associated with UK-like solvent schemes of arrangements (listed below in D-2) to the Rhode Island system.
- Because the Rhode Island statute allows for the formation or reactivation of a domestic company and the transfer of assets and liabilities to that company, certain parties view this as allowing a “ring-fence” of assets, unfairly shielding assets from creditors.

⁷² For a detailed discussion on the issue of enforceability, see David Wright, “A Question of Enforceability,” Run Off Business, Issue 12, Spring 2005, pp. 20-22.

MECHANISMS AVAILABLE TO INSURERS OUTSIDE THE UNITED STATES AND RELATED TERRITORIES

D. UK-LIKE SOLVENT SCHEMES OF ARRANGEMENTS

1. DESCRIPTION

A scheme of arrangement is essentially a statutory compromise or arrangement between a company and its creditors. The process is allowed under Part 26 of the United Kingdom Companies Act 2006 that requires majority creditor approval representing at least 75% in value of obligations; confirmation by the UK Financial Service Authority (FSA) of no objections; and court sanction. If approved, the process will bind all creditors, but does not necessarily bind reinsurers. The process has evolved over the years and includes a process for insolvent and solvent insurers.

The FSA maintains a very active role in reviewing the schemes with a review document containing approximately 30 questions. In July 2007, the FSA issued a process guide related to decisions made with schemes that included the following:

- Stresses that the scheme must comply with principles for businesses (e.g., treating policyholders fairly and communicating in clear terms).
- Established an FSA schemes review committee.
- Stated that the run-off should be at least five years old.
- Distinguishes between individual retail and small commercial policyholders, large commercial policyholders and other risk carriers.
- Distinguishes between insolvent risk carrier, marginally solvent risk carrier and substantially solvent risk carrier.
- In case of substantially solvent risk carrier, the FSA is likely to object to a scheme unless the risk carrier offers benefits designed to ensure that policyholders are not in a worse position than in a solvent run-off.
- Provides for a role of policyholder advocate.
- The FSA may not object to a scheme, even if it fails to satisfy the criteria stipulated, if the risk carrier can demonstrate that the scheme treats policyholders fairly (e.g., through suitable additional benefits for policyholders and/or safeguards for dissenting procedures).

As of September 2008, there have been approximately 174 solvent schemes of UK non-life business. However, in every instance when policyholders have mounted serious opposition, the UK courts have ruled in the policyholders' favor. In particular, objecting policyholders have successfully challenged the British Aviation Insurance Co. Ltd. (BAIC), Willis Faber Underwriting Management (WFUM) and Scottish Lion solvent schemes in the UK courts. These are the only solvent schemes involving direct policyholder coverage that have been challenged to date, and all three have resulted in the court rulings favorable to the policyholders. To date, no UK court has agreed to sanction a solvent scheme involving direct coverage (as opposed to reinsurance) in the face of a policyholder legal challenge to the scheme.

Claims being paid can include IBNR, and most schemes have the ability to pay for IBNR based on estimation methodology. Additionally, schemes will allow a creditor's methodology to be used, if reasonable.

Chapter 15 of the U.S. Bankruptcy Code may be used to assist with a scheme of arrangement in the United States. The effect is to grant a U.S. bankruptcy court authority to enforce the scheme and protect the company's assets from creditors. However, although no UK solvent scheme has yet been challenged under Chapter 15 of the U.S. Bankruptcy Code, there is a possibility that such challenges may arise, and the U.S. bankruptcy courts could reject solvent schemes.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Some advocates state that solvent scheme mechanisms, in particular, have proven to be very effective in the UK and other jurisdictions to permit closure of companies that have reduced their liabilities to fairly minimal levels and that can reasonably estimate their future liabilities.
- Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism from these companies will create an active market for investment in run-off companies.
- Companies using UK schemes of arrangements have statistically improved their net asset position by approximately 5%.
- Some insurers have made payments to creditors at or near 100%.
- Schemes may allow a creditor's claim estimation methodology to be used, if reasonable.

DISADVANTAGES

- Schemes may undermine the value of insurance contracts by not honoring contractual obligations.
- Lost coverage may hurt policyholders at the expense of American citizens and the economy.
- Schemes could pose a formidable collective action problem.
- Schemes could undermine the reliability of insurance institutions.
- Schemes may allow for the reduction or cancellation of contractual obligations outside the scope of the current receivership system by not adhering to the statutory priority of distribution rules. Under such a scheme, a troubled company could force certain policyholders to commute (or buy-back) mutually agreed-upon insurance coverage despite their objections.
- The use of terms "debtor" and "creditor" used in the restructuring arena may tactically create a new environment for insurance where risk transfer is not necessarily part of the product purchased.
- Enforceability across state lines.
- Schemes could be used by companies to simply reorganize their corporate structure to move reinsurance operations unencumbered by old claims under a different name.
- In its latest proposal, the Reinsurance (E) Task Force had a provision where an insurer engaging in solvent schemes would not be allowed to take a reduction of collateral.
- Chapter 15 is a relatively new provision of the Bankruptcy Code with relatively little case law to support it, thus leaving the ability for judges' discretion and leeway in its application.
- Schemes can involve reinsurers, where the reinsurance contract with an insurance company is negatively affected.
- Schemes could provide an opportunity for solvent insurers to avoid insurance and reinsurance obligations and return the risk to insureds of ceding companies who purchased

- the coverage in good faith.
- Schemes force creditors to trade insurance coverage for payments based on estimations of future claims that are inexact and possibly unfair.
 - The individuals chosen to adjudicate claims under a scheme may lack expertise in the necessary legal issues.
 - There is no oversight of solicitation by the company of scheme acceptances. Thus, some accepting creditors may have already achieved favorable settlements, while dissenting creditors are left to litigate their claims in an unfavorable forum.
 - Schemes do not allow dissenting policyholders to opt out of the scheme.
 - Schemes do not ensure continuation of coverage.
 - Schemes do not include a safety net of guaranty association protection.
 - Schemes do not allow a policyholder to seek judicial review of its claims against the insurer.

E. PART VII PORTFOLIO TRANSFERS

1. DESCRIPTION

Part VII of the Financial Services and Markets Act 2000 (FSMA) allows for a transfer of insurance business under a statutory and court process. The transfer allows a reinsurer to move all or certain of its reinsurance business (assets and liabilities) to another reinsurer without the consent of each and every policyholder but with the sanction of the UK High Court. The main statutory requirements are: 1) policyholder notification; 2) a report by an independent expert; 3) UK High Court approval; and 4) no objection by the FSA or other regulators and interested parties, including policyholders.

The court is involved in the process with the directions hearing, which is when court will grant leave to proceed. The court is also involved in the hearing to sanction the transfer (or final hearing). The relevant legislation and requirements can be found in VII. Appendix D4.

The transferee must be an insurance company established in a European Economic Area (EEA) state. However, the transferor can be authorized in the UK, an EEA branch of a UK firm, a UK branch of an EEA firm, an EEA firm with no UK branch, or a non-EEA that is permitted to carry on business in the UK.

Per the FSA Web site, the following are reasons why reinsurance firms undertake Part VII transfers:

- Rationalization—combine similar business from two or more subsidiaries, putting all into a single regulated entity.
- Efficiency—transfer business between third parties, separating old liabilities in run-off from new business, putting each into separate firms.
- Capital reduction—transfer business to a new firm and extract any surplus shareholders' funds.
- Exit—transfer business such as employers' liability that cannot be schemed.

The legal effect of a Part VII transfer is a statutory unilateral novation of the affected contracts of insurance or reinsurance, including any rights attaching to those contracts.

The two primary aspects for the protection of affected parties are as follows: 1) the independent expert's report, which needs only to consider the effect on policyholders; and 2) the court is required

to be satisfied that the transfer as a whole is fair as between the interests of different classes of persons affected by the transfer.

Per the FSA Web site, the FSA and the court are concerned whether a policyholder, employee, or other interested person or any group of them will be adversely affected by the scheme. This is primarily a matter of actuarial and regulatory judgment involving a comparison of the security and reasonable expectations of policyholders without the scheme with what would be the result if the scheme were implemented. The court will pay close attention to any views expressed by the FSA regarding whether individual policyholders or groups of policyholders may be adversely affected, though this does not necessarily mean that the transfer is to be rejected by the court.

The key question is whether the transfer as a whole is fair as between the interests of the different classes of persons affected. However, it is not the function of the court to produce what, in its view, is the best possible scheme. With regard to different transfers, the court may deem all fair, but it is the company's directors' choice to select the transfer to pursue. Under the same principle, the details of the scheme are not a matter for the court, provided that the scheme as a whole is found to be fair. Thus, the court will not amend the scheme, because individual provisions could be improved upon.

Overall, a loss portfolio transfer is a means of transferring outstanding net or gross legal liability from one insurer to another insurer. It has been viewed as a form of retrospective reinsurance. The transfers must be sanctioned by the court, and are subject to review and opinion by an independent expert that is approved by the FSA. Notice of the proposed transfer is usually required to be sent to all policyholders of the parties unless the court decides otherwise. A detailed report must also be provided setting out all the details and the independent expert's opinion. The FSA and any party who feels adversely affected by the transfer can make representation to the court for consideration.

The FSA is also required to assess a number of aspects (e.g., whether policyholders will be worse off moving from one place to another, or if there is any potential risk posed by the transfer). Rating agency ratings or the effect on ratings could be a component as part of the FSA's considerations, as well as other regulatory bodies.

There have been over 100 Part 7 transfers, and the majority dealt with internal reorganization within holding groups. Over 50% were performed in the life industry. Very few Part 7 transfers have seen business go from a company to a third party; however, they are becoming increasingly popular. The receiving company's motives for entering into these arrangements may stem from tax advantages to potential profits based on one's claims handling experience.

COMPARISON OF PART 7 TRANSFERS WITH U.S. ALTERNATIVES (*BINGHAM TABLES*)

	Part 7 Transfers	Assumption Reinsurance Solvent	Assumption Reinsurance Insolvent	Rehabilitation Proceedings
Creditor Voting	No	Yes	No	No
Regulatory Review	Yes	Yes	Yes	Yes
Creditor Input	Low	High	Low	Medium
Transparency	Low	High	Low	Medium
Court Review	Yes	No	No	Yes
Hold-ups & Hold-outs	No	Yes	No	No

	Schemes of Arrangement	Run-off with Commutations	Rehabilitation Proceedings
Who Runs the Case	Management	Management	Regulator
Stay of Proceedings	Yes	No	Yes
Hold-ups and Hold-outs	Yes	Yes	No
Creditor Votes	Yes	Yes	No
Regulatory Involvement	Review	Ongoing Monitoring	Control
Claims Adjudication	Management Appointee	Variety of Courts	Receivership Court

The foregoing tables compare schemes of arrangement and Part 7 transfers with analogous mechanisms available under U.S. law. While it appears that the mechanisms are similar in many respects, in practice they have proven to be quite different. Under UK schemes of arrangement, policyholders have been forced to accept payouts based on estimations of their claims so that equity holders can recapture the capital of the company. Under UK Part 7 transfers, policyholders have been forced to accept the credit of another insurer in order to permit the insurer from whom they bought the policy to exit business and recapture its capital. Current U.S. practice, with the possible exception of the Rhode Island statute, would not enable these results. Policyholders are only required to accept payment based on estimation in the U.S. where the company is insolvent and shareholders will not receive a return of their capital. Also, under current U.S. practice, policy transfers to a new insurer are not made involuntarily except where there is an insolvency of the transferor. While UK regimes certainly have safeguards in the form of voting (in the case of schemes) and court review (in the case of schemes and Part 7 transfers), the ultimate risk is left on the policyholder.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Permits more efficient management of transferred books of business, allows dedicated capital and focused solutions to be applied to run-off liabilities, and promotes efficient use of capital for ongoing business.
- Options can be explored to strengthen policyholder protections and reach regulator approval, such as altering deductibles, strengthening reserves, obtaining reinsurance, and other arrangements to share the risk.
- Might attract new capital to insurance businesses insofar as it can be invested directly in run-off liabilities, and strengthens ongoing companies by permitting the separation of those

- liabilities.
- Can reduce risk of exposure.
 - A recent amended UK rule introduces a simpler alternative where no court sanction is required for pure reinsurance business transfers if all the policyholders affected by the transfer consent to the proposal.
 - Substantial regulatory oversight is required.

DISADVANTAGES

- Could transfer obligations from the entity the creditor dealt with: to one that is completely unknown; to one with whom the creditor would have never willingly chosen to deal; from a differing country subject to different regulation; and to a less secure debtor.
- A Part VII-like transfer to an alien reinsurer from a U.S. domestic reinsurer may cause the primary insurer to lose its credit for reinsurance.
- Very difficult to quantify trapped capital in these scenarios.
- Problems could arise for a ceding company, if the Part VII transfer goes to a reinsurer with a lower rating, because the rating agency could lower the ceding company's rating.
- Could present unique accounting and reporting anomalies on both a statutory and GAAP basis.
- The regulator is not required to publicly explain its decision-making process.

IV. OBSERVATIONS AND CONSIDERATIONS BEFORE USING ALTERNATIVE MECHANISMS

A. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. STATE RECEIVERSHIP/GUARANTY FUND LAWS

Delinquency proceedings (receiverships) are instituted against an insurance company by an insurance department for the purpose of conserving, rehabilitating, or liquidating an insurance company. All require a court order, and the domiciliary state court will take jurisdiction over matters involving the resulting receivership estate. The court's role is to ensure transparency and due process and to be an independent arbiter of any disputes that may arise. The nature, timing, and extent of regulatory action in any given troubled insurer situation depend on the circumstances of the particular situation.

The U.S. Constitution in Article I, Section 10 states that "No state shall ... pass any ... law impairing the obligation of contracts." However, during certain delinquency proceedings, states may, on rare exceptions, impair contracts, but only where there is a legitimate public purpose behind the law.

It should be noted that the language in the rehabilitation statutes for most states is very broad and provides that anything that will restructure, revitalize, or reform the insurer can be proposed in a plan.

2. PRIORITY DISTRIBUTION STATUTES/PREFERENTIAL TREATMENT

One of the key consumer protections in the existing state delinquency proceedings are the priority distribution statutes that require payment of policyholder-level claims before the payment of any other claimants, including non-policy claims of the United States government, claims of other insurers and reinsurers, and general creditors. These same priority distribution statutes also require members of the same class or group of creditors to be treated similarly. The priority distribution statutes ensure that the needs of consumers, who might not be sophisticated in insurance matters, are placed ahead of non-policyholder level claimants and that everyone with the same level or type of claim is treated the same.

If assets are not sufficient to cover the remaining claims and administrative costs of an insurer using one of the alternative mechanisms, then all claims paid prior to that point have been given a preference at the expense of the claims to be paid in the future. As a result, the receiver could be statutorily required to attempt to recover these preferential payments.

B. CONSUMER PROTECTIONS AND PUBLIC POLICY CONSIDERATIONS

In order to ensure some baseline of protections for policyholders and consumers, there are certain core principles that regulators should strive to maintain with any alternative mechanism for troubled insurers. The first among these, a requirement that the company honor its contractual obligations to policyholders, is considered the primary and overriding principle. This first principle translates into no impairment of policy benefits and claims without the express, informed, voluntary consent of the policyholder. The others are corollary principles, all supporting that primary goal of honoring contractual obligations to policyholders. Any alternative mechanism for run-off or restructuring of a troubled insurance company's obligations should strive to establish parameters consistent with these principles.

Core Principles:

1. Honor Contractual Obligations to Policyholders. Alternative mechanisms should not be a way for an insurance company to sidestep its contractual obligations to policyholders. There should be no involuntary restructuring of policies or impairment of policy benefits or claims permitted outside of receivership. This would preclude any changes to policies, or reductions to policy claims or benefits, without the express, informed, voluntary consent of individual policyholders. Accordingly, there should be no cram-down approval of a mechanism by majority vote over the objection of policyholders; no involuntary transfer of risk back to policyholders through forced commutation of claims or otherwise; and no cancellation, termination, or non-renewal of coverage, except as permitted under the express terms of the policy. In short, every policyholder should be entitled to continue coverage and to receive all policy benefits for the full term of their policy.
2. Meaningful Notice and Information Sharing. This contemplates accurate, consistent, and timely notice and disclosures to all policyholders, creditors, and guaranty associations of meaningful information (including financial information, status plans, and any proposed assumption reinsurance or other significant transactions) at inception and on an established schedule thereafter. Disclosures should also identify creditors (at least below the policy level) in order to permit some meaningful, organized discussion among creditors.
3. Adherence to Priority Scheme. Alternative mechanisms should require adherence to statutory liquidation priority schemes. They should not provide a mechanism for circumventing the distribution priority to benefit the company, its shareholders, employees, other stakeholders, or specific groups of policyholders at the expense of other classes of policyholders. Controls on preferences and the outflow of assets are needed, and will require regular ongoing review. The company and/or equity shareholders should not be permitted to retain assets unless all claims having priority, as measured under state liquidation laws, have been satisfied in full.
4. Coherent, Comprehensive Financial Planning. Any alternative mechanism should be based on a fully developed and comprehensive financial plan that includes complete and meaningful financial data, and projections based on reasonable and realistic financial assumptions. There should be full disclosure and transparency in financial planning, monitoring, and reporting as a condition to approval of any such plan and throughout implementation. In addition, any such mechanism should provide a global solution addressing all in-force policies and pending policy claims. There should be no ring-fencing or piecemeal disposition of assets and liabilities that may result in unequal treatment of policyholder claims, and give rise to preference and priority concerns. Moreover, the fairness and reasonableness of any mechanism cannot be reasonably assessed on a transaction-by-transaction basis without consideration of the overall impact on other policyholders and creditors.
5. Procedural Safeguards. Any alternative mechanism should provide substantive procedural safeguards, including clear standards for disclosure, reporting, and external review; appropriate and timely notice; access to information and the opportunity for informed participation for all stakeholders; court and/or regulatory approval for all significant actions to be taken; and meaningful compliance monitoring and reporting.

V. OBSERVATIONS AND CONSIDERATIONS WHEN USING ALTERNATIVE MECHANISMS

C. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. USE OF PERMITTED PRACTICES

There have been situations where an insurer would be able to maintain operations for 20 years, but to date, since liabilities barely exceed assets based on NAIC accounting practices and procedures, the insurer is nearly or technically insolvent. A carefully thought-out permitted practice could allow a troubled insurer time to dramatically restructure in order to provide better results for consumers in terms of timely claims payments.

2. MODIFICATIONS TO EXISTING STATUTORY AUTHORITY

In some circumstances, state insurance regulators may want to consider modifying laws and regulations to provide for a more favorable environment for certain alternative mechanisms. For example, the Illinois Division of Insurance strongly supported the General Assembly's adoption of 215 ILCS 5/204 in the Illinois Insurance Code's provision on Prohibited and Voidable Transfers and Liens to protect transfers made during the Division's supervision of a solvent run-off. The language reads as follows:

m) The Director as rehabilitator, liquidator, or conservator may not avoid a transfer under this Section to the extent that the transfer was: ***

(C) In the case of a transfer by a company where the Director has determined that an event described in Section 35A-25 [215 ILCS 5/35A-25] or 35A-30 [215 ILCS 5/35A-30] has occurred, specifically approved by the Director in writing pursuant to this subsection, whether or not the company is in receivership under this Article. Upon approval by the Director, such a transfer cannot later be found to constitute a prohibited or voidable transfer based solely upon a deviation from the statutory payment priorities established by law for any subsequent receivership.

D. SURVEILLANCE MONITORING BY STATE INSURANCE REGULATOR

State insurance regulators need to consider whether the state has appropriate expertise on staff or whether the state needs to hire outside consultants of particular functions, such as claims assessment, reserves, reinsurance, etc. Please refer to the *Troubled Insurance Company Handbook* for a description of competency and skills of personnel assigned to conduct surveillance on troubled insurers.

1. SUPERVISION ORDERS/CONSENT AGREEMENTS/LETTER OF UNDERSTANDING

Regulators may want to consider various methods to articulate the regulator's expectations with an alternative mechanism, as well as the possible recourse that may occur with the insurer as a result of certain actions or behaviors. Such communication methods can be informal, such as a letter of understanding with the insurer, or formal, such as voluntary consent agreement or a confidential supervision order.

If a supervision order is taken under the commissioner's administrative provisions, the insurer's management will generally remain in place subject to restrictions in the supervision order and the direction of the supervisor. The supervision can be voluntary or involuntary and confidential or public. Confidential supervisions are becoming more infrequent, as disclosures of such regulatory actions have become more necessary under federal law for insurers within publicly traded groups. Some states may require court approval, as well.

2. FINANCIAL REPORTING/ANALYSIS/EXAMINATION

All active insurers that are not in liquidation proceedings should be filing quarterly financial statements to the NAIC Financial Data Repository to provide regulators, policyholders, creditors, and claimants meaningful information. Enhanced monitoring, such as monthly financial statements and claims/exposure reports, should also be considered.

All states should conduct analysis and examination practices in compliance with Part B of the Financial Regulation Standards and Accreditation Program.

3. COMMUNICATIONS

As a result of utilizing various alternative mechanisms, regulators should attempt to coordinate the situation and supervisory plan with other affected insurance departments/jurisdictions, other regulatory agencies, and guaranty associations. Coordination may be useful to avoid actions that may be counterproductive. Interdepartmental and intradepartmental communication is also important to ensure that key departmental officials possess all relevant information to permit decisions to be made on a timely basis.

E. BENEFITS, RISKS AND CONTROLS: FOR U.S. CLAIMANTS/POLICYHOLDERS WHEN A NON-U.S. INSURER OR REINSURER RESTRUCTURES

1. INTRODUCTION

This section considers the impact upon U.S. policyholders and creditors of the restructuring of non-U.S. insurers and reinsurers. It will not consider the impact upon U.S. policyholders and creditors of the restructuring of the U.S. branch of a non-U.S. insurer, because that will be governed largely by familiar U.S. laws and procedures. However, it should be noted that the extent to which the U.S. branch may realize economic support from its non-U.S. parent and/or affiliates is likely to be governed primarily by the laws of the jurisdiction(s) in which the latter are domiciled.

What this section examines is the possible impact on U.S. policyholders and creditors of the restructuring of a non-U.S. insurer or reinsurer outside the U.S. The restructuring of a non-U.S. insurer or reinsurer may be governed simultaneously by the laws of several jurisdictions. For example, as Solvency II becomes the norm in the European Union, an insurer or reinsurer doing business in many member jurisdictions may be subject to their various laws to varying degrees. However, the jurisdiction in which the parent is domiciled (or the group supervisor, if different) may be particularly influential even over the fate of subsidiaries in other jurisdictions. The continued evolution of group supervision as an integral part of Solvency II is likely to enhance the influence of the parent's domicile. Less predictable will be the management of the restructuring of insurers doing business simultaneously in EU and non-EU jurisdictions. There remains a wide disparity in the core principles underlying insurance regulatory

systems throughout the world—some attributable to the pace of economic development, others to fundamental cultural differences, and still others to specific national public policies.

This section endeavors to identify the key considerations that should be evaluated from the perspective of U.S. policyholders and creditors when their non-U.S. insurer or reinsurer is restructured. It seeks also to provide a sampling of illustrations of how those considerations might evolve in specific circumstances. Pre-purchase evaluation of how these considerations are addressed in a particular jurisdiction may enable the astute policyholder to avoid purchasing coverage that is apparently reliable but for which there is little effective protection upon restructuring.

2. POTENTIAL ADVANTAGES AND RISKS OF RESTRUCTURING MECHANISMS

In many non-U.S. jurisdictions, mechanisms are available for the restructuring of insurers and reinsurers short of formal rehabilitation or liquidation proceedings. A distinction should be drawn between restructuring in the face of potential insolvency (the focus of this paper) and restructuring as a business strategy not in response to immediate solvency concerns. In the latter case, there is little justification for compromising policyholder interests, and regulatory schemes typically do not permit that result. It is in the face of a potential insolvency that restructuring can present a meaningful dilemma.

On the one hand, restructuring mechanisms can be advantageous when compared to rehabilitation or liquidation proceedings in three key respects:

- a. Such mechanisms typically offer at least a realistic prospect of a faster resolution of the underlying financial challenge.
- b. Often, these mechanisms are cheaper and therefore consume fewer scarce resources in the implementation of the process itself.
- c. Often these mechanisms serve to preserve coverage that might otherwise have to be terminated in the context of formal proceedings.

On the other hand, there can be some serious draw-backs in these alternative schemes. The next subsection considers key factors in more detail. However, the principal concerns that may arise in the context of these alternatives include:

- a. Reduced regulatory and judicial oversight resulting in diminished policyholder protection.
- b. Greater likelihood that policyholder interests will be compromised for the sake of other constituencies, such as owners, managers, and other creditors.
- c. The probability that policyholders will have less influence in the process and a diminished ability to protect themselves from potentially adverse outcomes.

3. KEY CONSIDERATIONS

In the U.S., state insurance regulators are accustomed to the fundamental principle that the interests of policyholders (used here as including insureds), especially consumers, should take precedence over

those of unsecured non-policyholder creditors. This principle is not mandated in non-insurer bankruptcies in the U.S. and may not have the same importance in non-U.S. jurisdictions. It is helpful to identify the likely principal interests of policyholders (including insureds), as they may be affected in insurer restructuring.

In addition, this subsection will identify key considerations for reinsureds and creditors when a non-U.S. reinsurer restructures. The treatment of reinsureds is the primary consideration; however, a proper restructuring plan will keep tax authorities and other creditors informed as well. While the nature of the reinsured/reinsurer (sometimes referred to as cedent/assuming company) relationship invokes many of the same key considerations—because typically reinsureds are sophisticated business entities rather than individual consumers—slight differences may arise.

a. RIGHT OF PAYMENT

Not surprisingly, the principal interest of policyholders is likely to be assurance that claims (perhaps including those for return of unearned premium) will be paid promptly and in full. With the arguable exception of continuation of coverage, it is likely that policyholders' other interests (discussed below) are derivative of and ancillary to payment concerns.

The ability to obtain full payment of claims may turn on many factors, only some of which may be attributable to the nature of the proceeding. For example, the debtor's financial condition will always be a key consideration, regardless of the nature of the proceeding. The nature of the claim will also be an important consideration. For example, policyholders making claims based on IBNR must rely on actuarial estimates, which can vary widely. Such policyholders face a risk that any payment under a restructuring plan would be insufficient to meet future liabilities. This section does not address such considerations, which—however important—are unrelated to the nature of the proceeding or the regulatory or supervisory scheme under which it operates.

b. CONTINUATION OF COVERAGE

Under a variety of circumstances, it may be difficult for a policyholder to find acceptable coverage to replace that provided by the restructuring insurer. In the U.S., this interest is typically given more weight in the insurance rather than reinsurance context, and in the case of life accident and health insurance rather than in the context of property and casualty insurance.

c. CLAIM PRIORITIES

As noted, we are accustomed in the U.S. to the supremacy of policyholders over other unsecured creditors. This priority is critically important when available assets may not suffice to discharge fully all liabilities of the insurer. Of course, in insurer insolvencies, typically the category of general creditors includes most notably reinsureds. Thus, the interests of reinsureds and policyholders, treated as congruent in much of this section, may be very divergent in particular circumstances. Policyholder priority may not be observed as strictly, or at all, in other jurisdictions.

d. GUARANTY ASSOCIATION COVERAGE

Over the last four decades the U.S. insurance sector has implemented nearly universal guaranty fund mechanisms, providing at least basic protection for the insureds of most failed insurers. There are, of

course, notable exceptions like HMOs, risk retention groups, surplus lines carriers and certain lines (separate account annuities, fiduciary bonds, etc.) in the main; however, this “safety net” serves to soften the impact of insurer failure and effectively provides a standard against which are measured the anticipated results of restructuring. Most non-U.S. jurisdictions have not implemented nearly as comprehensive an insolvency protection scheme. The guaranty association mechanism is typically not available to reinsureds in the U.S. or elsewhere.

e. RIGHT TO VOTE

Although largely foreign to U.S. insurer restructuring and insolvency proceedings, in other jurisdictions, policyholders may have a right to vote on the restructuring plan. Most often, however, that right exists when the plan does not require that policyholder contracts be fulfilled in their entirety. In such plans, policyholders whose claims consist of incurred but not reported losses may have different rights from policyholders who have unsettled paid claims or outstanding losses.

f. CRAM DOWN

In certain jurisdictions, it is possible for policyholders and reinsureds to be compelled to accept a restructuring plan that requires that they make economic concessions. The plan may require approval upon the votes of creditors, or it may simply require regulatory or court approval. This should be contrasted with U.S. laws, which typically do not permit restructuring plans in which policyholders’ interests are compromised for the benefit of non-policyholder creditors.

g. VOICE IN REPLACEMENT

The restructuring plan may entail coverages being transferred to other insurers or reinsurers with whom policyholders and reinsureds had no relationship. In some cases (including instances in the U.S.), policyholders and reinsureds may have little discretion in the transaction (except potentially non-payment of premium and forfeiture of coverage).

h. TRANSPARENCY

The ability of creditors, including policyholders or reinsureds, to obtain information about the proceeding, and the financial factors upon which key decisions will be based, varies considerably from jurisdiction to jurisdiction. Access to relevant information, however, is often the essential first step in policyholders’ ability to protect their interest in a restructuring.

i. ACCOUNTABILITY

The individual or entity responsible for managing the restructuring may be a private practitioner engaged by the restructuring entity’s management, a group of creditors, or a regulatory authority. Alternatively, the process may be placed in the hands of a public official. The degree to which the individual or entity in charge of the process is accountable to a superior or independent authority can be critically important in ensuring the fairness and efficacy of the process. In those instances in which oversight consists principally of court supervision, the independence of the tribunal is important, as is the degree to which interested parties have access to that tribunal.

j. REGULATORY PROTECTION

In some jurisdictions (including the U.S.) statutory or common law (judicial decision) standards govern the manner in which an insurer may be restructured. They range from fundamental constitutional protections against the taking of property without due process to specific thresholds that must be satisfied before a Rehabilitation Plan can be approved. The availability of such protections and of viable enforcement mechanisms (such as an empowered administrative agency) are generally key to the prospect of a meaningful recovery or protection for policyholders and reinsureds.

k. ENFORCEMENT IN THE UNITED STATES

Non-U.S. restructuring plans have been enforced by the U.S. courts under Chapter 15 of the United States Bankruptcy Code. Chapter 15 governs cross-border insolvencies and is a framework whereby representatives in corporate restructuring procedures outside the U.S. can obtain access to U.S. courts. Chapter 15 permits a U.S. bankruptcy court to cooperate with a foreign procedure in which assets and affairs of the debtors are “subject to control or supervision by a foreign court, for the purpose of reorganization or liquidation.” Recent Bankruptcy Act amendments resulting in the current form of this provision were intended in part to bring U.S. law into greater harmony with the provisions adopted by the United Nations Commission on International Trade Law (UNCITRAL) and observed throughout much of the world. Applicability of these rules can be complex and often commences with a determination of which jurisdiction’s proceeding will control. The emerging trend is to defer to the jurisdiction in which lies the Center of Main Interest (COMI). However, it is important to note that the COMI may not necessarily be the domiciliary jurisdiction of the insolvent, and cases applying this principle sometimes reach puzzling results. While further discussion of these issues is beyond the scope of this section, the subject merits careful attention when applicable.

l. STANDING TO APPEAR

The ability to appear before the tribunal or agency conducting or overseeing the proceeding may be an important component of creditor protection. Of course, the fairness and impartiality of such a tribunal or agency are of critical importance. Moreover, the right to appear may be far less important when the individual managing or overseeing the process is charged principally or in material part with protection of policyholders and reinsureds and takes that responsibility seriously.

m. SET-OFFS, CLAIMS ACCELERATION AND ESTIMATION, PREFERENCES, AND VOIDABLE TRANSFERS

Insolvency proceedings can trigger a number of unique technical rules that are common in U.S. jurisdictions but may not receive the same treatment in other regimes. Among these are provisions that govern set-offs of claims and credits, acceleration and estimation of claims, when payments before commencement of a proceeding may be deemed to be reversible preferences, when such payments may constitute fraudulent or voidable transfers, and other such rules.

The issue of claims acceleration and estimation is illustrative of this difference in rules. Reinsurers have repeatedly expressed opposition to any system that could result in the accelerated and involuntary payment of their obligations based on any estimation of policyholder claims. Reinsurers oppose compelled payment of reinsurance recoverables based on IBNR on the basis that they are theoretical losses with theoretical values allocated in a theoretical fashion. Because reinsurance is a contract of indemnity, reinsurers assert that they cannot be required to pay losses, such as IBNR losses, which are unidentified or unknown.

While it is beyond the scope of this section to consider the details of each of these “technical” issues, it is important for the affected party to identify those that may be important in the particular case and determine how they are addressed in the specific proceeding. It should be noted that the application of these rules may not always be immediately evident. For example, if only part of a company’s business is subject to the restructuring plan, reinsurers may be concerned that they will lose existing set-off rights. This concern by reinsurers may affect the ability of reinsureds to receive full payment.

n. POLITICS

Finally, it should never be forgotten that “all politics are local.” In the U.S., the degree to which political considerations control an outcome is somewhat mitigated by cultural and legal constraints. These constraints, however, may not be as applicable in non-U.S. jurisdictions. Familiarity with the local environment is essential in order to avoid unpleasant surprises. And political considerations may not relate just to governmental entities—they may relate to the industry as well. For example, when the reinsured is also a reinsurer, it may be unwilling to help one of its potential competitors with arestructuring. The presence of existing disputes or investigations may also affect how a reinsured views a restructuring plan.

VI. CONCLUSION

Overall, although alternative mechanisms for troubled insurers can provide cost savings or greater efficiency over the current system, these mechanism can also pose unique risks for consumers and require specialized surveillance monitoring, practices, and procedures, particularly where the activities may occur outside of court-supervised receivership proceedings. In this context, regulators are encouraged to consider implementing standards and best practices responsive to these risks in order to preserve important consumer protections, increase transparency, and provide appropriate procedural safeguards.

First and foremost, it is the responsibility of regulators to protect insurance consumers. Thus, proponents of alternative mechanisms for troubled insurers should be pressed to prove to the regulator's satisfaction that the claims of greater efficiency or flexibility will not be used to strip policyholders and claimants of their policy rights so that value can be returned to investors. And regulators should ensure that all alternative mechanisms for troubled insurers place the interests of consumers ahead of other competing interests, coupled with a clear statement of goals and objectives and a meaningful oversight mechanism.

VII. APPENDIX

A. CASE STUDIES

This appendix describes troubled insurance company situations to illustrate some of the alternative concepts and techniques discussed earlier in this paper. The names of the insurers have intentionally been omitted. These case studies are not intended to reveal all problems or situations that may arise during the restructuring of a troubled reinsurance company. Additionally, the proposed actions with respect to the subject company may not be appropriate in all jurisdictions in light of changing market conditions and the possible differences in statutes, regulations, and implementing tools and resources.

1. RESTRUCTURED TROUBLED REINSURANCE COMPANY

Company characteristics, circumstances, and concerns:

- A property/casualty reinsurance company (treaty and individual risk basis).
- Primary reinsured lines included allied lines, commercial multiple peril, accident & health, workers' compensation, liability, and non-proportional reinsurance.
- Immediate parent and primary reinsurer of a direct property/casualty insurer.
- Non-U.S. ultimate parent.
- Parent refused to provide further financial support to its subsidiary.

BACKGROUND. Restructured Troubled Reinsurance Company (RTRC) was an established property/casualty reinsurer that appeared to be reporting significantly improving financials since two years earlier, accomplished through active re-underwriting and non-renewal of underperforming business. RTRC was a large reinsurer licensed or accredited in 27 states. Growth was moderate over the years, and the company remained adequately capitalized until significant adverse development constrained resources. Almost all property/casualty lines of reinsurance were written by RTRC with primary focus on workers' compensation, accident & health, liability, and proportional reinsurance. The group restructured through a series of transactions and separated its third-party assumed reinsurance business into an independent corporate structure. RTRC received a surplus note contribution from its ultimate parent that provided for semi-annual interest payments.

CAUSES OF TROUBLE. The Insurance Department had no information immediately on hand that would have raised a question regarding the solvency of RTRC. The financial statements reported much improved underwriting results, as well as ratios that were also continuing to show improvement. Approximately six months after the financial examination, but a few months prior to the restructuring, management met with the Department to discuss the rising amount of reinsurance recoverable related to its "Unicover" business. RTRC conducted a detailed internal review of its prior years' U.S. casualty business and found that significant reserve strengthening was necessary in its general liability and specialty liability lines, causing a substantial surplus strain and the triggering of the Department's hazardous financial condition regulation.

PRELIMINARY ACTIONS. The Department had several telephone conferences with RTRC management whereby the Department was informed that a capital contribution from RTRC's ultimate parent would be forthcoming as a result of the significant adverse development discussed above. Management then contacted the Department for a meeting on the premise that the Chairman was in town and wanted a face-to-face meeting to discuss what was going on at the group. During that meeting, the Department was informed that RTRC and its direct subsidiary would be placed in run-off and neither would it receive

a capital infusion as originally discussed. A firm was hired by RTRC's parent to assist in the development of a strategic plan for a solvent run-off.

CORRECTIVE ACTIONS. The Department sought to institute more rigorous financial monitoring. RTRC entered into a confidential letter agreement with the Department that required the Department's approval prior to, among other things, making any material changes to management; moving books and records; making any withdrawals from bank accounts outside the ordinary course of business; incurring any debt; writing or assuming any new business; or making dividend payments or other distributions. It also provided that the Department would receive a monthly report of commutation activity (which, as can be seen below, was the bedrock of the run-off plan); a copy of the final reserve analysis report prepared by an outside firm; and any additional reports the Department reasonably determined were necessary to monitor the financial condition. Finally, the agreement provided that senior management would meet with Department staff weekly, in person or by conference call.

RTRC hired outside actuaries to conduct an external audit. In addition to the reserve strengthening was a non-admission of its deferred tax asset.

A cash flow analysis was commissioned by the Department to conclude whether RTRC could, in fact, have a solvent run-off. RTRC developed a Business Plan/Run-off Plan, which combined commutations with expense cuts (staff and facilities reduction). Quarterly RBC filings were required. Employment levels were reduced commensurate with the Plan, and a retention plan was implemented to help retain talented, necessary staff and management. Surplus note interest payments were disapproved. The Department requested NAIC staff to set up a conference call for regulators to inform states of the situation and provide them time to ask questions or air concerns.

Ultimately, an RBC plan was approved by the Department. Subsequently, a revised Business Plan/Run-off Plan was filed and approved, and the agreement was extended for an additional year.

As commutations continued and improvements began to take hold, the company and its subsidiary were eventually sold. A new plan was developed, as—under new ownership with substantial resources—emphasis was no longer on an aggressive commutation strategy but was now on an aggressive asset management strategy. Monthly calls with management were temporarily put into place to ensure the Department would be aware of any changing circumstance. A less restrictive agreement was implemented as the Department was more comfortable with the possibility of a positive outcome. Ultimately, the subsidiary was again sold—another positive development for RTRC. The frequency of reserve reporting was reduced to an annual basis as long as there was no change in Chief Actuary, and RTRC was released from the agreement.

2. NEW YORK REGULATION 141 PLAN

Company characteristics, circumstances, and concerns:

- Professional property and casualty reinsurers and insurers that write such business and also assume reinsurance of property and casualty business.
- All property and casualty lines, but not life business.
- Member of a holding company group or stand-alone entity.
- Other members of the holding company would not or could not provide further financial help.

BACKGROUND. ABC Reinsurance Company (ABC) was a professional reinsurer incorporated in New York in 1977. ABC became capital-impaired and ceased underwriting in 1985. ABC's management sought approval to commute certain assumed contracts, but the New York Superintendent of Insurance maintained that these commutations would prefer certain creditors over others and that the Superintendent lacked statutory authority to approve such commutations under then-existing New York insurance laws.

CAUSES OF TROUBLE. The parent company refused to add capital. The Department, lacking the authority to authorize the commutations, moved to place ABC in rehabilitation pursuant to New York Insurance Law Article 74. In 1987, the Superintendent moved in Supreme Court, New York County, for an order of liquidation. ABC remained in liquidation until 1992.

During those five years, ABC's liquidator approved some cedents' claims, but paid none. In 1990, however, the New York Insurance Department introduced, and the legislature adopted, an amendment of NYIL 1321 to permit an impaired or insolvent New York insurer to commute reinsurance agreements and, with the Superintendent's approval, eliminate the risk that those agreements could be avoidable as a preference.

In May 1992, the Superintendent, in his role as ABC's liquidator, petitioned the court to approve a plan of reorganization based on a 100% quota share of ABC's portfolio of outstanding losses on all business that ABC wrote before its liquidation. XYZ Reinsurance Company of New York (XYZ) proposed the reorganization plan and provided the reinsurance cover.

After a July 1992 hearing, the court approved ABC's reorganization plan and entered a final order and judgment that terminated the liquidation proceeding. The XYZ quota share contained a \$305 million limit and an expansion of the quota share's limit that expanded based on a formula that included, among other things, paid losses, reinsurance recoveries, and interest income. ABC resumed operations with new directors and officers, but the plan also provided for a manager to administer ABC's run-off.

When the Superintendent petitioned the court in 1992 to approve the reorganization plan, ABC's projected liabilities were, as of December 31, 1990, \$295.3 million. By 1993, ABC and its quota share reinsurer had paid more than \$302.8 million to its ceding insurers. In 2002, ABC substantially increased its asbestos-related IBNR reserves, as did much of the industry. As reported on its 2002 annual statement, ABC's capital became impaired by more than \$12.7 million.

PRELIMINARY ACTIONS. As a result of its 2002 impairment, and pursuant to New York Insurance Law § 1321 and Insurance Regulation 141 (11 NYCRR Part 128) (Regulation 141), ABC submitted to the New York Insurance Department a plan to eliminate capital impairment pursuant to Regulation 141. As required under Regulation 141, ABC's board and the company's sole shareholder stipulated that if ABC's implementation of the Regulation 141 Plan failed to restore ABC's surplus to policyholders to the minimum required as determined in accordance with Regulation 141, ABC would not oppose a petition to again liquidate the company pursuant to New York Insurance Law Article 74.

Under Regulation 141, no commutation of ABC's assumed reinsurance could become effective, and no consideration for any such commutation agreement could be paid, until the Superintendent determined that a sufficient number of fully executed commutation agreements had been returned to restore ABC's surplus to the required minimum (11 NYCRR § 128.5). Regulation 141 also required that ABC provide the Superintendent with copies of all e-mail, correspondence, and other communications between ABC

and its ceding insurers relating to the current Regulation 141 commutation offers, including any such communications rejecting the offer.

The proposed 141 Plan and Regulation 141 also required that ABC offer the same, non-negotiable commutation terms to all of its ceding companies. The 141 Plan further required that an offer to commute reinsurance agreements be made to every ceding insurer for which ABC had paid losses and LAE (Paid Losses) or known case losses and LAE (Case Reserves) on its books as of June 30, 2003.

Under its Regulation 141 Plan, ABC offered to pay 100% of Paid Losses and 60% of Case Reserves to commute obligations under the reinsurance agreements. Cedents were required to respond to this offer within 90 days.

CORRECTIVE ACTIONS. In January 2004, the Superintendent approved the 141 Plan and allowed ABC to extend commutation offers to its cedents. Shortly thereafter, ABC mailed commutation offers pursuant to the Plan to about 580 cedents. In October, ABC delivered to the Superintendent more than 300 executed commutation agreements along with copies of all correspondence with cedents relating to the Plan. The Superintendent subsequently determined that these commutation agreements would, upon his approval, eliminate ABC's impairment.

With the Superintendent's approval, ABC paid \$22,558,221 to those ceding insurers that accepted its Regulation 141 commutation offers. The post-Plan ABC balance sheet showed a positive surplus of \$3,675,366 and the elimination of its 2002 impairment.

The completed Regulation 141 Plan left ABC with many cedents. No cedents were compelled to accept the 141 commutation offers, and the Superintendent's approval of the Plan was premised on ABC's sufficient surplus to policyholders to complete its run-off. At the same time, Regulation 141 gave the Superintendent the statutory authority to permit commutation with a troubled company—avoid a protracted receivership—while also respecting every cedent's right to reject the proposed commutation offers and run the risk that ABC would lack sufficient capital to complete its run-off.

3. COMMERCIAL INSURANCE COMPANY RUN-OFF

Company characteristics, circumstances, and concerns:

- A property/casualty insurance company, writing primarily commercial lines on a national basis.
- Primary lines included commercial multiple peril, accident & health, workers' compensation, general liability.
- Member of a large multinational property/casualty insurance and reinsurance group with a non-U.S. ultimate parent.
- Parent sought to provide sufficient capital support to its subsidiary.

BACKGROUND. Restructured Troubled Insurance Company (RTIC) was an established property/casualty insurer pursuing a business model outsourcing most of its underwriting and claims functions to managing general agents (MGAs) and third-party administrators (TPAs), respectively. RTIC was licensed and operated in 50 states and wrote directly and through six subsidiary companies. The company had been operating for over 50 years and independent for approximately six years prior to being purchased by its current parent. Following the acquisition, RTIC pursued a modified business strategy for three years before being placed into run-off. RTIC wrote most lines of commercial liability insurance with primary

focus on workers' compensation, accident & health, and general liability insurance.

CAUSES OF TROUBLE. Although the parent company installed new management and sought to reverse the business decline at RTIC following the acquisition, continued underwriting losses and adverse development from past years resulted in a ratings downgrade at the company. In addition, the California Insurance Department had been monitoring RTIC for some time due to the poor underwriting results and concern over the company's capitalization. The parent determined that the business model for the company was not appropriate for the then-current market and was not likely to result in a return to profitable business for the company. The parent also determined that the profitable lines of business RTIC was writing could be pursued through restructured and separately capitalized subsidiary companies, while the potential for continued adverse development in certain lines written by RTIC— particularly workers' compensation—would require substantial new capital for RTIC to regain its ratings. Accordingly, the parent determined to place RTIC into run-off.

PRELIMINARY ACTIONS. The parent developed a run-off plan that called for the capital and operational restructuring of RTIC. Representatives of the parent, RTIC, and the run-off manager met with the Department to present a detailed plan for RTIC in run-off. The plan included a restructured capital base intended to provide sufficient flexibility and liquidity for the run-off. A principal component of this restructuring was the merger of a subsidiary of the parent already in run-off into RTIC. This contributed company had been in solvent run-off for a number of years and held sufficient excess capital to support RTIC in run-off. The resulting merged entity was to be placed under the management team of the contributed company, a dedicated professional team with 10 years of experience in the operation of run-off companies.

Over the course of a three-month period, the Department and the company representatives met frequently to refine the run-off plan. The Department was receptive to a solvent run-off under the control of the parent, provided that the parent could demonstrate sufficient capitalization within RTIC, the establishment of certain financial standards for RTIC, and enhanced financial and operational reporting by the company. Upon approval by the Department of the run-off plan and the merger, RTIC was formally placed in run-off.

CORRECTIVE ACTIONS. The Department, the parent, and RTIC entered into an agreement that required RTIC to maintain a minimum RBC standard of 200%, a net-reserves-to-surplus ratio of no greater than 3-to-1, and a specified minimum surplus amount. The parent guaranteed that RTIC would meet these standards. RTIC also agreed to provide frequent and detailed reporting to the Department on the progress of the run-off.

Based upon the company's actuarial analysis and a separate review by the Department, RTIC strengthened reserves in certain lines. The run-off plan also included a restructuring of the capital of RTIC which, in addition to the merger, included the contribution of a three-year term note from the parent to insure liquidity and sufficient capital, and the transfer of the stock of certain affiliated companies from RTIC into a trust in favor of RTIC. Certain subsidiaries of RTIC were purchased by the parent to continue writing certain lines outside of the run-off. RTIC reduced staff, and certain operations were subsequently transferred directly to the run-off manager. A retention plan was created to help retain knowledgeable, talented staff and management for the run-off. RTIC met separately with the domestic regulators of its subsidiary insurance companies to inform them of the plan and obtain their approval where necessary. RTIC and the Department also coordinated with NAIC staff to inform all interested states of the situation at an NAIC regulator meeting and to provide

regulators with the opportunity to ask questions or air concerns.

With the Department's agreement, RTIC began to terminate its MGA and most of its TPA agreements and assumed direct control of most of its claims. The company then began to aggressively settle claims, reduce its overall exposures, and commute certain reinsurance contracts where protection was uncertain or disputed. The investment manager restructured RTIC's investment portfolio to better address the anticipated cash flow and capital requirements of the run-off.

PROGRESS OF THE RUN-OFF. The Department's cooperation with management and establishment of clear operating guidelines, the capital support at RTIC provided by the parent, and singular focus of management on the satisfaction of RTIC's obligations and responsible management of the company's assets have resulted in a stable and successful run-off. Five years into the run-off, RTIC had reduced open claims by approximately 85%, reduced reserves by approximately 40%, and increased surplus by over 70%. The stabilization of RTIC, its successful execution of the run-off plan, and gains in its investment portfolio have resulted in the Department's agreement to terminate the trust arrangements created for the affiliated company investments, deferral, and subsequent forgiveness of the third installment of the parent note and the return of excess capital from RTIC to the parent. RTIC continues to adhere to the established financial standards, maintaining a comfortable margin over the minimum requirements established by the Department. RTIC management and the Department continue to meet approximately quarterly to review the progress of the run-off.

4. RESTRUCTURED TROUBLED LONG-TERM CARE COMPANY

Company characteristics, circumstances, and concerns:

- A stock life, accident and health company.
- Part of a large national life and A&H group.
- Primary line of business is a closed block of predominately long-term care in force.
- Ceased writing new business five years prior to restructuring.
- Received large capital contributions from parent for many years.
- Continuous premium rate increase requests.
- Adverse claim development and reserve strengthening.
- Low RBC ratio.

BACKGROUND. Restructured Troubled Long-Term Care Company was a writer of predominately long-term care business, operating in most of the 46 states, D.C., and the U.S. Virgin Islands. It had held a firm niche position in the long-term care market with profitable operations and a conservative balance sheet. The long-term care block of business was written by the Company and its predecessor companies prior to being acquired by the Company in the 1990s.

CAUSES OF TROUBLE. Shortly after the acquisition of long-term care blocks in the 1990s, the Company reported a reserve deficiency. The Company phased in a new reserve valuation basis for long-term care policies, requested and implemented premium rate increases, and implemented tighter underwriting standards. The cause of trouble was under-pricing and under-reserving that became evident as the company experienced claim costs and utilization that exceeded expectations. The original pricing assumptions on long-term care assumed a 4% to 5% lapse rate, while the actual lapse rate was only 1% to 2%. Additionally, the Company's investment return assumptions were much higher than actual returns.

Over the course of more than a dozen years, the Company received capital contributions to offset losses. The Company reported an increasingly larger reserve deficiency each year from 1998 to 2007, several years in excess of \$100 million deficient. The Company reported net losses in each year from 1997 to 2007.

PRELIMINARY ACTIONS. In 2003, Company management decided to stop marketing insurance products and to place the Company in run-off. The insurance department began monitoring the Company monthly and meeting with Company management on a quarterly basis as a result of continued poor operating performance, reserve deficiencies, and multi-year rate increase requests. A study was conducted of the Company's incurred claims experience. As a result, the Company updated the claim cost assumptions underlying the contract reserves and unearned premium reserves for the long-term care policies. The change was made using the "pivot" method, such that the change in claim costs would be accrued into the reserve balance over time. Multiple premium rate increases were sought. Over the course of 15 years, the Company received over \$900 million in capital contributions from the parent. The parent company indicated that no future capital contributions would be forthcoming.

The Company also came under scrutiny for market conduct issues, including claims administration and complaint handling practices. The Company underwent a market conduct examination to get a further understanding of the market conduct problems within the Company and, as a result, a settlement agreement was reached, recommendations for corrective measures were made, and an improvement plan was developed. The settlement included a monetary penalty for violations; a contingent penalty for non-compliance with improvements, including systems upgrades and improved claims administration; and restitution and remediation regarding the reevaluation of denied claims.

CORRECTIVE ACTIONS. With the approval of the insurance department, the Company's parent transferred the stock of the Company to a non-profit independent trust. In connection with the transfer, the parent contributed additional capital to the Company to fund future operating expenses. The capital was in the form of senior notes payable, invested assets, cash, and the forgiveness of unpaid dividends. The trust is intended to operate the Company for the exclusive benefit of the long-term care policyholders, without a profit motive. It is governed by a board of trustees under the oversight of the insurance department, as outlined in the Form A Acquisition Order.

5. LIABILITY OF INSURERS TRANSFERRED TO THIRD PARTY – EUROPE

BACKGROUND. The European market is a provider of insurance and reinsurance to insureds and cedents worldwide.

Events that took place in Europe during the 1990s provide an example of an extreme case of a market coming to the brink of collapse, only to be saved by a series of transactions that were simple in concept but, of necessity, very complex in their implementation. Those transactions amounted to what has become a famous event in the history of insurance. Most recently the final transaction took place, which had the effect of removing the outstanding liabilities of the re/insurers in question.

CAUSES OF TROUBLE. In the early 1990s there was an unexpected, huge increase in long-tail liability claims (typically asbestos, pollution and health hazard) made against certain European market insurers. Many of these insurers faced collapse, as the liabilities swamping the market and the difficulty in estimating the IBNR and calculating an appropriate reinsurance premium were so great. The effect was that several troubled European insurers were without protection and remained exposed to the incoming claims.

CORRECTIVE ACTIONS. The situation was so dire that immense efforts were made to bring about a solution. One solution, in particular, allowed certain troubled European insurers to pay a premium (which varied according to exposure) and have all the liabilities for the exposed years 1992 and earlier to be reinsured by a specially formed company, ABC Reinsurer. Claims handling and all other aspects of the run-off were transferred to XYZ insurer (a wholly owned subsidiary of ABC Reinsurer). XYZ also reinsured ABC Reinsurer under a retrocession agreement. Certain rights of the original troubled insurers as reinsureds of ABC Reinsurer were held on trust for policyholders: In this way, the benefit of all reinsurance recoveries were applied in paying the liabilities due to policyholders. The intervening 10 years to 2006 found XYZ working to plan with a controlled program of inwards and outwards commutations as a means of dealing with the run off of these liabilities. In all practicality the original troubled insurers had finality—i.e. they were no longer financially exposed personally so long as XYZ remained solvent. However, as a matter of law, they did remain personally liable to policyholders for any excess liability over and above that paid by XYZ.

By early 2006, the market in the purchase of portfolios in run-off had taken off. XYZ was the world's largest business in run-off, so large that the number of likely purchasers was very limited. However, fortunately by the end of 2006, the two-stage deal with a large conglomerate—XOX—was announced, the stages being:

- 1) XYZ retroceded to XOX's subsidiary, BOB, its liabilities to ABC Reinsurer arising under the agreement. Cover was limited to approximately \$6 billion (U.S.) over and above existing reserves of approximately \$9 billion, as of March 2006. The premium was all of XYZ's assets less approximately \$340 million, plus a \$145 million contribution from some of the original troubled insurers. Staff and operations were transferred to another XOX subsidiary, RRR.
- 2) A "Part VII transfer" of all the liabilities of the original troubled European insurers (and the protection of the ABC Reinsurer–XYZ–BOB reinsurance chain) to a third-party company. Provided the transfer was to take place before December 2009, XYZ would be entitled to purchase further reinsurance from BOB of up to \$1.3 billion if XYZ's net undiscounted reserves had not deteriorated by more than \$2 billion from their March 31, 2006, position.

Part VII of the UK Financial Services & Markets Act 2000 (FSMA) provides a statutory novation of business (i.e., reinsureds' obligations to their policyholders) by a transferor re/insurer to the transferee re/insurer, provided that strict procedures are complied with. The novation is effected by court order. The court order has the effect of vesting the transferor's business in the transferee without the need for consent of the policy holders/reinsureds. The court can and usually does order assets attributable to the underlying business to be transferred—i.e., including the outwards reinsurance contracts. There are strict definitions of business that are subjected to a Part VII transfer. Put broadly, it applies to transfers of business carried on in the UK or elsewhere within the European Economic Area (EEA) with a UK connection as defined and where the transferred business is to be carried on from an establishment of a transferee in an EEA state. There are various conditions and exclusions.

The unusual position of these particular re/insurers, should they wish to avail themselves of Part VII, was recognized at the time Part VII first became law. However, additional changes to the legislation had to be made to facilitate this transaction, and they became law in 2008. In particular, the Part VII provisions in the FSMA were extended to a further cohort of these particular re/insurers.

Under the Part VII transfer procedure, there are two court applications. The first gives directions as to notices to be served and other technical requirements allowing any opposing reinsureds or outwards reinsurers to object to the transfer. In the case of the XYZ Part VII, certain requirements were dispensed with taking into account the high volume of notices that would have to be given to individual names and other relevant parties. An essential part of the procedure is the report provided by an independent expert whose identity is approved by the Financial Services Authority (FSA). Furthermore, the FSA itself provides a report indicating its views that is made available to those interested in the transfer. Time is allowed for any objectors to produce their own case in the context of the independent expert report and the FSA's report. In the case of the XYZ transfer, the FSA indicated that it would not object to the transfer.

The second and final stage of the process is the application for sanction by the court. The court has discretion whether to sanction the transfer scheme but may not do so unless it considers it appropriate in all the circumstances of the case. Under case law on the statutory provisions, the court is concerned as to whether a policyholder, employee or other interested person will be adversely affected by the transfer scheme. The hearing took place in mid-year 2009, and the judge concluded that the Part VII transfer scheme should go ahead.

During the hearing, the judge was satisfied that other requirements protecting policyholders of the business being transferred had been fulfilled, such as that certificates of solvency for the transferee company were obtained confirming the adequacy of the transferee's solvency for the purpose. Presentations explaining the import of the transfer had been carried out in the UK and in the jurisdiction of XOX to transferring policyholders, the original troubled insurers, and their representatives. Help lines and a Web site had been set up. Numerous telephone calls, e-mails or letters had been sent in response by the Part VII advisers, with less than 10 people raising substantive issues.

ENFORCEMENT IN OTHER JURISDICTIONS. Part VII of the FMSA originates from EU Directives. The sanction order is thereby recognized throughout the EEA. A further step would be needed to ensure enforcement in the United States and other countries where policyholders were located. However, the shape of the scheme is such that enforcement in the United States and other jurisdictions is most probably unnecessary. Policyholders would be entitled to drawdown on trust funds located in the United States, Canada, Australia and South Africa, providing them with security for amounts accruing due to them over time should there be any default payment.

PROGRESS. With the sanction of this transfer scheme granted during mid-year 2009, the two-stage transaction provided by the XOX group was completed in time. Because the transfer was affected prior to December 2009, it is believed that the further amount of \$1.3 billion (U.S.) reinsurance cover will be available to secure future payment of all policyholder claims.

B. SAMPLE DOCUMENTS

1. SAMPLE SUPERVISION CONSENT ORDER

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In the Matter of:			
	§		
The Administrative Supervision of		§	
RESTRUCTURED TROUBLED		§	
REINSURANCE CORPORATION, a		§	Docket No. EX xx-xx
Connecticut domiciled property and casualty insurance company.	§		
-----	§		

CONSENT ORDER

This Consent Order is entered into by and between Restructured Troubled Reinsurance Corporation (RTRC) and the Insurance Commissioner of the State of Connecticut (the Commissioner) to provide supervision and regulatory oversight of RTRC in the run-off of its insurance and reinsurance obligations in force.

WHEREAS, the Commissioner hereby finds, and RTRC agrees, as follows:

1. The Commissioner has jurisdiction over the subject matter and of RTRC.

2. RTRC is a Connecticut-domiciled property and casualty insurer and reinsurance company having its principal office at XXX Street, Anywhere, XX 00000, and holds a certificate of authority to transact the business of insurance and reinsurance in Connecticut and is licensed or accredited in a number of other states.

3. RTRC is a wholly owned direct subsidiary of Restructured Troubled Corporation (RTC), a Delaware corporation and an indirect subsidiary of Restructured Troubled (Barbados) Ltd., a Barbados corporation which is a wholly owned direct subsidiary of Restructured Troubled Group Ltd. (RTG), a Bermuda corporation.

4. Due to the significant deterioration of RTG’s financial condition in 20XX, on December 3, 20XX, RTRC entered into a “letter of understanding” with the Connecticut Insurance Department (Department) as part of the Department’s continuing financial monitoring of RTRC pursuant to which RTRC agreed that it would not take certain actions without the prior written approval of the Connecticut Insurance Commissioner or her designee, including, among others, disposing of any assets, settling any intercompany balances or paying any dividends.

5. RTRC has submitted to the Department a risk-based capital report, (the RBC Report) pursuant to CONN. AGENCIES REGS. § 38a-72-2. The RBC Report indicates that RTRC was at the “Regulatory Action Level Event” as of December 31, 20XX. On July 30, 20XX, RTRC filed with the Department an updated RBC Report which estimates that RTRC was at the “Authorized Control Level Event” as of June 30, 20XX.

6. RTRC has ceased underwriting activities and has determined that it is in the best interests of its

policyholders and creditors to run-off the existing operations of RTRC in such a manner as would maximize the availability of funds to satisfy the interests of policyholders, creditors, and other constituents.

7. RTRC has retained the services of a firm with expertise and experience in run-off management to review the operations of RTRC and its subsidiaries in run-off, to supplement its internal resources, and to accelerate the successful completion of the run-off, all pursuant to a comprehensive run-off plan (including therein, among other items, a plan to effectuate commutation of existing reinsurance obligations). The run-off management consultant will develop and submit, along with a more extensive run-off engagement agreement retaining their services to manage the run-off, to the RTRC Board of Directors for approval and, if such plan and agreement are approved, to the Commissioner, creditors of RTC, and other constituencies for approval.

8. On April 15, 20XX, the Department commenced a targeted examination of the financial condition of RTRC pursuant to CONN. GEN. STAT. § 38a-14. The examination was called based on RTRC's submission of a Cash Flow Projection Model to demonstrate that RTRC has sufficient assets and cash flow to pay both claims and operating expenses as those obligations become due.

9. On August 20, 20XX, RTG and RTC filed for protection under Chapter 11 of Title 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware.

10. RTRC is in such condition that regulatory control of the insurer is appropriate to help safeguard its financial security and is in the best interests of the policyholders and creditors of the insurer and of the public as RTRC administers the run-off of its existing business.

IT IS THEREFORE ORDERED AND AGREED THAT:

11. RTRC hereby consents to and shall be placed under the administrative supervision of the Commissioner pursuant to CONN. GEN. STAT. § 38a-962b and under the terms herein.

12. RTRC hereby knowingly and voluntarily waives receipt of written notice under CONN. GEN. STAT. § 38a-962b of grounds for the Commissioner to effectuate administrative supervision by the Commissioner.

13. The period of administrative supervision by the Commissioner shall commence upon execution of this Consent Order. The period of supervision pursuant to this Consent Order shall be coterminous with the run-off of RTRC's existing business, unless the Commissioner takes action pursuant to Paragraph 27 hereof.

14. The determination that RTRC shall be subject to administrative supervision by the Commissioner may be abated and thereby released from administrative supervision by the Commissioner if RTRC complies with the orders of supervision provided herein and, during the period of supervision, RTRC shall have attained sufficient liquidity, surplus, and reserves necessary to exceed and maintain Company Action Level RBC, as defined in CONN. AGENCIES REGS. § 38a-72-1, or the Commissioner in her sole discretion determines the supervision of RTRC is no longer necessary for the protection of policyholders, claimants, creditors, or is no longer in the public interest.

15. During the period of supervision, RTRC shall not undertake, engage in, commit to accept, or renew

any insurance obligations including without limitation, insurance or reinsurance policies or any similar arrangements or agreements of indemnity or, without the prior written approval of the Commissioner, make any material change in any insurance or reinsurance agreement which would increase the financial obligations of RTRC in any material respect. Moreover, RTRC shall not engage in activities beyond those that are routine in the day-to-day conduct of its business in run-off and are otherwise consistent with its comprehensive business run-off plan (Run-off Plan) to be filed with, and found acceptable by, the Commissioner, without the prior approval of the Commissioner or her designee. The routine day-to-day conduct of RTRC's business in run-off includes but is not limited to: (a) paying claims and operating expenses as such obligations become due and in accordance with the applicable law and the settlement and commutation of claims and insurance and reinsurance obligations, unless otherwise provided in the following paragraph or otherwise directed or approved by the Commissioner or her designee; (b) defending RTRC and persons insured or claiming to be insured by RTRC against claims arising from or related to insurance policies and reinsurance agreements previously issued, assumed, or ceded by RTRC; (c) settling or otherwise resolving or attempting to adjust and resolve such claims; (d) engaging, directing, discharging, and compensating counsel (including reasonable costs incurred) with respect to such claims or other matters; (e) paying settlements or judgments with respect to such claims; and (f) investing the assets of RTRC and liquidating such assets in an appropriate manner as required to pay claims, operating expenses, settlements, commutations, and other charges in the ordinary course of business and subject to the provisions of this Consent Order.

The routine day-to-day conduct of RTRC's business in run-off also includes but is not limited to: (a) submitting information to reinsurers with respect to RTRC's reinsured losses and loss adjustment expenses; (b) advising reinsurers of all sums due to RTRC under their respective reinsurance contracts and treaties with RTRC (including settlement and commutation thereof, provided, however, that RTRC shall not enter into commutation of liabilities (either inward or outward including obligations of others to RTRC) or settlements of claims other than for amounts not in excess of \$250,000 except as otherwise provided in the Run-off Plan or otherwise approved by the Commissioner or her designee); and taking all actions necessary and appropriate to recover all sums due to RTRC from reinsurers and others.

The following activities, to the extent not necessary for the adjusting and payment of losses and expenses associated with claims adjusting and settlement or commutation of reinsurance agreements are understood to be outside the day-to-day conduct of RTRC's business in run-off, and in no event shall RTRC engage in or undertake the following activities without the prior approval of the Commissioner or her designee:

- (a) Dispose of, convey, or encumber any of its assets or its business in force.
- (b) Withdraw any of its bank accounts.
- (c) Lend any of its funds.
- (d) Invest any of its funds.
- (e) Transfer any of its property.
- (f) Incur any debt, obligation, or liability.
- (g) Merge or consolidate with another company.
- (h) Write new or renewal business.
- (i) Enter into any new reinsurance contract or treaty.
- (j) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except for nonpayment of premiums due.
- (k) Release, pay, or refund premium deposits, unearned premiums, or other reserves on any insurance policy, certificate, or contract.

- (l) Make any material change in management.
- (m) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

RTRC shall make a recommendation with the reasons therefore in writing to obtain the prior approval of the Commissioner as to any of the foregoing actions.

16. The Commissioner shall have the final authority to approve or disapprove the initiation, settlement, or withdrawal by RTRC of any action, dispute, arbitration, litigation, or proceeding of any kind involving RTRC that is not in the ordinary course of business or would require payment in excess of \$250,000. RTRC shall prepare a written report to the Commissioner with a recommendation for approval or disapproval with the reasons therefore.

17. Without the prior written approval of the Commissioner, RTRC shall not (i) add any individual who is not currently a senior executive officer of RTRC, or one of its affiliates, to the board of directors of RTRC or (ii) move the principal offices or records of RTRC to a location outside of Connecticut.

18. RTRC shall file with the Department a monthly financial statement consisting of a balance sheet and income statement on the 25th day of each month as of the end of the prior month.

19. At least annually, RTRC shall submit an actuarial analysis prepared by a qualified actuary as defined in CONN. AGENCIES REGS. § 38a-53-1 of the loss and loss adjustment expense reserves.

20. RTRC shall submit a report on a quarterly basis containing detailed information on all commutations of reinsurance treaties and related activities which have occurred year-to-date, including specific impact on RTRC's statutory financial statement.

21. RTRC shall submit to the Department any additional reports that the Department reasonably determines as necessary to ascertain the financial condition of RTRC.

22. RTRC shall submit any and all reports or items required by this Consent Order, and all requests for the Commissioner's action or approval to:

_____ (name)
Connecticut Insurance Department
P.O. Box 816
Hartford, Connecticut 06142-0816
(860) 297-3823
(860) 566-7410 FAX

23. The Commissioner may retain, at RTRC's expense, such experts (including, but not limited to, attorneys, actuaries, accountants, and investment advisors) not otherwise a part of the Commissioner's staff, as the Commissioner reasonably believes is necessary to assist in the supervision of RTRC.

24. RTRC hereby knowingly and voluntarily waives all rights of any kind to challenge or to contest this Consent Order, in any forum now available to it, including the right to any administrative appeal pursuant to CONN. GEN. STAT. § 4-183.

25. This Consent Order of supervision, and proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the administrative supervision by the Commissioner of RTRC are subject to the confidentiality provisions of CONN. GEN. STAT. § 38a-962c and § 38a-8.

26. RTRC shall continue to comply with all obligations under law, including applicable financial, regulatory, and tax reporting requirements.

27. Nothing in this Consent Order shall preclude the Commissioner from taking further action as the Commissioner in her sole discretion deems appropriate and in the best interest of RTRC’s policyholders and the public, including commencement of further legal proceedings if and as necessary under Chapter 704c of the Connecticut General Statutes.

28. This Consent Order shall supersede in all respects the “letter of understanding” between RTRC and the Department referenced to in Paragraph 4 of this Consent Order, which letter shall have no further force and effect.

29. The Board of Directors of RTRC, at a specially called meeting or by unanimous written consent, has simultaneously, with the entry of this Consent Order, approved and provided resolutions complying with the terms of this Consent Order, which is effective upon entry of this Consent Order.

The foregoing Consent Order for Restructured Troubled Reinsurance Corporation is entered and shall be effective at 3:00 p.m. on this _____ day of September 20XX.

(name)
Insurance Commissioner

Agreed and Consented to by RESTRICTURED TROUBLED REINSURANCE CORPORATION on this _____ day of September 20XX.

By: _____
(name)
President

(Corporate Seal)

On this _____ day of September 20XX, before me, the subscriber, personally appeared

_____, the President of Restructured Troubled Reinsurance Corporation, who I am satisfied is the person who has signed the preceding Consent Order, and he did acknowledge that he signed, sealed with the corporate seal, and delivered the same as such officer aforesaid and that the Consent Order is the voluntary act and deed of such company made by virtue of the authority vested in him by its Board of Directors.

(name), (Title)

2. SAMPLE REINSURER LETTER AGREEMENT

November , 20XX

President
Restructured Troubled Reinsurance CompanyXXX Street
Anywhere, XX 00000

Dear_____:

The Any State Insurance Department (Department) continues its financial monitoring of Restructured Troubled Reinsurance Corporation (RTRC or Company).

The Company's parent, Restructured Troubled Group Ltd. (RTG) reported an operating loss of \$245 million for the third quarter of 2002 and an operating loss of \$252.6 million for the first nine months of 2002. The loss resulted principally from approximately \$100.7 million of loss reserve increases recorded by the operating subsidiaries and a \$64.5 million loss related to the establishment of a deferred tax valuation reserve. The operating results for the first nine months of 20XX included approximately \$33 million of loss development related to the September 11th terrorist attacks recorded in the first quarter of 20XX. On October 18, 20XX, A.M. Best Company lowered the ratings of the operating subsidiaries of RTG from A- to B+. Subsidiary Insurance Company was lowered from A- to B. The downgrade constituted an event of default under RTG's bank credit facility, under which banks had issued \$336 million in letters of credit to support RTG's underwriting at its Lloyd's operation. On November 1, 20XX, with the approval of the Department, the Company entered into an Underwriting and Reinsurance Arrangement with Facility Re, Inc., whereby new business is underwritten by Facility Insurance Company, a member of the Facility Group. On November 14, 2002, A.M. Best again lowered the ratings of the operating subsidiaries of RTG from B+ to B-. Subsidiary Insurance Company was lowered from B to C++.

In order to protect the existing quality and integrity of RTRC's assets, reserves, and management to protect policyholders/reinsureds and the public, it is requested that the Company agree to the following:

1. RTRC shall not take any of the following actions without the prior written approval of the Insurance Commissioner or her designee:
 - a. Dispose of, convey, or encumber any of its assets or its business in force.
 - b. Withdraw any of its bank accounts except in the ordinary course of business.
 - c. Settle any intercompany balances.
 - d. Lend any of its funds.
 - e. Transfer any of its property.
 - f. Make any investments other than cash equivalents.
 - g. Incur any debt, obligation, or liability, except liabilities in the ordinary course of business.
 - h. Make any material change in management.

- i. Make any material change in the operations of the Company.
 - j. Move any books and records from its office in Stamford, Connecticut.
 - k. Pay any dividends, ordinary or extraordinary.
 - l. Enter into any affiliated reinsurance contracts, affiliated commutation agreements, or settlement agreements.
 - m. Enter into any unaffiliated insurance or reinsurance contracts that would constitute new or renewal business, or any unaffiliated commutation agreements or settlement agreements in excess of \$1 million not in the ordinary course of business.
 - n. Enter into affiliated transactions of any nature.
2. Senior management shall meet with the Department, in person or by conference call, with such frequency as may be deemed necessary by the Insurance Commissioner or her designee, to provide updates on the status of the parent and any changes in the status of the Company.
 3. A monthly financial statement consisting of a balance sheet and income statement shall be filed with the Department on the 25th day of each month as of the prior month end.
 4. The above-described terms shall continue in effect until such time as the Insurance Commissioner shall deem they are no longer necessary or issues an order that supersedes this agreement.
 5. RTRC acknowledges that nothing contained herein shall in any way limit any power or authority given the Insurance Commissioner under the laws of the State of Connecticut, including the right to initiate any further actions as she deems in her discretion to be necessary for the protection of RTRC's policyholders/reinsureds and the public.

I have enclosed two originals of this letter to your attention. Please sign and date both originals, retain one for your file, and return one executed original to me.

Sincerely,

_____, Chief Examiner
Financial Analysis & Compliance

AGREED TO this _____ day of November, 20XX, by a duly authorized representative of RTRC.

C. SAMPLE OUTLINE FOR RUN-OFF PLANS

The following is a sample outline for a run-off plan.

- I. Introductory Overview
 - A. Executive Summary: Providing an executive level summary of the history, current business conditions, recent significant transactions, and proposed run-off solution.
 - 1. Status
 - 2. Mission
 - 3. Business (Guiding) Principles
 - B. Plan Objectives: Describing the ability of the plan to fully and timely settle all valid policyholder claims in compliance with the liquidation priorities of state distribution scheme.
 - C. Advantages
 - D. Benefits
- II. Corporate History
 - A. Summary
 - B. Recent Happenings: Description of business plans, significant transactions, prior restructuring plans, and financial performance related thereto.
 - 1. Mergers & Acquisitions
 - 2. Employment
 - 3. Internal Growth
 - 4. External Factors
 - 5. Current Position
 - C. Business Description: Including a comprehensive description of organizational and corporate structure, lines of insurance, nature of policyholder and other risks, and claim-handling function associated with the run-off.
 - 1. Lines
 - 2. Programs
 - 3. Markets
 - D. Reserve Development
 - 1. Environmental Issues
 - 2. Underwriting Issues
 - 3. Adverse Development
 - 4. Reserves by Line – Summary

E. Financial Condition: Summary of recent financials

1. Summary
2. Statutory Surplus
3. Consolidated Financial Statement(s)
4. Operating Expenses
 - a. Staffing
 - b. Insurance
 - c. Real Estate
 - d. Fixed Costs
 - e. Information Technology
5. Taxes

F. Operations: Description and historical comparison of staffing, real estate, expenses, insurance and information technology, and other pertinent operations associated with run-off.

1. Claims Handling
2. Reinsurance
 - a. Outstanding Balances
 - b. Disputes
 - c. Solvency Issues
 - d. Uncollectables
 - e. Write-offs
 - f. Collateral
 - g. Lines of Business
 - h. Programs
 - i. Processes & Systems

III. Run-off Plan: Description of initiatives and priorities, including demonstration of Run-Off Plan serving the best interests of policyholders and other claimants.

A. Summary

B. Financial Projections: Including description of surplus-enhancing initiatives and transactions, loss development, liquidity and expense projections.

1. Key Factors
2. Assumptions
3. Revenues

4. Expenses
 5. Surplus Projection
 6. Liquidity Projection
- C. Initiatives
1. Surplus Enhancing
 - a. Policy Buybacks
 - b. Expense Reductions
 - i. Operating Expenses
 - a. Staffing
 - b. Real Estate
 - c. Fixed Costs
 - d. Insurance/Benefits
 - e. Information Technology
 - ii. Allocated Loss Adjustment Expenses
 - c. Reinsurance Commutations
 2. Liquidity
 - a. Asset Portfolio Assessment
 - b. Encumbered Assets
 - c. Unencumbered Assets
 - d. Statutory Deposits
- D. Risk Factors: Description and projection of risks associated with Run-Off Plan, including regulatory concerns, preferences, and risks associated with policyholders, and guaranty funds/associations, including identification of critical elements for plan success.
1. Define Uncertainties
 - a. Business
 - b. Economic
 - c. Regulatory
 2. Additional Adverse Loss Reserve Development
 3. Increased Reinsurance Disputes
 4. Unexpected Liabilities
 5. Drastic Asset Value Changes
 6. Financial Market – Investments

- E. Voluntary Run-off vs. Receivership: Analysis and comparison between the alternative mechanisms from best interests of policyholders, claimants, and guaranty funds/associations.
- F. Regulatory Reporting: Description of proposed regulatory supervision and reporting requirements—e.g., monthly statutory basis financial statements (balance sheet, statement of income and statement of cash flow), including comparison of actual results to Plan projections; quarterly reports demonstrating reinsurance recoverables and premium receivables past due, in dispute, litigation or arbitration; report demonstrating material credit exposures, related collateral held, and identity of credit impaired transactions; unpaid losses on state-by-state basis; weekly cash flow report; periodic review of loss reserves and amortization of any permitted loss reserve discounting, including appropriate actuarial certification; copies of all internal and external audit reports within five business days of issue; approval of all transactions exceeding pre-determined thresholds; and identification of prohibited transactions.
- G. Corporate Governance: Description of proposed governance and internal controls.

D. RELEVANT NAIC MODEL LAWS & REGULATIONS AND STATE STATUTES

This appendix section provides current and relevant NAIC Model Laws and Regulations, as well as specific state statutes that pertain to an insurance department's authority and responsibilities in dealing with troubled insurers. The sections are not intended to be all-inclusive, but rather a reference source.

1. NAIC MODEL LAWS & REGULATIONS

- Administrative Supervision Model Act
- Insurers Receivership Model Act
- Model Regulation to Define Standards and Commissioners' Authority for Companies Deemed to be in a Hazardous Financial Condition
- Criminal Sanctions for Failure to Report Impairment Model Bill

2. RULES AND REGULATIONS OF THE STATE OF NEW YORK – TITLE 11 INSURANCE DEPARTMENT – CHAPTER IV FINANCIAL CONDITION OF INSURER AND REPORTS TO SUPERINTENDENT – SUBCHAPTER D REINSURANCE – PART 128 COMMUTATION OF REINSURANCE AGREEMENTS (REGULATION 141)

(Text is current through February 15, 2008.)

Section 128.0. Purpose.

Section 1321 of the Insurance Law authorizes the Superintendent of Insurance to permit an impaired or insolvent domestic insurer or an impaired or insolvent United States branch of an alien insurer entered through this state to commute reinsurance agreements as a means of eliminating such an impairment or insolvency. This Part sets forth applicable standards that the superintendent will use in determining whether such commutations will be approved.

Section 128.1. Applicability.

This Part shall be applicable to any domestic insurer or United States branch of an alien insurer entered through this state, other than a life insurance company as defined in section 107(a)(28) of the Insurance Law.

Section 128.3. General provisions.

- (a) Nothing in this Part shall require the superintendent to give prior consideration to a plan which contains the commutation of reinsurance agreements in lieu of taking any other action against an impaired or insolvent insurer in accordance with the Insurance Law, including proceeding against such insurer pursuant to article 74 of the Insurance Law.
- (b) All the terms and conditions of any plan which contains the commutation of reinsurance agreements are subject to approval by the superintendent and no such plan will be approved by the superintendent unless the effect of the plan shall eliminate the insurer's impairment or insolvency and restore the insurer's surplus to policyholders to the greater of the minimum amount required to be maintained pursuant to the applicable provisions of the Insurance Law or to the amount the superintendent determines is adequate in relation to the insurer's outstanding liabilities or financial needs. The determination regarding the adequacy of the insurer's surplus to policyholders shall be made in accordance with the factors set forth in section 1104(c) of the Insurance Law.

Section 128.4. Requirements.

- (a) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall provide that:
 - (1) the offer to commute reinsurance agreements is made to each and every ceding insurer to which the impaired or insolvent insurer has obligations;
 - (2) the terms of the commutation agreement to be offered to each and every ceding insurer are the same, except that the percentage by which the impaired or insolvent insurer proposes to discount obligations due to each

ceding insurer may vary in regard to the type of business being commuted. Any variance by type of business shall be reasonable, actuarially sound and supported by documentation justifying such a variance; and

- (3) the impaired or insolvent insurer agrees to enter into a stipulation with the superintendent consenting to an order of rehabilitation or liquidation in the event that the implementation of the plan by the insurer does not result in restoring the insurer's surplus to policyholders to the minimum required as determined in accordance with section 128.3(b) of this Part.
- (b) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall include:
- (1) a balance sheet that reflects the insurer's impairment or insolvency as determined by the superintendent, a pro forma balance sheet reflecting the financial condition of such insurer subsequent to the effective date of the plan, and a reconciliation between both balance sheets;
 - (2) an exhibit setting forth the obligations due to each and every ceding insurer as of the proposed effective date of such plan and the consideration to be offered each and every ceding insurer for the commutation of such obligations. The obligations shall be classified in accordance with the categories contained in the definition set forth in section 128.2(c) of this Part; and
 - (3) details regarding any retrocessionaire's participation in the plan.

Section 128.5. Procedures.

- (a) Any plan which contains the commutation of reinsurance agreements shall be submitted to the superintendent by the impaired or insolvent insurer within a period designated by the superintendent, which shall not be more than 90 days from the determination of the insurer's impairment or insolvency.
- (b) If the superintendent has no objection to any of the plan's terms and conditions and determines that the impaired or insolvent insurer's surplus to policyholders will be restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the proposed plan shall be approved and the insurer shall offer the commutation proposals to its ceding insurers. No commutation agreement shall become effective and no consideration for any commutation agreement shall be paid by the impaired or insolvent insurer until the superintendent determines that, as a result of the commutation proposals agreed to and executed by the ceding insurers, along with the effect of any other components of the plan, the impaired or insolvent insurer's surplus to policyholders is restored to the minimum required.
- (c) Within 10 days after the superintendent approves the plan, the impaired or insolvent insurer shall deliver the proposed commutation agreements to each ceding insurer. The terms of any commutation agreement shall not be subject to negotiation between the impaired or insolvent insurer and the ceding insurer.
- (d) The impaired or insolvent insurer shall submit to the superintendent, within a designated period as determined by the superintendent, copies of the executed commutation agreements from those ceding insurers agreeing to the proposed terms, copies of rejections of the commutation agreements by those ceding insurers not agreeing to the proposed terms and copies of any other correspondence pertaining to all such offers made to the ceding insurers. This submission shall include a balance sheet that reflects the effect of the executed agreements, together with any other components of the plan, upon the insurer's impairment or insolvency as determined by the superintendent. The insurer shall also submit copies of executed agreements with any retrocessionaires which either modify, commute or assign any retrocession agreement.
- (e) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the executed commutation agreements shall become effective.
- (f) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is not restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the superintendent may proceed against the insurer in accordance with the stipulation executed pursuant to section 128.4(a)(3) of this Part.

Section 128.6. Reporting requirements.

Any impaired or insolvent insurer which eliminates such impairment or insolvency using commutations approved by the superintendent in accordance with the provisions of this Part shall exclude all historical data pertaining to such

commutations from the loss development schedules contained in future financial statements filed in accordance with applicable provisions of the Insurance Law. The historical data pertaining to the business commuted shall be reported on a supplemental loss development schedule in a form consistent with the schedule contained in statutory financial statements as filed with this department. The supplemental schedule shall show the aggregate experience of such business as of the effective date of commutation agreement.

3. RHODE ISLAND STATUTE AND REGULATION – VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS TITLE 27 CHAPTER 14.5 AND REGULATION 68

§ 27-14.5-2 Jurisdiction, venue, and court orders.

- (a) The court considering applications brought under this chapter shall have the same jurisdiction as a court under chapter 14.3 of this title.
- (b) Venue for all court proceedings under this chapter shall lie in the superior court for the county of Providence.
- (c) The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this chapter. No provision of this chapter providing for the raising of an issue by a party in interest shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of process.

§ 27-14.5-3 Notice.

- (a) Wherever in this chapter notice is required, the applicant shall, within ten (10) days of the event triggering the requirement, cause transmittal of the notice:
 - (1) By first class mail and facsimile to the insurance regulator in each jurisdiction in which the applicant is doing business;
 - (2) By first class mail to all guarantee associations;
 - (3) Pursuant to the notice provisions of reinsurance agreements or, where an agreement has no provision for notice, by first class mail to all reinsures of the applicant;
 - (4) By first class mail to all insurance agents or insurance producers of the applicant;
 - (5) By first class mail to all persons known or reasonably expected to have claims against the applicant including all policyholders, at their last known address as indicated by the records of the applicant;
 - (6) By first class mail to federal, state, and local government agencies and instrumentalities as their interests may arise; and
 - (7) By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in any other locations that the court overseeing the proceeding deems appropriate.
- (b) If notice is given in accordance with this section, any orders under this chapter shall be conclusive with respect to all claimants and policyholders, whether or not they received notice.
- (c) Where this chapter requires that the applicant provide notice but the commissioner has been named receiver of the applicant, the commissioner shall provide the required notice.

§ 27-14.5-4 Commutation plans.

- (a) *Application.* Any commercial run-off insurer may apply to the court for an order implementing a commutation plan.
 - (1) The applicant shall give notice of the application and proposed commutation plan.
 - (2) All creditors shall be given the opportunity to vote on the plan.
 - (3) All creditors, assumption policyholders, reinsurers, and guaranty associations shall be provided with access to the same information relating to the proposed plan and shall be given the opportunity to file comments or objections with the court.
 - (4) Approval of a commutation plan requires consent of: (i) fifty percent (50%) of each class of creditors; and (ii) the holders of seventy-five percent (75%) in value of the liabilities owed to each class of creditors.
- (1) The court shall enter an implementation order if: (i) the plan is approved under subdivision (b)(4) of this section; and (ii) the court determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders.
- (2) The implementation order shall:

- (i) Order implementation of the commutation plan;
 - (ii) Subject to any limitations in the commutation plan, enjoin all litigation in all jurisdictions between the applicant and creditors other than with the leave of the court;
 - (iii) Require all creditors to submit information requested by the bar date specified in the plan;
 - (iv) Require that upon a noticed application, the applicant obtain court approval before making any payments to creditors other than, to the extent permitted under the commutation plan, payments in the ordinary course of business, this approval to be based upon a showing that the applicant's assets exceed the payments required under the terms of the commutation plan as determined based upon the information submitted by creditors under paragraph (iii) of this subdivision;
 - (v) Release the applicant of all obligations to its creditors upon payment of the amounts specified in the commutation plan;
 - (vi) Require quarterly reports from the applicant to the court and commissioner regarding progress in implementing the plan; and
 - (vii) Be binding upon the applicant and upon all creditors and owners of the applicant, whether or not a particular creditor or owner is affected by the commutation plan or has accepted it or has filed any information on or before the bar date, and whether or not a creditor or owner ultimately receives any payments under the plan.
- (3) The applicant shall give notice of entry of the order.
- (1) Upon completion of the commutation plan, the applicant shall advise the court.
- (2) The court shall then enter an order that:
- (i) Is effective upon filing with the court proof that the applicant has provided notice of entry of the order;
 - (ii) Transfers those liabilities subject to an assumption reinsurance agreement to the assumption reinsurer, thereby notating the original policy by substituting the assumption reinsurer for the applicant and releasing the applicant of any liability relating to the transferred liabilities;
 - (iii) Assigns each assumption reinsurer the benefit of reinsurance on transferred liabilities, except that the assignment shall only be effective upon the consent of the reinsurer if either:
 - (A) The reinsurance contract requires that consent; or
 - (B) The consent would otherwise be required under applicable law; and
 - (iv) Either:
 - (A) The applicant be discharged from the proceeding without any liabilities; or
 - (B) The applicant be dissolved.
- (3) The applicant shall provide notice of entry of the order.
- (e) *Reinsurance.* Nothing in this chapter shall be construed as authorizing the applicant, or any other entity, to compel payment from a reinsurer on the basis of estimated incurred but not reported losses or loss expenses, or case reserves for unpaid losses and loss expenses.
- (f) *Modifications to plan.* After provision of notice and an opportunity to object, and upon a showing that some material factor in approving the plan has changed, the court may modify or change a commutation plan, except that upon entry of an order under subdivision (d)(2) of this section, there shall be no recourse against the applicant's owners absent a showing of fraud.
- (1) The commissioner and guaranty funds shall have the right to intervene in any and all proceedings under this section; provided, that notwithstanding any provision of title 27, any action taken by a commercial run-off insurer to restructure pursuant to chapter 14.5, including the formation or re-activation of an insurance company for the sole purpose of entering into a voluntary restructuring shall not affect the guaranty fund coverage existing on the business of such commercial run-off insurer prior to the taking of such action.
 - (2) If, at any time, the conditions for placing an insurer in rehabilitation or liquidation specified in chapter 14.3 of this title exist, the commissioner may request and, upon a proper showing, the court shall order that the commissioner be named statutory receiver of the applicant.
 - (3) If no implementation order has been entered, then upon being named receiver, the commissioner may request, and if requested, the court shall order, that the proceeding under this chapter be converted to a rehabilitation or liquidation pursuant to chapter 14.3 of this title. If an implementation order has already been entered, then the court may order a conversion upon a showing that some material factor in approving the original order has changed.

- (4) he commissioner, any creditor, or the court on its own motion may move to have the commissioner named as receiver. The court may enter such an order only upon finding either that one or more grounds for rehabilitation or liquidation specified in chapter 14.3 of this title exist or that the applicant has materially failed to follow the commutation plan or any other court instructions.
- (5) Unless and until the commissioner is named receiver, the board of directors or other controlling body of the applicant shall remain in control of the applicant.

RI Regulation 68 – www.dbr.state.ri.us/documents/rules/insurance/InsuranceRegulation68.pdf

Section 2 *Purpose*

The purpose of this Regulation is to outline the procedural requirements for insurance companies applying for the implementation of a Commutation Plan pursuant to R.I. Gen. Laws § 27-14.5-1, *et seq.* and related matters.

4. PART VII OF THE FINANCIAL SERVICES AND MARKETS ACT 2000 (FSMA)

www.opsi.gov.uk/acts/acts2000/ukpga_20000008_en_1

<http://fsahandbook.info/FSA/html/handbook/SUP/18>

<http://fsahandbook.info/FSA/html/handbook/PRIN>

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
BOB WAKE COMMENTS

Restructuring Mechanisms

An NAIC White Paper

October 22, 2021

**Created by the
Restructuring Mechanisms (E) Working Group
of the
Financial Condition (E) Committee**

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Section 1: Overview of IBT and Corporate Division Laws and Mechanics

A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period requiring insurers to record a liability for these incurred but not reported claims. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders- because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer’s business model and left to slowly run off. For some insurance companies, runoff business¹ remains embedded with the core business without the ability to segregate the runoff business. There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers or individual policy novation. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remains with the original insurer. The only way to transfer a block of business with finality is an individual policy novation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled “Liability-Based Restructuring White Paper.” (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off “material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities²” from current insurer operations. The white paper achieves this focus by inclusion of various section on related topics as well as multiple appendixes. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled “Alternative Mechanisms for Troubled Companies.” (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States (“US”) at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendixes.

Commented [RAW1]: The accounting is of secondary importance in this context – what’s more important than how it looks on the balance sheet is that the liability is very real, and the claimants will need that money.

Commented [RAW2]: “Runoff” as a single word is a noun or an adjective, not a verb.

Commented [RAW3]: I would delete the “Individual,” which implies the need to negotiate a separate deal with each policyholder. I think every state has “assumption reinsurance” laws that allow novations on an opt-out basis – though it’s slow, and there’s still a lack of finality if one or more policyholders do opt out. Maine has also had, since time immemorial (*i.e.*, before 1969) a “bulk reinsurance” law that allows novation of an entire block with regulatory approval (after notice, hearing, and opportunity to appeal) in lieu of policyholder consent.

Commented [RAW4R3]: Also, the phrase “individual policy novation” might be misread as referring to individual as opposed to group policies.

Commented [RAW5]: Or a policy commutation, where the policyholder takes back the tail risk. (Though I suppose you could call that a “novation to self-insurance.”)

¹ For purposes of this paper “runoff business” is defined as a block of insurance business that is no longer being actively written by an insurance company and no premiums are being collected, except where required to in accordance with contractual or regulatory obligations, and where the existing or assumed group of insurance policies or contracts are managed through their termination. This definition was developed based on comments received by the Restructuring Mechanism Subgroup from both regulators and industry interested parties; however, this definition has not yet been adopted by the subgroup.

² Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper (1997).

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be broken down into two categories generally referred to as insurance business transfer (“IBT”) and corporate division (“CD”). Several states, including Arkansas, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes while other states such as Arizona, Connecticut, Illinois, Iowa, Arkansas, Pennsylvania, and Michigan have enacted CD statutes. The stated intent of all these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the United Kingdom (“UK”) are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, better allocate specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsureds and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as redirect regulatory focus away from the insurer’s on-going business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.

Commented [RAW6]: The decision to lead with the UK in Section 2 makes sense, to provide the historical context and explain some of the inspiration for the US laws, but if we address them first in the body of the paper, that suggests giving them a similarly prominent role in this introduction.

Commented [RAW7]: But see “C” below. If capital is “freed” from a runoff book, what protects the policyholder, unless the policy is commuted, or some other source of capital is found that’s more willing to make a long-term commitment to support the runoff.

Commented [RAW8]: But what happened in the *Allianz* (General Star) case discussed in Part V?

Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such as mass tort, asbestos, environmental and general liability risks. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business.³ With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities.⁴ One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; 2) finality of economic transfer; and 3) operational efficiencies.⁵

Commented [RAW9]: But they also need not only to provide value to the runoff specialist, but also preserve value for the policyholder.

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulatory Concerns with Restructuring Plans

While restructuring may provide value to the insurer, regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that could provide less capital than is needed to satisfy the insurer's obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to

³ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁴ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁵ David Scasbrook (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.

approve the restructuring plan. Regulators have utilized procedures to ensure that the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

Section 2: History of Restructuring in the United Kingdom

A. Part VII Transfers and Solvent Schemes of Arrangement in the United Kingdom

IBT and CD laws and regulations are relatively new in the US, but the legal mechanism for the transfer or termination of insurance business has been implemented and operational in the UK for over twenty years. Part VII of the Financial Services and Markets Act of 2000⁶ (“Part VII” and “FSMA”) enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 300⁷ successful Part VII transfers have taken place in the UK providing guidance to American insurers on how this process could continue to unfold in the US.

A Part VII transfer is a regulatory mechanism, governed by sections 104–116 within Part VII of the FSMA. This act allows an insurer or reinsurer to transfer both long-term as well as and general insurance business from one legal entity to another, subject to approval of a court. Many insurers use the procedure to give effect to group reorganizations and consolidations. Part VII transfers have also been used extensively in response to Brexit.

In accordance with the FSMA, the Prudential Regulatory Authority (“PRA”) and the Financial Conduct Authority (“FCA”) maintain a Memorandum of Understanding which describes each regulator’s role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. Under the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

Section 110 of the FSMA allows both the PRA and the FCA to be heard in the proceedings. The Memorandum of Understanding confirms that both the PRA and the FCA may provide the court with written representations setting out their views on the proposed scheme, and the PRA may prepare a report regarding the IBT.

As set out in the Memorandum of Understanding, before nominating or approving an independent expert under section 109(2)(b) of FSMA . . . the PRA will first consult the FCA. Further, the PRA will consult appropriately with the FCA before approving the notices required under the Business Transfers Regulations.

Part VII transfers require a “scheme report.” This report is A similar report is required under to the independent expert report under US IBT laws, however, becausebut the word “scheme” is not used

Commented [RAW10]: Does the UK have CD? If so, mention at least briefly even if it’s not commonly used. Otherwise, say something like “Restructuring laws are relatively new in the US ...”

Commented [RAW11]: Compared to how many failures? If it’s described accurately below in Part V, I would not call the General Star transfer at issue in the *Allianz* case a success from the public’s perspective.

Commented [RAW12]: Need to define these terms, especially if my guess is correct that long-tail casualty is considered “general” insurance.

Commented [RAW13]: Do we need to briefly explain what the roles are? The names almost speak for themselves if you’re familiar with the concept, but not all readers will be.

⁶ Financial Services and Markets Act of 2000, 48 Eliz. 2, part 7 (Eng.). FOR CITATION TO ONLINE SOURCE USE: Financial Services and Markets Act of 2000, part 7 (Eng.), <https://www.legislation.gov.uk/ukpga/2000/8/contents>.

⁷ Comment letter from the IBT Coalition Interested Parties to the Restructuring Mechanisms (E) Subgroup dated July 22, 2019.

~~because has a different~~ ~~it has negative context connotations~~ in the US, the word “scheme” is not used American English. Under section 109(2) of FSMA, ~~an independent expert~~ ~~the scheme~~ report may only be made by an independent expert person who:

- (a) appears ~~ing~~ to the PRA to have the skills necessary to ~~enable him to~~ make a proper report; and
- (b) is nominated or approved by the PRA.

The regulators expect the independent expert making the report to be a neutral person, who:

- (a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and
- (b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group’s discussion of the Part VII transfers, consumer representatives raised the UK court’s decision in *In re Prudential + and Rothesay*⁸ which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity

⁸ As noted by Birny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. Note this was overturned by The Prudential Assurance Company Limited v. Rothesay Life PLC [2020] EWCA Civ 1626.

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Commented [RAW14]: Need to rewrite the Prudential/Rothesay section to address the issues, but make the outcome clearer from the beginning. But what **is** the outcome? The Court of Appeal didn’t actually approve the transfer, but remanded the case to the High Court to be heard by a different judge.

The hearing at the High Court has concluded but the judgement has not yet been handed down.... We will continue to keep this webpage updated. ☺

transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals⁹ found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

- (1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.
- (2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries' capital.
- (3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.¹⁰

Despite this set of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of transferred. While such an arrangement may provide some of the same features as a Part VII transfer, the solvent scheme does not continue the coverage with a new insurer the way a Part VII transfer does. Other differences may exist in law, but ~~are not deemed to be relevant to this is the most significant for purposes of this specific~~ white paper.

Commented [RAW15]: Do we mean that they do exist, or has the research not been done yet?

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. ~~These~~ One type of restructuring law generally follows ~~ing~~ the UK structure, ~~began with~~ Rhode Island was the first state to take

⁹ *Prudential Assurance Company Ltd and Rothesay Life Plc, Re*, England and Wales Court of Appeal (Civil Division)(Dec. 2, 2020).

¹⁰ *Id.* at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15

~~this approach, in 2002~~ adopting a statute ~~in 2002~~ titled Voluntary Restructuring of Solvent Insurers¹¹ patterned after Solvent Schemes of Arrangements. ~~This type of Rhode Island refers to this process was renamed as a “Commutation Plan,”s and it differs from the UK law a Solvent Scheme~~ in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.¹² ~~Commutation Plans continue to be available under RI law.~~

~~Although Commutation Plans continue to be available under Rhode Island law, Rhode Island updated its law in ????~~ to provide an additional option: ~~In 2015 Rhode Island adopted an Insurance Business Transfer Plans, regulation¹³ structured These are similar to the Part VII transfers, but a-~~ Again, in contrast to the UK, the ~~Rhode Island~~ regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments receives continues to believe that it meets the statutory requirement have been met, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act (“LIMA”).¹⁴ LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act¹⁵ modeled after UK’s Part IV regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed two IBTs in October 2020 and September 2021, involving a Rhode Island and Wisconsin insurer respectively, which are described below. Neither of the plans were challenged in the state court proceedings. |

In 2021, Arkansas adopted the Insurance Business Transfer Act¹⁶ which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is be made for an

Commented [RAW16]: This needs work, but wasn't there a time lag between the enabling legislation and the promulgation of the regulation that enabled the implementation of the process.

Commented [RAW17]: Why do the blank single-line paragraphs have a different indent than the text paragraphs?

¹¹ [R.I. Gen. Laws Chapter 27-14.5.](#)

¹² [In re GTE Reinsurance Co., No. PB 10-3777, 2011 WL 7144917, at *5-6 \(R.I. Super. Ct. Apr. 25, 2011\)](#)

¹³ 230 RICR 20-45-6.

¹⁴ See Legacy Insurance Management Act, 2014 Vt. Acts & Resolves 93 (codified as amended at VT. STAT. ANN. tit. 8, §§ 7111-7121 (West 2017)).

¹⁵ Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 *et seq.*

¹⁶ As announced by the Arkansas Department of Insurance July 8, 2021, ACA §§ 23-69-501, *et seq.* (See Arkansas statute at <https://www.arkleg.state.ar.us/Bills/Detail?id=SB203&ddBienniumSession=2021%2F2021R>

extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report.

And we need more about CDs here...

The National Council of Insurance Legislators has promulgated a model IBT law¹⁷ modeled after the Oklahoma IBT statutes, as well as a model CD law¹⁸. A number of states have adopted CD statutes, whether specific to insurance or based on the state's general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania¹⁹. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

A. Similarities and Differences between Statutes

Rhode Island's IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer's domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer plan on policyholders considering whether the security position of policyholders is materially adversely affected by the transfer. All states also require notification to all affected policyholders as well as the opportunity to be heard at a public hearing.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate runoff books of business from an insurer.

The Illinois' Domestic Stock Company Division Law²⁰ requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless at least one of the following characteristics exist/disqualifying factors is found:

- (1) policyholder/shareholder interests are not protected;
- (2) each insurer would not be eligible to receive a license in the state;

¹⁷ Insurance Business Transfer Model Act (Nat'l Council of Ins. Legislators 2020).

¹⁸ Insurer Division Model Act (Nat'l Council of Ins. Legislators 2021).

¹⁹ See A.R.S. §§ 29-2601, *et seq.*; C.G.S.A. §§ 38a-146, *et seq.*; 215 ILCS 5/35B-1 *et seq.*; M.C.L.A. §§ 500.5500 *et seq.*; A.C.A. §§ 23-69-501, *et seq.*; 15 Pa.C.S. §§ 361 *et seq.*

²⁰ 215 ILL. COMP. STAT. 5 as found at <https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1249&ChapterID=22>.

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Commented [RAW18]: This doesn't really fit here. The introduction to IBTs ought to be followed by a description of CDs that operates as a similar level, and then the comparison between IBTs and CDs, which is probably where the NCOIL Model goes – it can be included in the comparison with existing state law..

Commented [RAW19]: Some of the material below needs to go above – there should be an introduction to the CD concept at about the same level of detail as the introduction to the IBT concept.

Commented [RAW20]: As written, Director must find all 5 in order to disapprove. I hope that's not what the law says.

- (3) division violates the ~~Uniform Fraudulent Act~~;
- (4) division is made for the purpose of hindering, delaying, or defrauding other creditors;
- (5) any of the companies ~~are~~ is insolvent after the division is complete.

Commented [RAW21]: There's a noun missing. Fraudulent Transfer(s)??

The Connecticut CD statute²¹ creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the ~~domestic dividing~~ insurer; (2) the ~~names of the~~ resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing.

Commented [RAW22]: Can a division have only one resulting insurer?

The Pennsylvania CD statute²² was enacted in 1990 and is ~~the subject of discussed in~~ the NAIC 1997 white paper on Liability-Based Restructuring, ~~attached to this paper as an appendix~~. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the states' equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

Commented [RAW23]: All the body of the paper has is a single paragraph mentioning that two states had recently adopted CD laws, without even naming the states. The only specific discussion of Pennsylvania is the CIGNA case study at the beginning of Appendix 1..

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist

²¹ C.G.S.A. §§ 38a-146, *et seq.*, Public Act No. 17-2 as found at <https://www.cga.ct.gov/2017/act/pa/pdf/2017PA-00002-R00SB-01502SS1-PA.pdf>

²² 15 PA. CONS. STAT. §§ 361 *et seq.*

in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal experts.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in 1995, when the Pennsylvania Insurance Department approved a division of the Cigna Corporation, which is commonly referred to as the “Brandywine transaction,” after the name of one of the resulting insurers. ~~announced that it had approved a transaction that transferred a book of business from one entity to another.~~ This transaction is discussed in more detail within Attachment 1, which is Appendix 1 of the 1997 Liability-Based Restructuring White Paper, ~~and is commonly referred to as “the Brandywine” transaction, but within the 1997 White Paper is discussed within Appendix 1 and relates to Cigna, where more information is available. During the Working Group’s discussions in 2019, the Pennsylvania Insurance Department, which is captured in the following paragraph.~~

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and immaterial to the policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re²³ completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision²⁴ on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company’s (“PWIC”) IBT plan.²⁵ The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company (“Sentry”), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for

²³ C.A. No. PB 10-3777 (R.I. Super. Apr. 25, 2011)

²⁴ State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777 <https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/decisions/10-3777.pdf>

²⁵ Judgment & Order of Approval & Implementation of the IBT Plan, In re Transfer and Novation of Insurance Policies from Province Wash. Ins. Co., et al., CJ-2019-6689 (D.Ct. Okla. Cnty Oct. 15, 2020) at <https://www.oscn.net/dockets/GetCaseInformation.aspx?db=oklahoma&number=CJ-2019-6689&cmid=3831864>.

Commented [RAW24]: Why was it immaterial to policyholders? Do we mean immaterial to consumers? But what about claimants? What ultimately happened to Brandywine. A quick Google search turns up this from 2005:

Allstate Insurance Company, American International Group Inc., Chubb & Son and St. Paul Travelers are challenging the proposed sale of three of its asbestos and environmental run-off subsidiaries by ACE Limited to Randall & Quilter Investment Holdings of Great Britain. The insurers have asked Commissioner Diane Koken and the Pennsylvania Department of Insurance to closely examine the proposed transaction.

On Jan. 6, ACE announced that it planned to sell its ACE American Reinsurance Company, Brandywine Reinsurance Co. (UK) Ltd. and Brandywine Reinsurance Company S.A.-N.V. to Randall & Quilter. It also said it would take \$279 million in after tax reserve charges on Brandywine, and another \$19 million relating to the ACE Westchester Specialty unit. Century Indemnity Company, an indirect, wholly owned subsidiary of ACE, is also involved. The sales require the approval of the Pennsylvania department and the U.K. Financial Services Authority.

ACE acquired the companies as part of the acquisition of INA from Cigna in 1999. They subsequently were found to have large exposures to asbestos and environmental claims, and have become a liability for the ACE Group.

The protesting insurers fear that the sale to the U.K.-based Randall & Quilter could weaken the security relied on by policyholders and other insurance companies. They question whether, if asbestos and environmental claims continue to require increases in reserves, Randall & Quilter would have the funds needed. If the transaction is not approved, ACE’s affiliates would remain liable for such continuing obligations.

The insurers’ petition further suggests that the sale is an attempt to shift a share of Century’s run-off liabilities onto British firms outside of U.S. regulatory authorities. The insurers said ACE is trying to “place more distance between itself and the legal obligations of its subsidiaries” and to avoid Pennsylvania’s “continuing scrutiny, moral pressure and directives.”

approval.²⁶ This IBT transfers a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2020. The transaction was a transfer of risks with distinct characteristics into a single insurer within a holding company structure. All the transfers originated and ended within the same holding company. The Illinois Department of Insurance has indicated that it will issue a detailed regulation as experience develops with CD plans proposed and completed under the statute.

Commented [RAW25]: How is that a CD?

Section 4: Impact of IBTs and CDs to Personal Lines

A. Guaranteey Association Issues

~~An important issue for corporate restructuring is the availability of guaranty association coverage in the event of the insolvency of the restructured insurer. In order to uphold the stated declaration that prevent restructuring should not from materially adversely affecting consumers, it is essential to ensure that guaranty association coverage should is not be reduced or eliminated by the restructuring.~~ Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine association coverage. Although most states pattern their laws after the NAIC model law, there could potentially be different results concerning guaranty association coverage depending on where the insured resides.

The Working Group received input from both the National Organization of Life and Health Insurance Guaranty Associations (“NOLHGA”) and the National Conference of Insurance Guaranty Funds (“NCIGF”). NOLHGA described how the concerns for insurance consumers of personal lines business is particularly pronounced.

NOLHGA indicated that for there to be guaranty association coverage in the event of an insurer insolvency, there are three conditions that must be present. Those conditions are:

- (1) The consumer seeking protection must be an eligible person under the statute; typically, this is achieved by being a resident of a state who has a guaranty association;
- (2) The product must be a covered policy; and
- (3) The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state or have been licensed in the state.

²⁶ Approval Order in Case No. 20-0582-IBT from Oklahoma Insurance Commissioner, filed on November 23, 2020, at <https://www.oid.ok.gov/wp-content/uploads/2020/11/20-0582-IBT-SAW-Order-11-23-20.pdf>.

In most states, coverage can also be provided for an “orphan” policyholder of the insurer, who was eligible for protection when the coverage policy is issued but the policyholder has since moved to a state that where the insurer is not a guaranty association member. Those policies are covered under the state in which the insolvent insurer is domiciled. However, this provision is designed to plug the gap in these rare situations. Orphan coverage was not designed to provide coverage to all policyholders regardless of domicile, only to plug the one specific gap in coverage that has been identified. It might occur if the resulting insurer in an IBT or CD does not otherwise meet the requirements for guaranty association coverage, it is unlikely that the “orphan” policyholder clause would help. If there are gaps in coverage, or coverage is uncertain, legislative action is necessary in each affected state in order to protect policyholders and third-party claimants. These issues can be addressed in legislative and regulatory manners including maintaining a certificate of authority in each state, so the insurer is a guaranty association member insurer in each state. However, if an insurer is unwilling or unable to meet such requirements it could impede the ability to complete a restructure.

NCIGF and NOLHGA have both taken the position that where there was guaranty association coverage before the IBT or CD, state regulators the law should ensure that there is coverage after the IBT or CD.²⁷ An IBT or CD should not reduce, eliminate or in any way impact guaranty association coverage. An CD or IBT should not create, expand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states that have adopted the NAIC Property & Casualty Guaranty Association Model Act.²⁸

One interpretation of the NAIC Property and Casualty Insurance Guaranty Association Model Act (Model # 540)²⁹ is that based on the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claim Transaction” an orphan policyholder could not be covered by the state guaranty association.³⁰ Consequently, there is a concern that no guaranty association coverage would be provided if policies are transferred to a nonmember insurer. Many statutes require that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred. These limitations, however, are designed to avoid coverage being provided when the policy at issue did not “contribute” to the association, which would not exist in the case of an assessable policy later transferred to a nonmember insurer that was not a member at the time the policy was issued.

Fulfilling this intent may require guaranty association statutes to be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee’s work is discussed in the Recommendations section below. It should be noted that the same membership and timing issues that are raised by IBTs could also be raised in the case of any other policy novation, including the assumption reinsurance transactions discussed below.

Commented [RAW26]: We need to be careful not to use “coverage” to mean both the insurance policy and the GA protection, at least not in the same sentence.

Commented [RAW27]: Do IBTs use the term “resulting” insurer?

Commented [RAW28]: If the law leaves a gap, regulatory action is unlikely to be able to close it. And the insurer’s willingness (or ability) to be licensed in every state shouldn’t be the issue. Licenses in every state where the transferring/dividing insurer did business should be conditions of the transaction, and there’s no reason they should be obligated to get licenses in other states.

Commented [RAW29R28]: Note that the NOLHGA/NCIGF joint submission to NCOIL merely recommended (my emphasis) that “the IBT Model Act should clearly provide that assuming insurers will be licensed so that policyholders maintain guaranty association coverage in the same state where they had it immediately prior to an IBT transaction”

Commented [RAW30]: I think this material moved from below duplicates the first half of this paragraph, and says it more clearly

Formatted: Indent: First line: 0.5”

Commented [RAW31]: Do we want to say anything about 520?

Commented [RAW32]: Membership at the time of the transfer is still essential.

Commented [RAW33]: And have been in Maine by our P&C GA.

²⁷ See NOHLGA and NCIGF joint submission to NCOIL dated February 24, 2020 for more information. Available at <http://ncoil.org/wp-content/uploads/2020/02/2020-02-24-Comment-on-NCOIL-IBT-Model.pdf>.

²⁸ Property and Casualty Guaranty Association Model Act (Nat’l Ass’n of Ins. Comm’r’s 2009).

²⁹ Available at https://content.naic.org/sites/default/files/inline-files/MDL_540.pdf.

³⁰ See NOHLGA and NCIGF joint submission to NCOIL dated February 24, 2020 for more information. Available at <http://ncoil.org/wp-content/uploads/2020/02/2020-02-24-Comment-on-NCOIL-IBT-Model.pdf>.

B. Assumption Reinsurance

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholders with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, in situations where the solvency of the insurer might be at risk. There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.³¹

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be effectuated. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act by implication prohibit an IBT or a CD. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholder's express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper. The issue has not yet been addressed by any court nor raised in the proceedings on restructurings. Therefore, while it is raised here for informational purposes, resolution of the issue is left unanswered for now and for the courts to determine in the future.

C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the regulator's willingness to consider the restructuring of certain lines of business. During the Working Group's discussion, it was noted by a number of regulators that restructuring of certain lines of business, such as long-term care, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care, is likely to be subject to a great deal of opposition. Even where permitted, it could be ~~and~~ subject to higher capital requirements for the insurers involved.

³¹ Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)

Commented [RAW34]: The argument makes no sense to me, if they're talking about a single state's statutory scheme. If a state's assumption law conflicts with its restructuring law, that's just a matter of sloppy drafting and all they have to do is fix it. The more interesting question is whether a foreign state could prevent its own policyholders from being transferred without consent. This wouldn't necessarily be limited to implicit conflicts with preexisting assumption laws – if a state **explicitly** sought to block or impose conditions on foreign IBTs affecting domestic business, which state prevails?

Commented [RAW35R34]: As I see we get to in 5(A) below.

Commented [RAW36]: What does this sentence add? What issues can any white paper resolve?

Commented [RAW37]: See previous comment

The nature circumstances of long-term care policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. Furthermore, if the block of business has been in runoff for a substantial period of time, the policyholders will be aging and many will be disabled. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others,³² a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. The US Constitution includes the Full Faith and Credit Clause as well as the Privileges and Immunities Clause (also referred to as the doctrine of Comity) in Article IV. These clauses create methods of extending the effect of a restructuring mechanism beyond the state that issued the judgment and giving that state's judgment effect in all other states in which the insurer does business.³³

Thus, the Privileges and Immunities Clause or the Full Faith and Credit Clause are two methods stemming from the US Constitution that provide for recognition of court orders from other states. We will briefly touch on both concepts but leave these non-core insurance topics to others to discuss in more depth.

The policyholder challenging the decision must first identify the property of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to the resulting insurer, but alleges no additional harm, may have difficulty identifying the property interest of which they have been deprived. The determination on full faith and credit will likely rely upon the issues raised and considered in the Court of the domestic state.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a

³² Gendron, Matthew Esq. (2018) "Rhode Island's Voluntary Restructuring of Solvent Insurers Law and Similar Efforts in Other States," *Roger Williams University Law Review*: Vol. 23: Iss. 3, Article 3, available at: https://docs.rwu.edu/rwu_LR/vol23/iss3/3. That article briefly raises questions about whether full faith and credit or comity would apply to help insulate an IBT transaction from collateral challenge in a court outside the approving state.

³³ The same analysis does not apply to jurisdictions outside the United States and is not addressed in this white paper.

Commented [RAW38]: As noted below, the doctrine of comity is separate from these two constitutional provisions

Commented [RAW39]: This whole section needs some editorial work

state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK.³⁴ This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis,³⁵ while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. *Narragansett Electric Co. v. American Home Assurance Co.* is one such case.³⁶ In *Narragansett Electric Co.*, the court reviewed claims by a London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier.³⁷ Equitas had assumed a block of business from Lloyd's of London in a Part VII transfer, but argued that it had not assumed the obligations at issue. As the court summarized, "Equitas's motion to dismiss raises the question whether this [Part VII] transfer of insurance obligations from Lloyd's to Equitas is effective and enforceable under U.S. law." First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent to US policyholders raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a

³⁴ See SIDLEY AUSTIN LLP, PART VII TRANSFERS EFFECTUATED PURSUANT TO THE UK FINANCIAL SERVICES AND MARKETS ACT 2000 (2017), <https://www.sidley.com/-/media/publications/part-vii-transfers.pdf>.

³⁵ See Jennifer D. Morton, Note, *Recognition of Cross-Border Insolvency Proceedings: An Evaluation of Solvent Schemes of Arrangement and Part VII Transfers under U.S. Chapter 15*, 29 FORDHAM INT'L L.J. 1312, 1314-15 (2006).

³⁶ See *Narragansett Elec. Co. v. Am. Home Assur. Co.*, No. 11 Civ. 8299(PKC), 2012 WL 4075171 (S.D.N.Y. Sept. 12, 2012). There, a claim originating in Pawtucket, Rhode Island, but with waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co.*, 57 N.E.3d 18, 24 (Mass. App. Ct. 2016).

³⁷ See Steven E. Sigalow & Richard E. Stewart, *How Lloyd's Saved Itself*, 37 THE INS. FORUM (2010), reprinted in JONES DAY, <http://www.jonesday.com/files/Publication/dae28676-d6c8-4de6-9cbb-c05aee419d4b/Presentation/PublicationAttachment/533860ba-d4f1-4056-85d9-78b84dc71af5/How%20Lloyd's%20Saved%20Itself.pdf> (last visited June 9, 2021).

Commented [RAW40]: Was "Part VII" just added for clarity, or did it replace other verbiage in the opinion?

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UK's independent expert's report.³⁸ Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. *Allianz-Insurance Co.* is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. *Allianz-Insurance Co.* also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

Allianz-Insurance Co. concerned involved a dispute over liabilities incurred by General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared an ultimate parent company—Berkshire Hathaway.³⁹ At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in *Allianz-Insurance Co.* seemed to be that the post-Part VII transferee insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden's potential asbestos claims.

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law.⁴⁰ The court determined that, given the location of the petitioner's assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action.⁴¹ The court in *Hopewell* also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.⁴²

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for

³⁸ *Air & Liquid Sys. Corp. v. Allianz Ins. Co.*, No. 2:11-CV-00247-JFC, 2012 U.S. Dist. LEXIS 121553 (W.D.P.A. 2012).

³⁹ *Id.* at *12. This interrelated nature is not unusual and is referred to as an intra-company-group transaction.

⁴⁰ *In re Bd. of Dirs. of Hopewell Int'l Ins. Ltd.*, 238 B.R. 25, 31–32 (Bankr. S.D.N.Y. 1999).

⁴¹ Written by ~~then~~ the then-Chief United States bankruptcy judge in the Southern District of New York, Tina Brozman, this decision detailed relevant history behind the Bermuda schemes of arrangement, including the different methods available to companies. One arrangement involved a cut-off scheme, developed in 1995, in which companies have no more than five years to submit additional claims prior to a bar date. This scheme greatly reduced the time for a run-off to wind down its business.

⁴² Citing to 11 U.S.C. § 101(23) (2012), the court applied a standard that “a foreign proceeding is a foreign judicial or administrative process whose end is to liquidate the foreign estate, adjust its debts or effectuate its reorganization.” *Id.* at 49 (internal quotations omitted).

Commented [RAW41]: If we're calling it the *Allianz* case, where did Allianz fit in? Did Allianz have to pay more due to the General Star failure? Were they responding to a different layer of the same claims and just happen to be a co-defendant in the same case?

Commented [RAW42]: Also referred to as an inter-company transaction, but that term is confusing when the context doesn't make crystal clear that all the “companies” in question are necessarily affiliated.

Commented [RAW43]: Was this expected at the time of the transfer? If not, was there any recourse possible under UK law?

evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The Working Group believes that trust in these mechanisms, and protection of the policyholders who will be impacted by them, demands a standard set of financial principles under which to judge the transaction. ~~As such~~ Accordingly, the Working Group created a subgroup to specifically address these financial issues.

Commented [RAW44]: Is this important?

The Restructuring Mechanism Subgroup (“Subgroup”) has been charged with the following initial work related to this White Paper:

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.⁴³

Members of the Subgroup have studied ~~and acknowledge that the~~ UK Part VII procedures, ~~and have concluded that they~~ set forth robust processes and that ~~setting~~ similar requirements should be ~~applied to established for~~ IBTs and CDs.

Commented [RAW45]: This looks like a placeholder. Has the Subgroup concluded that there are no gaps or room for improvement? What about the refinements noted earlier in some US laws?

As of the date of this paper, the charge related to best practices has not been completed. The Subgroup will continue its work with the goal of developing financial best practices. Those practices will be exposed for comment and discussion ~~prior to before~~ referral to other groups.

Commented [RAW46]: This should go first. Reading the two paragraphs together, it sounds like it’s saying “So far, what they’ve concluded is that the best practices should include, but not be limited to, standards similar to the guardrails imposed by UK law for Part VII transfers.”

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. A number of states—Connecticut, California, and Oklahoma—have enacted statutory solutions to these issues. In addition, NCIGF has provided proposed statutory language. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.

Commented [RAW47]: Any chance we’ll know more about best practices before this paper is finalized? It seems like a really important ingredient in an effective white paper.

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the guaranty association issues to assure that consumers are not harmed by the transaction.

C. Statutory Minimums

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

Commented [RAW48]: How does this differ from Best Practices? If the intent is a two-tier recommendation, that’s awkward: “A good system will do X, but any system had better at least do Y” Furthermore, if there’s going to be a two-tier system, the “Best” should be more robust and detailed than the “minimum,” and we have the opposite here.

⁴³ Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).

- (1) Requirement of court approval must be required for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.
- (2) Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.
- (3) Requirement of a notice to stakeholders, a public hearing, robust regulatory process, and an opportunity to submit written comments are necessary for all policyholders, reinsurers, and guaranty associations.

None of the restructuring mechanisms are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes are different and drafted by the legislatures of the respective states ~~which enacted the statutes~~. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transactions. Other transactions, however, may not need all of these provisions. For example, an intra holding company transaction ~~may not need full faith and credit~~.

While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies have difficulty getting licensed in the various states either because of “seasoning” issues or because a they are state may be hesitant to grant a license to a company that is not writing ongoing business ~~so the state may be hesitant to grant a license~~. There are two possible outcomes, neither of them desirable. Either the restructuring fails to go forward, even though it is in the public interest, or the resulting or transferee company operates without a license, creating gaps in guaranty association coverage and Lack of licensure can provide a lack of regulatory control over the company’s ongoing operations, which can lead open the door to actions which that harm consumers. The Working Group, therefore, recommends that the appropriate committee look at licensing standards for runoff companies that states may wish to adopt.

Commented [RAW49]: Do they really need any lesser standard of review? If anything, an IBT to a nonrelated party might need fewer guardrails because the assuming company has its own interests to consider – but we’ve all seen transactions where that self-interest isn’t enough to prevent the assuming company from going down in flames and taking policyholders along for the ride. Note that all CDs, by their nature, are intra-group transactions at the time they’re consummated. And we’ve seen that both CDs and intra-group IBTs can seriously harm people who are left in the Bad Company.

Commented [RAW50]: Why not?

Liability-Based Restructuring White Paper

**Liability-Based Restructuring Working Group of the
NAIC Financial Condition (EX4) Subcommittee
June 1997**

Adopted by Liability-Based Restructuring Working Group & EX4 in June 1997

Attachment One

**by Executive Committee in September 1997
Adopted by Plenary in December 1997**

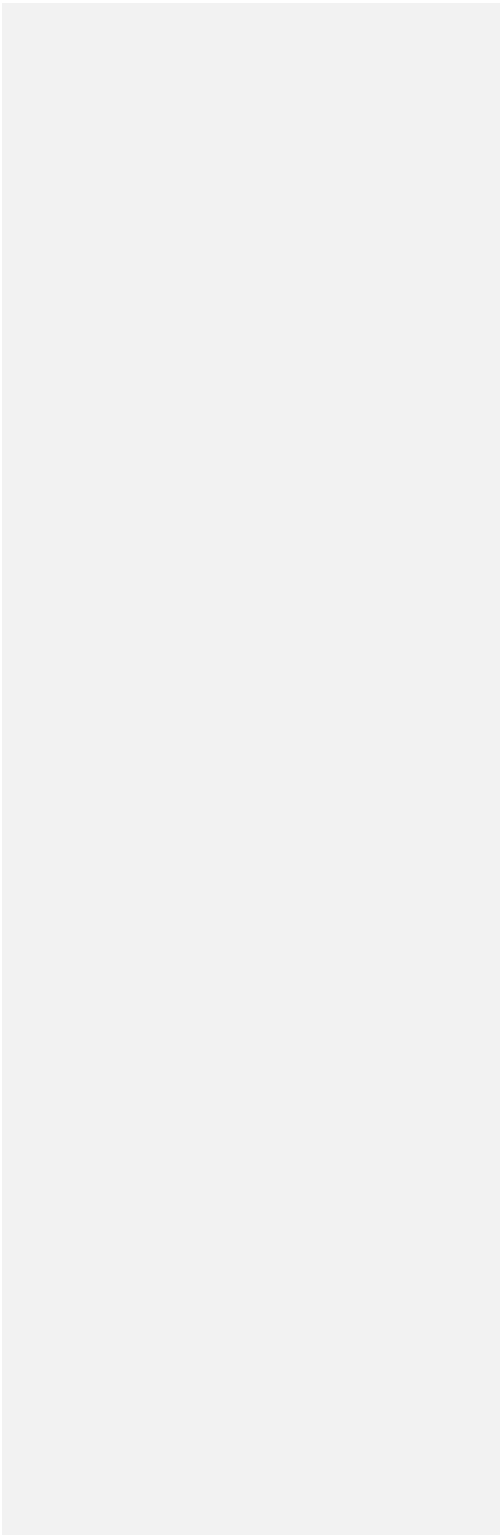


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I. SCOPE

In general, restructurings can be effected through various forms and occur for different reasons: a parent company may divest itself of insurance operations by walling off and trying to sell certain operations, or making material changes to pooling arrangements in a way that, in effect, results in a corporate restructuring. Similarly, an insurance organization may spin-off some of its operations, possibly taking a private company public, may separate commercial and personal lines operations, or may create an off-shore entity to which problematic liabilities and/or assets are transferred due to favorable regulatory and tax environments. The most common specific examples of restructuring during the past several years have been liability-based restructurings (LBRs) of insurance operations into discontinued and on-going operations, primarily because of material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities. Policyholders, insurers, regulators and guaranty funds have expressed concerns about these transactions. Descriptions of some recent restructurings are summarized in Appendix 1.

Conceptually, an LBR is an extraordinary transaction, or series of transactions, in which one or more affiliated insurance companies wholly or partially, isolate their existing insurance obligations from their on-going insurance operations. The notion of isolation is one of substantive change that creates a legal separation, such that policyholders and other creditors holding the isolated existing insurance obligations have limited or no financial recourse for their direct satisfaction against the on-going insurance operations. The concept of an LBR does not, in the absence of such isolation, include restructurings to achieve capital allocation or business-mix decisions, such as changes in pooling percentages, changes of the primary insurance writer or the separation of on-going insurance operations from other on-going insurance operations.

The purpose of this paper is to identify and discuss regulatory, legal and public policy issues surrounding such LBRs of multistate property/casualty companies and their affiliates. Single-state insurers and their affiliates may undertake similar LBRs and many of the issues contained herein may apply; individual states may choose to utilize this paper as a resource in those transactions. While restructurings of life and health companies are known to have occurred, such transactions may present different issues and considerations and therefore are excluded from discussion in this paper.

This paper is not intended to establish a position either for or against LBRs since each case must be evaluated on its own merits by the regulatory authority. Furthermore, this paper is not intended to address every insurance company merger, acquisition, divestiture, withdrawal from one or more lines of business or states, or other corporate transaction which impacts a company's obligation to its policyholders or its ability to meet those obligations. These are typically addressed under other applicable statutes or regulations.

II. BUSINESS REASONS

A. Rating Considerations

One of the major considerations in recent LBRs has been the insurer's desire to maintain or obtain favorable financial and other rating designations from the private rating agencies. Ratings play a major role in determining whether an insurer can remain competitive in its target market and may

affect its ability to attract new capital. Insurers that have been subject to earnings drag due to the adverse development of APH or other liabilities may be faced with rating downgrades. By separating problem liabilities from on-going operations, the insurer may improve or maintain its rating. In turn, this may allow the insurer to more effectively take advantage of business opportunities, potentially achieve higher returns on its capital, and become more attractive to the financial markets.

B. Solvency Issues

Through an assessment of its APH or other liability exposures, an insurer may realize that recognition of probable ultimate liabilities in these areas will have a material impact on its financial condition. By separating these liabilities from the on-going operations, the insurer can dedicate surplus to support the restructured operations and eliminate the drag on earnings in its on-going operations and avoid further commitment of capital for pre-existing liabilities.

It should be recognized that an LBR, by itself, does not create resources from which claims can be paid. Accurately establishing adequate reserves to meet probable ultimate liabilities may eliminate the drag on earnings. If the establishment of such reserves materially weakens the insurer's financial condition, it is unlikely that it will be able to dedicate appropriate surplus to support both the restructured and on-going operations without additional capital. In these circumstances, if additional capital is not forthcoming, the regulatory authority should take appropriate action.

C. Other

Other reasons an insurer may consider restructuring include, but are not limited to, the need to raise capital or a desire to exit a line of business. In some cases, restructuring may be considered as a method to exit the insurance business or to camouflage financial and other problems.

III. ADVANTAGES AND DISADVANTAGES

LBRs may result in a more effective use of existing capital, a more competitive on-going insurance operation, more effective claims management, better management of ultimate liabilities related to problematic lines of business, and improvement of the availability and affordability of insurance coverage. In addition, an LBR may result in the attraction of additional capital and the enhancement of shareholder value.

On the other hand, underfunded LBRs may reduce the likelihood certain policyholder claims will be paid by the insurer. In addition, LBRs may be difficult to structure equitably due to the uncertainty associated with estimating APH liabilities, may pose questions related to policyholder participation and guaranty fund coverage in the event a restructured entity fails, and may have a negative impact on the public trust in the property and casualty insurance industry and the effectiveness of insurance regulation.

Each LBR will present certain advantages and disadvantages. An advantage to future policyholders (availability and affordability) may arise from a disadvantage to existing and prior policyholders (reduced likelihood of having their claims paid). The regulatory process requires that these advantages and disadvantages be assessed in light of applicable law and the impact upon policyholders. A pre-approval checklist is attached at Appendix 2.

IV. FINANCIAL SOLVENCY ISSUES

A. General Solvency Considerations

Regardless of the nature of an LBR, a key responsibility of the regulatory authority in assessing whether to approve the transaction will be to analyze financial solvency issues. The regulatory authority must determine whether the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. To make this determination, the regulatory authority will need to assess reserve adequacy, collectibility of reinsurance balances, and the value and liquidity of assets. Before formulating a conclusion based on these assessments, the regulatory authority should also consider the adequacy of capital and surplus levels and whether financial support is available from the parent company or other affiliates.

The restructuring insurer should provide the regulatory authority a detailed analysis of business and operational aspects of the LBR, including a detailed business plan, historical, current and pro-forma financial statements, and a description of the transaction's tax consequences. The financial information provided should include a balance sheet of the insurer as if the restructuring plan were approved, and schedules detailing assets and liabilities to be reallocated as a part of the restructuring plan. Any special charges or write-downs that will be made as a result of the LBR should also be specifically identified. The detailed business plan should also include a discussion of how the LBR will impact obligations to policyholders and other creditors. In addition, a statement should be provided describing the consequences if the LBR is not approved.

The regulatory authority should consider the engagement of experts to provide opinions about the impact on obligations to policyholders and other creditors, solvency, and the financial condition of the companies affected by the LBR, both immediately before and after restructuring.

B. Reserve Adequacy

Determining a reasonable estimate for liabilities will be a key part of the regulatory review process. Long-tail liabilities, especially those related to APH exposure, are most difficult to estimate. Although it is acknowledged that there is a high degree of uncertainty related to estimation of APH reserves, some regulatory authorities have concluded that sufficient information and actuarial methodologies exist to assess and estimate these exposures. The regulatory authority should consider taking the following actions to thoroughly review the adequacy of reserve estimates:

First, the regulatory authority should engage a qualified actuarial firm to: a) review methodologies used by the insurer to estimate reserves; b) review the insurer's economic approach to funding the run-off liabilities, including reserve discounting, if any; c) determine whether the claims unit is adequately staffed with qualified professionals and that its approach to settling claims is consistent with industry "best practices"; d) opine on the adequacy of reserves on a gross and net of reinsurance basis, by accident year and line of business; and e) review the funding of the discount and the adequacy of reserves net of the discount, if reserve discounting will be permitted. Second, if liabilities include material exposures to APH liabilities, consideration should be given to performing a "ground-up" review of reserves to estimate known and incurred but not reported (IBNR) reserves. This review should include the evaluation of all known liabilities on a case-by-case, policy-by-policy basis, including IBNR reserves.

Third, the regulatory authority should consider requiring the development of a cash flow model stress test to evaluate the adequacy of assets, including reinsurance, to fund the liabilities. The ultimate liabilities, payment patterns and cash flow assumptions should be included in the review. The stress test should consider varying loss payment patterns and investment yields.

C. Reinsurance

1. Collectibility of Reinsurance Balances

The success of an LBR may depend, in large part, on the LBR's effect upon existing reinsurance agreements and the collectibility of reinsurance balances stemming from those agreements. Depending on the materiality of these balances, the regulatory authority should consider requiring an independent analysis of reinsurance recoverables including: a) a review of the process used to monitor, collect, and settle outstanding reinsurance recoverables; b) an analysis of existing and projected reinsurance balances, including the expected timing of cash flows; c) an analysis of the quality and financial condition of the reinsurers and prospects for recovery; d) a detailed description of write-offs or required reserves based on the independent analysis taken as a whole; e) disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes; and f) a discussion of the impact of the LBR on the collectibility of the reinsurance balances. The regulatory authority may also consider requiring a legal analysis of the effect a liquidation or rehabilitation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and the legal rights of reinsurers to claim offsets against such recoveries.

2. Reinsurance Coverage

LBRs may include reinsurance stop loss or excess of loss coverage as an integral part of the transaction. These treaties are often complex and may require the regulatory authority to retain qualified experts to ensure that coverage is adequate, and that the treaty will perform as anticipated. The treaty may be analyzed to determine how it will operate, how the reinsurance premium will be calculated and how it will be paid, and whether the quality and financial condition of the reinsurer(s) is adequate. The regulatory authority should determine whether the amount of coverage provided by the treaty, in combination with other resources, is sufficient to meet the obligations of the restructured entity.

In addition to a stop loss or excess of loss treaty, the LBR may involve new or amended quota-share or pooling agreements within the group. The regulatory authority should review the agreements and supporting documentation to understand the movement of business and to determine the financial impact of the changes on the run-off and on-going companies.

The regulatory authority should also consider reviewing existing reinsurance programs to determine that provisions are consistent with other information provided and that adequate coverage exists for on-going operations.

D. Liquidity and Value of Assets

Although proper estimation of liabilities is critical to the success of an LBR, equally as important is the assessment of whether existing assets and future cash flow are sufficient to fund the liabilities.

Much of the work related to determining whether there is a proper matching can be achieved through an appropriate stress testing process. The asset assumptions used in the stress test should be evaluated by the regulatory authority, especially if assets have high volatility, liquidity uncertainties, material valuation issues or lack diversification.

Consideration should be given to obtaining current appraisals for any material real estate or mortgage holdings; and obtaining independent investment expertise to value limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other asset for which the regulatory authority has concerns about the carrying value.

The regulatory authority should also consider reviewing assumptions as to investment yield and determine how the reallocation of assets might impact historical yields. This review will be the key determination of allowable discount rates and the spreads to be required between investment yield and reserve discount.

Should the asset analysis indicate there are problems related to asset matching, the regulatory authority may consider requiring: a) reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk; b) parental guarantee of investment yields; c) collateralized parental guarantee of asset valuation; and d) disposition of assets prior to transaction approval.

Commented [RAW51]: Since this is a noun, it should probably be "guaranty,"

E. Capital and Surplus Adequacy

One of the most difficult aspects of reviewing an LBR is determining what level of capital and surplus is adequate. In general, standard provisions of the NAIC's Risk-Based Capital (RBC) For Insurers Model Act (the Model Act) should apply.

Unlike an on-going insurance company, run-off entities do not compete for new or renewal business. There may be other differences in the risk profile of run-off entities that could indicate the need for reassessment of the applicability of the Model Act in individual circumstances. The reserve, underwriting, and investment factors generating the majority of required RBC were developed to measure risks retained by a run-off entity. The Model Act makes specific provision for exempting a property and casualty insurer from actions to be taken at the Mandatory Control Level if that insurer is writing no business and is running-off its existing business. Under such circumstances the insurer may be allowed to continue its run-off operations with the regulatory authority's oversight.

Other factors to consider in determining the adequacy of capital and surplus levels include

volatility and uncertainty related to reserve estimates, the quality of assets, and the degree of parental and affiliated support.

F. Support From Parents and Other Affiliates

As discussed in previous sections, support from parents or affiliates may play an integral part in the LBR and may be a significant factor in whether the transaction is approved. The regulatory authority should consider analyzing the change in organizational structure resulting from the LBR, placing special emphasis on the extent to which the resulting corporate structures have common ownership, overlapping management, substantial reinsurance arrangements, and on-going business ties. If the financial and marketing futures of the corporate structures are materially tied together, it may be less likely that any part of the organization will be abandoned.

If one of the resulting insurer structures is perceived to be weaker than another, the parent may show its intention of continued support through issuance of “cut-through” provisions for the benefit of policyholders of the “weaker” entity. These provisions give policyholders the legal right to file a claim against the entity issuing the cut-through should the insurer liable under the insurance contract (policy) be unable to meet its obligations. (Note: Some states have enacted laws prohibiting cut-through transactions.)

Stop loss and excess of loss reinsurance transactions have been discussed earlier in this report. The importance of these transactions, especially if with affiliated entities, should not be minimized. These transactions are often used to provide a cushion for the uncertainties related to asset and liability assumptions and can often be structured to strengthen the transaction. The regulatory authority should determine whether parental or affiliated support is available should the collectibility of reinsurance balances deteriorate.

The parent or affiliates should be encouraged to provide financial and managerial support to all entities. This support lends credibility to the LBR and provides an additional layer of security to policyholders.

V. LEGAL AND PUBLIC POLICY ISSUES

A. Applicable Laws

LBRs may implicate, directly or indirectly, a number of laws in the state of domicile including both general corporate statutes and insurance code provisions. A thorough review of all potentially applicable laws is necessary to fully understand the requirements and potential ramifications of an LBR. To the extent changes to an insurer’s corporate structure affect relationships with policyholders in other states, the laws of those jurisdictions may apply. Following is an overview of the principal laws that may need to be considered by the regulatory authority with regard to an LBR.

1. General Corporation Statutes

Corporate organization is governed by each state’s corporation law. Many states have

enacted the Revised Model Business Corporation Act (RMBCA)¹ or a similar law. In most states, the corporation law applies to insurers, unless stated otherwise. The state insurance codes supplement the corporate law with additional or different requirements for insurers.²

The general corporation law addresses the existence and internal governance of the corporation. Corporation laws set forth minimum requirements and procedures to be adhered to in connection with extraordinary transactions affecting corporate existence and structure such as reorganizations, mergers, exchanges, divisions,³ disposal of assets and dissolutions. Such extraordinary transactions may require the approval of shareholders in addition to that of the board of directors.

a. Mergers and Consolidations

State law governs consolidation and mergers of insurers. The procedures and requirements regarding changes to the corporate structure of an insurer are usually the same as those for other corporate entities. Insurers may be subject to more regulatory scrutiny than general business corporations. A merger occurs when one corporation absorbs the other and the identity of the absorbed corporation disappears. In consolidation, the separate corporate entities disappear and a new corporate entity emerges.

Statutes governing consolidations or mergers, for the most part, require that notice be given to all stockholders or members. Mergers or consolidations of stock insurers do not require the approval of policyholders but do require approval by the regulatory authority. Mergers or consolidations of mutual insurers must be approved by both the policyholders and the regulatory authority.

b. Divisions

Division statutes have recently been enacted by two jurisdictions. These statutes permit the division of a single corporation into two or more resulting corporations. In a division, assets and liabilities are allocated among the resulting corporations. An LBR that includes a division may also include other transactions such as changes to a pooling agreement that may require regulatory review in other jurisdictions.

2. Insurance Code Provisions

a. Insurance Holding Company Act⁴

¹ As of 1996, 22 states have enacted the current version of the RMBCA or substantially similar laws.

² Neb.Rev.Stat. § 44-301 (Reissue 1993) states in pertinent part: "...[T]he Nebraska Business Corporation Act except as otherwise provided... shall apply to all domestic incorporated insurance companies so far as the Act is applicable or pertinent to and not in conflict with other provisions of the law relating to such companies. "

³ 15 Pa.Cons.Stat. §§ 1951-1960 (1995), effective in 1989; Tex.Bus.Corp.Act § 5.01 *et seq.* (Vernon Supp. 1990), effective in 1989.

⁴ The Insurance Holding Company System Regulatory Act (Holding Company Act) adopted by the NAIC is enacted in some form in 48 states.

Certain aspects of an LBR may be subject to the Holding Company Act even though the act does not explicitly address LBRs. An LBR may be subject to review by the regulatory authority under the Holding Company Act if the insurer is a member of an insurance holding company system. For example, if an LBR results in a change of control⁵ of a domestic insurer, the transaction must be pre-approved by the regulatory authority in accordance with certain stated criteria.⁶

In addition, the Holding Company Act governs transactions between the domestic insurer and other members of the insurance holding company system even if there is no change in control.⁷ Some of these transactions trigger advance notification to the regulatory authority depending upon the nature and extent of the transaction. All of these transactions must be on terms that are fair and reasonable. An LBR will probably be subject to these requirements of the Holding Company Act if inter-company agreements such as management agreements, reinsurance agreements or tax allocation agreements are affected.

Finally, the Holding Company Act also governs dividends or distributions by a domestic insurer. For example, if an extraordinary dividend or distribution is part of an LBR, the prior approval of the regulatory authority may be required.⁸

b. Examination Law

All states have examination statutes that provide the authority and responsibility to conduct examinations of insurers to determine their financial condition and compliance with insurance laws and regulations. This authority includes targeted examinations triggered by a wide array of events such as deteriorating financial condition, risk-based capital results, financial analysis results, financial ratios and LBRs. Generally, a periodic examination of insurers is contemplated; however, the regulatory authority may also conduct an examination as often as deemed appropriate.⁹ The regulatory authority has the discretion within statutory confines to determine the scheduling, nature and scope of an examination. The regulatory authority is also granted examination powers under the Holding Company Act.¹⁰

Generally, the regulatory authority may retain attorneys, appraisers, actuaries, certified public accountants, loss-reserve specialists, investment bankers or other professionals and specialists at the cost of the insurer being examined.¹¹ Given the extraordinary nature and complexity of LBRs, it is essential that the regulatory

⁵ Control is presumed to exist with the power to vote 10% or more of the voting securities of an insurer.

⁶ Regulatory jurisdiction under the NAIC Insurance Holding Company System Regulatory Act is of domestic insurers, but some states assert jurisdiction over non-domestic insurers on the basis of the insurer being "commercially domiciled" in that jurisdiction due to the volume of business. See CAL. INS. CODE § 1215.4 (1993).

⁷ The NAIC Insurance Holding Company System Regulatory Act at Section 5A. Similar authority as to insurers that are not a part of an insurance holding company system can be found in the Disclosure of Material Transactions Model Act adopted by the NAIC.

⁸ *Id.* at Section 5B.

⁹ The Model Law on Examinations adopted by the NAIC has been enacted in 41 states, see Section 3A.

¹⁰ The NAIC Insurance Holding Company System Regulatory Act at Section 6A.

¹¹ The NAIC Model Law on Examination at Section 4D.

authority have the ability to contract for the services of all experts and specialists deemed necessary and to assess such costs to the insurer.

The examination statutes generally provide for the confidentiality of all workpapers, recorded information and documents obtained by, or disclosed to, the regulatory authority in the course of an examination and that these materials may not be made public, subject to some limited exceptions.¹² The examination authority under the Holding Company Act contains a similar provision regarding confidentiality of examination materials. These confidentiality provisions are necessary for the regulatory authority to conduct a thorough examination. The examination statutes provide the regulatory authority an important tool to evaluate LBRs, but the examination law prevents the regulatory authority from disclosing examination documents that might be of interest to policyholders. (See § 5(B)(4)).

c. Other Laws

Other insurance regulatory laws that may need to be considered regarding an LBR relate to the orderly withdrawal from insurance business in the state,¹³ demutualization, or redomestication¹⁴ of the insurer to another state. Issues regarding guaranty fund coverage and assumption reinsurance requirements deserve special consideration and are discussed in separate sections of this paper. Other insurance laws and regulations may need to be considered in connection with an LBR. Therefore, it is important to evaluate all the ramifications of an LBR and the component steps and transactions necessary to achieve the LBR. This may involve regulatory issues not identified in this paper.

B. Due Process

What do the concepts of due process and equal protection mean in the context of the review of an LBR by the regulatory authority? The requirements of due process and equal protection are triggered by action of the state through its authorized governmental agencies. The concept of due process includes both procedural and substantive aspects. Procedural due process concerns the right of interested parties to notice and the opportunity to be heard. Substantive due process requires that government action be based on legislation that is within the scope of legislative authority and reasonably related to the purpose of the legislation. Not every proposed LBR will affect private interests to the extent that the requirements of due process and equal protection will be applicable.

The regulatory authority should consider the persons whose interests are affected by a proposed LBR and who is entitled to notice and the opportunity to be heard. The regulatory authority should consider whether a public hearing concerning the LBR is required or should be held.¹⁵ The regulatory authority should consider whether interested parties should be allowed to present evidence, call witnesses and cross-examine the witnesses of other parties. The regulatory authority should consider whether policyholder consent is necessary.

¹² *Id.* at Section 5F (Six of the 41 states that have enacted the Model Law have not adopted the section on confidentiality).

¹³ See N.J. Stat. Ann. § 17:33 8-30 (1994).

¹⁴ The Redomestication Model Bill adopted by the NAIC is enacted in 37 states.

¹⁵ The United States Supreme Court has held that due process of law does not require a hearing in every case of government action. See 16A Am. Jur. 2d 1054, citing *Boddie v. Connecticut*, 401 U.S. 371 (1971).

The regulatory authority should consider the information that should be disclosed and to whom disclosure should be made. The regulatory authority should consider the persons that may be aggrieved by its decision. These questions may well have their answers in general (*i.e.*, non-insurance) administrative and state and federal constitutional law. If not, local law may govern policyholder relationships and rights. Finally, the regulatory authority should consider whether the action to be taken is reasonable under all the attendant circumstances.

C. Assumption Reinsurance

Corporate restructurings may be subject to the assumption reinsurance transactions statutes. The Assumption Reinsurance Model Act was drafted by state insurance regulators and adopted by the NAIC Dec. 5, 1993. The model act establishes notice and disclosure requirements intended to protect consumers' rights in an assumption reinsurance transaction. Under these statutes, insurers must seek prior approval from the regulatory authority for a transfer of business as well as notify all policyholders affected by the transfer. Policyholders must be informed that they have the right to reject the transfer.

An assumption reinsurance agreement is any contract that both transfers insurance obligations and is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations and/or risks under the contracts are extinguished. If the laws of the domiciliary states of both the transferring and assuming insurer contain provisions substantially similar to the model act, the assumption reinsurance transaction is subject to prior approval by both states' regulatory authorities. If no substantially similar requirements exist, the transaction is subject to the prior approval of the regulatory authorities of the states in which affected policyholders reside. Policyholders receive a notice of transfer by mail and may reject or accept the transfer. If the policyholder does not respond, the policyholder will be deemed to have given implied consent and the novation of the contract will be effected.

The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. In addition, a domiciliary regulatory authority has the necessary discretion to effect a transfer and novation if an insurer is in hazardous financial condition and the transfer of its insurance contracts would be in the best interests of the policyholders. These statutes may also come into play if an insurer transfers business through bulk reinsurance or a contract of bulk reinsurance. Bulk reinsurance or a contract of bulk reinsurance is an agreement whereby one insurer cedes by an assumption reinsurance agreement a certain percentage of its business to another insurer. The transaction must be filed with and approved by the regulatory authority of the insurer's state of domicile.

D. Policyholder Consent

When a new agreement replaces an existing agreement, a novation has occurred.¹⁶ Because the

¹⁶ See, e.g., *Black's Law Dictionary* 1064 (6th ed. 1990) which defines "novation" as, in part: "A type of substituted contract that has the effect of adding a party, either as obligor or obligee, who was not a party to the original duty. Substitution of a new contract, debt, or

Assumption Reinsurance Model Act specifically states that it is intended to provide for the regulation of assumption reinsurance transactions as novations of contracts,¹⁷ general rules of contract law apply to any disputes arising under the assumption reinsurance agreements.

Many courts have found that the type of implied consent required by the Assumption Reinsurance Model Act is legally sufficient. For example, in *State Dept. of Public Welfare v. Central Standard Life Ins. Co.*,¹⁸ the Supreme Court of Wisconsin found implied consent to an assumption agreement where the policyholder retained the original policy, was silent after receiving a certificate of assumption and subsequently paid 15 premiums to the assuming insurer.

Furthermore, in *Sawyer v. Sunset Mutual Life Insurance Co.*,¹⁹ the Supreme Court of California held that when an insured's beneficiaries sued the insurer that had assumed the insured's life insurance policy, "the bringing of suit is sufficient evidence of assent on the part of respondents to said agreement and undertaking."

However, other courts have required express consent by the policyholder to an assumption reinsurance transaction. For example, in *Security Benefit Life Ins. Co. v. Federal Deposit Insurance Corp.*,²⁰ the U.S. District Court for the District of Kansas found that where a series of assumption reinsurance agreements was executed, the agreements were not enforceable without proof that the policyholder or at least one of its successors in interest consented to the novation. Acquiescence to the transaction did not constitute policyholder consent to the assumption reinsurance transaction.

In *Travelers Indemnity Company v. Gillespie*,²¹ the Supreme Court of California stated that even when an insurer obtained reinsurance and assumption agreements pursuant to the state's withdrawal statute, policyholder consent to the transaction was still required.

In *Prucha v. Guarantee Reserve Life Ins. Co.*,²² the policyholder wrote to his insurer and said he did not consent to the transfer of his policy to another insurer through an assumption reinsurance agreement, but he paid premiums to the new company. The Court of Appeal of Florida, Third District, found that the policyholder's payment of premiums did not constitute implied consent to the novation because the policyholder had no opportunity to consent and his premium payments were merely an effort to protect his investment.

E. Rights of Other Interested Parties

What persons have an interest in a proposed LBR in addition to policyholders and insurance regulators in non-domiciliary states? Guaranty funds have an interest in the approval of LBRs because they may be called upon to step in and pay claims if the restructured entity is subsequently

obligation for an existing one, between the same or different parties.... A novation substitutes a new party and discharges one of the original parties to a contract by agreement of all parties...."

¹⁷ NAIC Assumption Reinsurance Model Act § 1 (1993).

¹⁸ *State Dept. of Public Welfare v. Central Standard Life Ins. Co.*, 120 N.W.2d 687 (Wis. 1963).

¹⁹ *Sawyer v. Sunset Mutual Life Insurance Co.*, 66 P.2d 641 (Cal. 1937).

²⁰ *Security Benefit Life Ins. Co. v. Federal Deposit Insurance Corp.*, 804 F.Supp. 217 (D.Kan. 1992).

²¹ *Travelers Indemnity Company v. Gillespie*, 785 P.2d 500 (Cal. 1990).

²² *Prucha v. Guarantee Reserve Life Ins. Co.*, 358 So.2d. 1155 (Fla. App. 1978).

found to be insolvent. Third parties having pending claims against an insured of the restructuring insurer may also be interested persons. Other interested persons, depending upon the circumstances in each case, may include reinsurers, ceding insurers, general creditors, shareholders, if the restructuring insurer is a stock company, and the public.

The regulatory authority should consider the type of notice to be given to interested persons. The regulatory authority should also consider whether certain persons should be afforded the opportunity to intervene in the proceedings concerning an LBR. Finally, the regulatory authority must consider the fiscal impact of giving notice to a large number of interested persons and the participation of those persons in the approval process.

F. Disclosure of Information

In an LBR the regulatory authority should consider the extent to which financial information about the insurer involved must be disclosed to interested persons or the public. Applicable state laws may require the regulatory authority to disclose certain information. However, most of the states have enacted laws that provide for maintaining the confidentiality of sensitive information acquired by the regulatory authority during an examination of an insurer or in the course of certain other regulatory activities. Use of the examination law to evaluate an LBR may prevent the regulatory authority from disclosing materials that the regulatory authority would prefer to release to interested persons or the public.

The regulatory authority should determine whether disclosure requirements or confidentiality provisions are applicable to the review of an LBR. In the absence of explicit statutory guidance, the regulatory authority should balance due process considerations and the public's right to know with the need to protect sensitive or proprietary information.

G. Guaranty Fund Coverage

An important issue for the regulatory authority with regard to an LBR is the availability of guaranty fund coverage in the event of the insolvency of the restructured insurer. From the viewpoint of the insurance consumer, absent express consent, guaranty fund coverage should not be reduced or eliminated by an LBR.

1. Overview of Guaranty Fund System

Each state has a guaranty fund, created by statute, to provide a safety net for policyholders and third party liability claimants in the event of the insolvency of an insurer writing property and liability lines of insurance. Although the majority of state guaranty fund statutes are based upon the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act, there are variations from state to state that should be taken into account by the regulatory authority when reviewing a proposed LBR. First, the lines of business covered may differ. Also, the amount of coverage provided per claim varies. Although the Model Act and many state statutes provide for payment of covered claims of up to \$300,000, some state laws provide more or less coverage. Several states have enacted net worth provisions that exclude from coverage the claims of persons whose net worth

exceeds a certain benchmark, the rationale being that such persons are sophisticated purchasers and can afford to absorb some loss.²³

Since each state guaranty fund is a separate entity, each fund makes its own determination with respect to coverage. Therefore, potentially, the guaranty funds in some states may determine that claims arising from the policies of the restructured insurer are covered, while other guaranty funds may reach a different conclusion.

Finally, although the regulatory authority reviewing an LBR should consider the potential availability of guaranty fund coverage as one of many factors in deciding whether to approve the LBR, it is important to note that the existence of guaranty fund coverage can only be conclusively determined if and when the insurer becomes insolvent.

2. The Availability of Guaranty Fund Coverage May Depend Upon the Form of Restructuring

Whether guaranty fund coverage is available to policyholders, claimants, and creditors of an insurer involved in an LBR may depend upon the form of the restructuring. The regulatory authority should determine the effect of an LBR on the availability of guaranty fund coverage in the event the restructured insurer subsequently becomes insolvent. Issues to be considered include:

- a. Whether an unlicensed insurer is involved in the LBR;
- b. Whether the restructured insurer that could become insolvent is the insurer that issued the policy;
- c. Whether the restructured insurer that could become insolvent was the insurer at the time the insured event occurred;
- d. Whether the guaranty fund coverage in other states varies from the coverage available in the regulatory authority's jurisdiction.

3. Conclusion

Guaranty fund coverage and the provisions for triggering the guaranty fund vary by state. Regulators involved in the approval of an LBR should determine the effect of the LBR on the availability of guaranty fund coverage for policyholders in the event the restructured insurer subsequently becomes insolvent. If it is concluded that an LBR places the availability of guaranty fund coverage in serious question, the structure of the proposed transaction or questionable component should be modified before approval.

VI. ON-GOING REGULATORY OVERSIGHT

²³ It might be questioned whether such exclusions are appropriate if policies are transferred to a restructured entity without the insured's consent.

A. General

The responsibility of the regulatory authority does not end with the approval of an LBR. Subsequent to the completion of the transaction there will be one or more insurers with obligations to policyholders and other creditors. These insurers will continue to require regulatory oversight. Because of the existence of obligations to policyholders and other creditors, the insurance laws of the state of domicile should continue to apply to the restructured insurer. However, the LBR may also result in the need for additional regulatory oversight. As an LBR can take many forms, the exact nature of the oversight is dependent on the risks created by an individual restructuring. To the extent that these risks can be identified prior to the approval of the LBR, the regulatory authority should consider incorporating any additional regulatory requirements in the order approving the transaction.

This section assumes that the restructured insurer remains domiciled in the United States. If this is not the case, most of this section will not apply, as the regulatory authorities approving the transaction will no longer have jurisdiction over the restructured insurer. This should be considered prior to approving the LBR.

In the end, any LBR will be judged on the reorganized insurer's ability to meet its obligations to policyholders and other creditors. If approved, the regulatory authority has the responsibility to identify new risks created by the LBR, and institute appropriate regulatory safe-guards to help ensure that all obligations to policyholders and other creditors will be met. An outline of a program for on-going regulatory oversight is attached at Appendix 3.

B. Oversight

One of the primary areas of concern regarding a restructured insurer is the availability of sufficient resources to meet all of its obligations to policyholders and other creditors. Although the restructured insurer would still be subject to the domiciliary state's examination law, additional oversight may be required to help mitigate additional risks created by the LBR. For instance, if a dedicated pool of assets is created to meet obligations to policyholders the regulatory authority should consider additional oversight measures designed to ensure the assets will be available to pay policyholder claims. See Appendix 3 for examples of conditions and requirements for on-going regulatory oversight of an LBR.

One of the factors that will be analyzed prior to approving an LBR is future corporate affiliations. In cases where there are continuing affiliations, the regulatory authority's oversight would most likely include monitoring compliance with agreements between the resulting insurers. For example, the regulatory authority should consider on-going evaluations of statutory compliance with any capital maintenance agreement, and review of management or administrative agreements or other inter-company agreements or transactions. In addition, the regulatory authority should review compliance with the requirements set forth in the order approving the LBR.

Where there is common management and/or ownership of on-going and run-off operations of a restructured insurer, the regulatory authority needs to be aware of any potential conflicts of interest between the two entities. This may lead to inappropriate influence by the on-going entity of the run-off entity's operations. For example, it might be in the interest of the on-going entity for the run-off

entity to settle claims of current on-going entity customers on a preferential basis. This could have the effect of jeopardizing whether the run-off entity will have sufficient assets to settle other policyholders claims. A similar conflict exists if there is a block of policies whose obligations revert to the on-going entity upon the insolvency of the run-off entity. If such conflicts exist the regulatory authority should consider an examination of the claim settlement patterns of the run-off entity as part of its regular examination process.

If an LBR results in one or more insurers that have no on-going operations, the regulatory authority should consider requiring regulatory approval before the run-off entity can begin or resume on-going operations. Prior to approving the reactivation of operations, the regulatory authority should consider the financial and operational resources available to the restructured insurer, and be able to determine that such a reactivation will not place existing policyholders at any additional risk.

The regulatory authority should evaluate residual market obligations before approval of an LBR. Consideration should be given to requiring that these types of obligations be assumed by the on-going entity.

VII. CONCLUSIONS AND RECOMMENDATIONS

The Liability-Based Restructuring Working Group concludes and recommends as follows:

- LBRs present both advantages and disadvantages, and therefore, LBRs should not be prohibited per se, but each should be evaluated on its own merits by the regulatory authority.
- LBRs are extraordinary transactions that vary widely in form, method and circumstances, and therefore, a “one size fits all” stand alone model law approach is not recommended at this time. Insurance regulatory authorities must have adequate statutory authority with sufficient flexibility and discretion to respond to the situation presented. The Working Group believes that existing regulatory authority is generally adequate, but recommends that the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, the Assumption Reinsurance Model Act, and the Insurance Holding Company System Regulatory Act be revisited to consider whether amendments may be appropriate in light of LBRs.²⁴
- An LBR should be subject to approval or disapproval by the domestic regulatory authority(ies) on the basis of a comprehensive and thorough review. The regulatory authority should have the ability to engage all experts necessary to assist in the review at the expense of the LBR applicant.
- The LBR applicant has the burden of justifying the LBR to the regulatory authority. The regulatory authority should not approve a proposed LBR if the transaction is likely to jeopardize the financial stability of the insurers, prejudice the interests of policyholders or be unfair or unreasonable to policyholders. An LBR is not an acceptable alternative to appropriate regulatory action, such as the rehabilitation or

²⁴ More specifically: the working group recommends that; (1) the NAIC review its Post-Assessment Property and Liability Insurance Guaranty Association Model Act to consider whether the definitions of “covered claim” and “insolvent insurer” should be amended to make it clear that coverage continues when there has been a division; (2) that the Assumption Reinsurance Model Act be reviewed to consider whether to clarify that a division transaction is subject to all the requirements of that Act; and (3) that the Insurance Holding Company System Regulatory Act be reviewed to consider whether any of the filing requirements should be amended in order to more fully address LBR transactions.

liquidation of insurers in hazardous financial condition, unless the hazardous financial condition is corrected in association with the LBR.

- If the effect of the LBR is intended to extinguish an insurer's obligation to its policyholders, consent of the policyholders should be required. Such transactions result in a novation or have the same effect on policyholders as a novation and therefore should satisfy the procedural and legal requirements of a novation. States should consider adopting the Assumption Reinsurance Model Act or other legislation that will safeguard the interests of policyholders.²⁵

- Public confidence in insurance and the integrity of the regulatory process requires that regulatory authorities strive to respond to LBRs as consistently as possible. Consideration should be given to developing a standardized regulatory review process through filing requirements, guidelines, protocols and best practices. The Pre-approval Checklist, Appendix 2, and On-going Regulation Oversight, Appendix 3, are examples of such regulatory guidelines.

- Interstate cooperation and communication are especially important. LBRs are likely to trigger the regulatory jurisdiction of more than one state and will be of interest to all states where affected policyholders reside. The domiciliary state of the parent or largest insurer involved in the LBR should coordinate activities among the states having jurisdiction over some aspect of the LBR, make basic information available to non-domiciliary states and respond to specific inquiries from non-domiciliary states as necessary.

- Policyholders should have an opportunity for direct participation in the LBR approval process. At a minimum, this should include notice to policyholders of the proposed LBR with an explanation of the LBR and its effect on policyholders, meaningful access to information about the LBR, and a public hearing that affords policyholders an opportunity to be heard. Meaningful access to information necessarily requires that policyholders be given access to information that may be sensitive and proprietary. The competing interests of the policyholders and the insurer in this regard should be balanced with appropriate measures such as protective orders or confidentiality agreements to allow policyholders access to such information while protecting the insurer's interests, in accordance with applicable public information laws.

- The review of all financial aspects of a proposed LBR culminate in a determination of the adequacy of capital and surplus. It should be demonstrated that each insurer in the group will have adequate capital and surplus to support its own liabilities and plan of operation. The capital facilities at the holding company level also should be reviewed for adequacy should a member of the group require additional capital infusions, guarantees or other support measures.

Commented [RAW52]: Guaranties?

- A key regulatory consideration in evaluating an LBR is whether there will be an on-going parental or affiliate involvement with the restructured insurer after the completion of the LBR. This involvement may take many forms, including, but not limited to, overlapping management, capital and surplus guarantees, reinsurance agreements, cut-through provisions and investment yield guarantees. The form and extent of the involvement or support will depend on the structure of the LBR and the entities involved.

- Material exposures to asbestos, pollution and health hazard claims (APH) have been the motivating factor in recent noteworthy LBRs. The Working Group recommends that the NAIC request that the

²⁵ Arizona recently enacted Title 20, chapter 4, article 1, section 20-736 which requires policyholder consent or approval by the Director of Insurance of transfer or assignment of an insurer's direct obligations under insurance contracts covering Arizona residents.

Attachment One

Casualty Actuarial (Technical) Task Force consider documenting and evaluating the analytical techniques in use to estimate such long-tail exposures.

- The major LBRs that have generated concern and raised issues are a fairly recent development. The nature of future LBRs and their frequency remains to be seen. The NAIC should consider monitoring the evolution of these transactions in order to determine whether additional regulatory responses are necessary.

APPENDIX 1

Case Studies

Cigna Corporation Property and Casualty Division

An intercompany reinsurance pooling arrangement existed between a substantial portion of the property and casualty insurance companies of Cigna Corporation. The lead company in the pool was the Insurance Company of North America (INA), a Pennsylvania-domiciled insurer.

For some years the pool's loss reserves experienced adverse development mainly from its 1986 and prior general liability policies which included APH and other long-tail liabilities. During 1994, A.M. Best downgraded the rating of the companies within the pool to B++. After a mini-restructuring in 1994 that created two separate intercompany reinsurance pooling arrangements, A.M. Best gave the pools two separate ratings, one being A- with developing implications, the other a B+ with negative implications.

To alleviate A.M. Best's and market concerns over the operations of Cigna, a second restructuring proposal was submitted to the Pennsylvania Insurance Department in October 1995. The restructuring plan called for the use of the Pennsylvania Business Corporation Law's division statute to divide INA into two companies. The two companies resulting from the division would be controlled by two separate holding companies. Simultaneously with the division, Cigna would amend its two pooling arrangements. The effect would be that the one resulting insurer, CCI (which would then be merged into Century Indemnity), would receive the 1986 and prior liabilities along with certain assets and be placed in run-off. The other resulting insurer, INA, would receive the remaining liabilities and assets, continue to write business and enter into a new intercompany reinsurance pooling arrangement with a substantial portion of the Cigna companies (active companies). As part of the restructuring, a capital infusion of \$500 million was contributed by Cigna Corporation to Century Indemnity. In addition, the active companies supported Century Indemnity through an \$800 million excess of loss reinsurance agreement and a \$50 million dividend retention fund.

The Pennsylvania Insurance Commissioner approved the division and changes to the intercompany reinsurance pooling arrangements. Seven other states, Texas, Ohio, Indiana, Illinois, California, New Jersey and Connecticut, approved changes in the intercompany reinsurance pooling arrangements and a change of control of certain insurers. The reorganization became effective on Dec. 31, 1995.

Restructuring of the Crum and Forster Group

Prior to the 1993 restructuring, the Crum and Forster Group, ultimately owned by Xerox Corporation, included 21 property and casualty insurance companies, five of which directly participated in an inter-affiliate pool. The lead company of the pool was United States Fire, which, along with affiliates Westchester Fire and Constitution Reinsurance, was domiciled in New York. International Insurance Company was the sole Illinois domestic participant in the inter-affiliate pool. International Surplus Lines, an Illinois domestic, ceded 100% of its business to International Insurance Company, so it was an indirect participant in the pool.

Following a preliminary restructuring in 1990 which included exiting from the standard personal lines market and other market-related action to improve on-going operational results, Xerox announced plans to

exit the financial services business. During the latter part of 1992, in preparation for the LBR, the group greatly strengthened loss reserves, after having suffered significant losses from Hurricanes Andrew and Iniki. Although the LBR was intended to enhance the salability of the insurance operations, an immediate goal was to realign the business into stand-alone company groups. Each group was to be dedicated to a particular purpose with greater management accountability and better focus.

The initial step of the LBR was to de-pool the group's operations. Seven separate operating groups were created: (1) Constitution Reinsurance – treaty and facultative reinsurance; (2) Coregis – professional liability, public entity and other property and casualty programs; (3) Crum & Forster Insurance – commercial property and casualty insurance through a select network of independent agents; (4) Industrial Indemnity – workers' compensation coverage and services; (5) The Resolution Group – reinsurance collection services and management of run-off businesses; (6) Viking – non-standard personal auto; and (7) Westchester Specialty Group – umbrella, excess casualty and specialty property business. To this end, various assumptive and indemnity reinsurance contracts were executed among the affiliates, and a stop loss contract was entered with Ridge Re, an affiliated reinsurer funded by the group's direct parent, Xerox Financial Services. Additional capital constituting \$235 million in cash and \$100 million in notes was contributed to the group.

The LBR received approval in the 15 states in which the 21 property and casualty insurance companies were domiciled. The primary states were New York, Illinois, California, and New Jersey. Initial discussions with the states began during the first part of 1993, and approval from all states was received by September 7 of that year. Regulators granted approvals to Form A exemptions, restatement of unassigned funds/quasi-reorganization, various reinsurance agreements, the merger of International Surplus Lines into International Insurance Company, various service agreements, and assumption certificates.

ITT Corporation

In 1992, the Connecticut Insurance Department approved a series of transactions through which ITT Corporation restructured its insurance business into discontinued and on-going operations. Effective Sept. 30, 1992, First State Insurance Company (FSIC) redomesticated from Delaware to Connecticut. Ownership of FSIC and its Connecticut domiciled subsidiaries, New England Insurance Company and New England Reinsurance Company, collectively referred to as the First State Companies, was transferred from Hartford Fire Insurance Company (HFIC) to ITT Corporation through an extraordinary dividend. Since Connecticut was domicile to FSIC and its subsidiaries, no other state was required to approve the transaction. All approvals were made pursuant to Connecticut's holding company act and notification was made to all states requiring notice regarding the discontinuation of writing new and renewal business.

The Home Insurance Group

Prior to mid-1995, the Home Insurance Company and five of its seven property/casualty insurance subsidiaries operated under a pooling agreement for the writing of commercial business. Following several years of losses, the Home's upstream parents, Home Holdings, Inc. and Trygg Hansa AB, entered into an agreement in principle in December 1994 with the Zurich Insurance Group to sell the Home Companies. The agreement virtually put the Home and its subsidiaries into run-off. The issues surrounding the acquisition and related transactions involved adequacy and funding of reserves, including asbestos and environmental, reinsurance, mergers and redemptions, and placement of renewal business. In addition, Home Holdings, Inc. had outstanding public shareholders and public bondholders.

Attachment One

New Hampshire, the domiciliary regulatory authority for the Home Insurance Company, coordinated a multistate review. Provisions of the modified agreement included a guaranteed investment rate of 7.5%, excess of loss reinsurance coverage of up to \$1.3 billion, deferral of servicing fees over cost, policyholder access to a Zurich company for new and renewal business, renewal fees paid by Zurich to fund interest on public debt, and the buyout of Home Holdings' publicly held capital stock. The states of New Hampshire, New York, New Jersey, Illinois, Indiana, California and Texas participated in approving all or part of the transaction, and all insurance subsidiaries except U.S. International Reinsurance Company were eventually merged into the Home Insurance Company in run-off. New Hampshire has maintained continual regulatory oversight since the transaction was approved in June 1995.

APPENDIX 2

Pre-Approval Checklist

Following is a list of information and data that, if not included in the original filing, should be requested by the regulatory authority and considered in the review of an insurer's proposed LBR. This list should be used as general guidance and is not intended to be all inclusive. An LBR may be effected through various forms. The regulatory authority may find it necessary to request additional information, dependent upon the complexity of the proposal, the level of regulatory oversight warranted and other circumstances specific to the proposal or the insurer.

1. Narrative

A general written summary of the proposed LBR, explaining:

- a. Reasons for undertaking the LBR;
- b. All steps necessary to accomplish the LBR, including legal and regulatory requirements and the timetable for completing such requirements;
- c. The effect of the LBR on the insurer's financial condition;
- d. The effect of the LBR on the insurer's policyholders;
- e. The consequences if the LBR is not approved.

2. Business Plan

- a. On-going Operations
 - i. A listing of the insurer's major markets/products.
 - ii. A description of the insurer's strategy covering major markets/products and customers and the critical success factors for achieving these strategies.
 - iii. A description of the insurer's competitive positioning for each of its major markets/products and a discussion of growth potential, profit potential and trends for each.
 - iv. Identification and a discussion of the significant trends in the insurer's major markets/products, *e.g.*, demographic changes, alternative markets, distribution methods, *etc.*
 - v. Identification of the largest risk exposures of the insurer, *e.g.*, financial market volatility, environmental exposures, geographic distribution, *etc.*
 - vi. A description of the major business risks of the insurer, *e.g.*, sales practices, data integrity, service delivery, technology, customer satisfaction, *etc.*
- b. Run-off Operations
 - i. A description of all plans regarding any run-off operations.

3. Financial Information

- a. Historical financial statements, including the most recently filed annual and quarterly statutory statements.
- b. Financial statements (in a spreadsheet format) detailing the accounting of the proposed LBR including:
 - i. Schedules detailing assets and liabilities to be reallocated as part of the LBR.
 - ii. An accounting of any special charges, reevaluations, or write-downs to be made as part of the LBR.
- c. Pro-forma financial statements of the insurer(s) as if the LBR were approved including an explanation of the underlying assumptions.
- d. Financial projections for three years (assuming the LBR is approved) for both the run-off and on-going entities and an explanation of the assumptions upon which the projections are based.
- e. A description of any tax consequences of the LBR.

4. Analysis of Reserves

Retain qualified independent actuarial experts.

- a. The actuarial expert should perform a “ground-up” actuarial review of case and incurred but not reported reserves for asbestos, pollution, health hazard and other long-tail claims.
- b. The actuarial expert should also opine on:
 - i. Methodologies used by the insurer to estimate reserves.
 - ii. The adequacy of reserves on a gross and net of reinsurance basis.
 - iii. The adequacy of the expertise of the insurer’s claims unit.
 - iv. The insurer’s economic approach to funding the run-off liabilities, including cash flow model stress tests.
 - v. If reserve discounting is permitted, funding of the discount and the adequacy of reserves net of discount.

5. Analysis of Reinsurance

- a. An analysis of reinsurance recoverables by a qualified expert including:
 - i. A review of the process used to monitor, collect and settle outstanding reinsurance recoverables.
 - ii. An analysis of existing and projected reinsurance balances including the expected timing of cash flows.
 - iii. An analysis of the quality and financial condition of the reinsurers and prospects

for recovery.

- iv. A detailed description of write-offs or required reserves based on the independent analysis taken as a whole.
 - v. Disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes.
 - vi. A discussion of the impact of the LBR on the collectibility of reinsurance balances.
- b. A legal analysis of the effect that a rehabilitation or liquidation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and on the legal rights of the reinsurers to claim setoffs against such recoveries.
- c. If reinsurance stop loss or excess of loss coverage is an integral part of the transaction, a copy of such agreement and a written opinion from a qualified expert as to:
- i. The adequacy of coverage;
 - ii. The ability of the treaty to perform as anticipated and be unaffected by delinquency proceedings;
 - iii. The practical operation of the treaty;
 - iv. The timing and method of payment of reinsurance premium;
 - v. The financial condition of reinsurers;
 - vi. The sufficiency of coverage and other resources.
- d. A discussion of existing or proposed reinsurance programs, whether with affiliates or other reinsurers, to assist the regulatory authority in determining that provisions are consistent with other information provided and that adequate coverage exists for both on-going and run-off operations.
- e. Any proposed amended, cancelled, or new pooling agreements, including explanations of significant differences before and after the restructuring, flowcharts to demonstrate the proposed movement of business, and the anticipated financial impact upon the affected companies.

6. Analysis of Liabilities Other Than Reserves

An analysis of material liabilities other than reserves, including a discussion about any reallocations or dispositions as part of the LBR, especially as they relate to reinsurance agreements and inter-company cost and tax-sharing agreements. The analysis should include all non-reserve related accruals and outstanding debt line items found on the Property/Casualty Annual Statement (page 3) for liabilities, including write-ins.

7. Analysis of Assets

An analysis should be performed to determine if existing assets and future cash flows are sufficient to fund liabilities. This analysis should include:

- a. Disclosure of assumptions regarding the assets of the insurer(s) involved in the LBR,

especially those assets with high volatility, liquidity uncertainties, material valuation issues, or representing a material percentage of the invested asset portfolio.

- b. Current appraisals of any material real estate or mortgage holdings, independent valuation of limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other assets of concern.
- c. A list of assumptions used by the insurer(s) as to investment yield, and disclosure of the effect that the reallocation of assets will have on historical investment yields.
- d. If the asset analysis performed by the insurer indicates a potential asset/liability matching problem, documentation that the insurer plans to take action such as:
 - i. Reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk.
 - ii. Securing a parental **guarantee** of investment yield.
 - iii. Securing a parental guarantee of asset valuation or a parental agreement to substitute the insurer's assets.
 - iv. Disposing of assets prior to approval of the LBR.

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8. Parental Support

- a. The plan should provide for the provision of financial and managerial support by the parent company to all entities.
- b. The plan should provide for a commitment of parental support to run-off operations in the event of:
 - i. Inadequacy of reserves;
 - ii. Asset deterioration;
 - iii. Deterioration in the collectibility of reinsurance recoverables.

9. Organizational Impact

- a. The plan should affirm that the restructured entity was either licensed or an approved surplus lines carrier in all jurisdictions in which it wrote business, and will be licensed in all jurisdictions where it takes on business as a result of the restructuring.
- b. Analysis of the change in organizational structure resulting from the transaction. Areas to emphasize include:
 - i. Ownership of the resulting corporate structures;
 - ii. relation between management of the resulting entities;
 - iii. Substantial reinsurance arrangements between resulting entities;
 - iv. Other on-going business ties between the resulting entities.

10. Analysis of Issues Affecting Policyholders

Attachment One

- a. Consider whether to require that “cut-through” provisions be put in place for policyholders of the weaker entity.
- b. Obtain a legal opinion that policyholders of restructured entities will not lose guaranty fund coverage as a result of the LBR.
- c. Hold discussions with affected guaranty funds and National Conference of Insurance Guaranty Funds (NCIGF) regarding any coverage issues.
- d. Consider whether to require that a mechanism be put in place to obtain policyholder consent regarding any novations.

APPENDIX 3 ON-GOING REGULATORY OVERSIGHT

The following are examples of conditions and requirements for on-going regulatory oversight of an LBR.

- Reporting
 - Require periodic operating reports.
 - Require financial statements and management reports more frequently than required by statute.
 - Require periodic reports on certain losses, including payments.
 - Require financial projections annually.
 - Require reports on actual results compared to plans.
- Balance Sheet Discipline
 - Require recurring actuarial reviews of reserves. This requirement could include departmental approval of the actuarial firm selected and the scope of the review.
 - Require periodic independent reviews of reinsurance recoverables.
 - Establish guidelines for future investments of inactive operations.
 - Limit discounting of reserves as allowed by law, so long as investment earnings continue to support the rate of discount.
- Specific Transactions
 - Prohibit dividends by inactive operations without prior approval.
 - Prohibit dividends by active operations for a set period of time.
 - Require creation of a dividend “sinking fund,” with contributions from inactive operations requiring regulatory approval and payments to be made from the principal amount. The fund would be maintained in a separate account and could not be terminated without prior written approval from the regulatory authority.
 - Require intercompany balances with the inactive operations be settled within 90 days of each quarter.
 - Require prior approval of affiliated transactions between inactive and active operations.
 - Require prior approval for inactive operations to establish security deposits with any

other jurisdictions except to the extent required by law.

- Communications
 - Require notice to all known policyholders and claimants affected by the transaction.
 - Require a written response to any inquiry regarding the LBR.
- General Monitoring
 - Require on-site monitoring facilities.
 - Require right to notice of and right to attend all Board of Directors meetings.

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Alternative Mechanisms for Troubled Companies

An NAIC White Paper

February 2010

**Created by the
NAIC Restructuring Mechanisms for Troubled Companies Subgroup
of the Financial Condition (E) Committee**

Drafting Note: This white paper is limited to situations where the legal entity is in a financially troubled condition that could potentially lead to an insolvency in the foreseeable future. It will not consider situations where the insurer is merely inconvenienced by a particular book of business.

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I. INTRODUCTION

A. BACKGROUND/PURPOSE

State insurance regulators have well-developed receivership statutes, practices, and procedures to handle impaired and insolvent insurers. These statutes, practices, and procedures serve, first and foremost, the goal of consumer protection. They are a critical and essential part of the Regulatory Solvency Framework. However, given improvements in regard to the early detection of financially troubled insurers and insureds' requirements for A-rated coverage, a new landscape has emerged with a growing number of troubled insurers seeking to engage in mechanisms of run-off or restructuring as an alternative to being placed in traditional receivership proceedings. For example, as of mid-year 2008 alone, there were approximately 129 active insurers in voluntary run-off domiciled in the United States with over \$36 billion in claims in progress. As a result of a changing landscape and the fact that the NAIC has little formal documentation available to regulators dealing with alternative mechanisms for winding-down troubled companies, the Receivership and Insolvency (E) Task Force during 2007 began drafting charges to undertake a study of alternative mechanisms and relative best practices. These charges were presented to the Financial Condition (E) Committee during the 2007 NAIC Winter National Meeting. The Committee members supported the charges, but felt the topic of active troubled insurers required the expertise and perspective of regulators involved in the active solvency monitoring process, as well as receivership process. Thus, a Restructuring Mechanisms for Troubled Insurers Subgroup was formed directly under the Committee with regulators representing both perspectives. The Subgroup's 2008 adopted charges were as follows:

Undertake a study of alternative mechanisms, such as solvent schemes of arrangement, solvent run-offs, and Part VII portfolio transfers (a transfer leaving no recourse to original contractual obligor/insurer) and any other similar mechanisms to gain an understanding of:

- i. How these mechanisms are utilized and implemented.
- ii. The potential effect on claims of domestic companies, including the consideration of preferential treatment within current laws.
- iii. How alien insurers (including off-shore reinsurers) who have utilized these mechanisms might affect the solvency of domestic companies.
- iv. Best practices for state insurance departments to consider if utilizing similar mechanisms in the United States and/or interacting with aliens who have implemented these mechanisms.

The study is documented in the form of this NAIC white paper. Additionally, the study was limited to situations where the legal entity was in a financially troubled condition that could have potentially led to an insolvency in the foreseeable future. The Subgroup did not consider situations where the insurer was merely inconvenienced by a particular book of business or wished to exit the insurance business for reasons unrelated to solvency.

B. AUTHORITY & APPLICABILITY

The information in this white paper is meant to provide guidance to state insurance regulators and be an advisory resource. It discusses approaches and concepts that are available within and outside the United States in order to assist regulators with assessing possible alternatives for handling troubled insurers. Mechanisms discussed in this white paper may not be available or applicable in all jurisdictions due to differences in statutes, regulations, and implementing tools and resources, as well

as changing market conditions. In fact, statutes and regulations that define the authority and duties of regulators may require, or provide for, specific procedures to be implemented in certain circumstances. In addition, although this white paper was intended to generally apply to all risk-assuming entities that are subject to the authority of the insurance department, the majority of the Subgroup's discussion was focused on property/casualty insurance companies. Due to their unique characteristics, the mechanisms mentioned in this white paper, may not be appropriate in the context of life, health, or other personal lines of insurance for which guaranty association protections are available, or for certain types of specialized risk-assuming entities (e.g., health maintenance organizations, syndicates, risk retention groups, chartered purchasing groups, chartered self-insured groups or pools, captives, insurance exchanges, etc.). Lastly, an appropriate mechanism for a particular troubled insurer will also depend on the specific circumstances of the situation.

C. OTHER CONSIDERATIONS

As state insurance regulators consider the relative advantages and disadvantages of these alternative mechanisms, they should do so in the context of the overall policy objectives behind each alternative. Different policy objectives will inevitably lead to very different results. The current system that utilizes liquidation and provides for guaranty fund protection for certain policyholder claims reflects a legislative policy that places the rights of policyholders and claimants above the interests of other creditors of the insolvent company. While these laws may vary somewhat from state to state, they share several key features. The interests of policyholders and claimants are granted priority over claims brought by other insurers, the government, and general creditors. The laws seek to preserve, to the greatest possible extent, the insurance protection that the policyholder believed he/she was getting when he/she purchased his/her policy from the now-insolvent insurer. The law treats all similarly situated claimants in the same manner, thereby prohibiting preferential treatment for certain favored individuals or entities. Finally, they preserve, in some meaningful form, the right of judicial review. These elements form the foundation of the existing system that exhibits a clear legislative choice to place the interests of consumers above the interests of investors and large institutions that are better equipped to withstand the losses resulting from insurer insolvency.

II. GENERAL ADVANTAGES AND DISADVANTAGES FOR UTILIZING ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

A. ADVANTAGES

- Alternative mechanisms can be useful tools for a troubled insurer's management and regulators, potentially leading to a quicker resolution than a traditional receivership.
- Alternative mechanisms typically allow for continuous claims payments, or at least orderly claims processing and partial claims payments without interruption.
- Alternative mechanisms can cost less than receiverships, thus resulting with maximum dollars paid out to policyholders/claimants.
- Alternative mechanisms may allow greater flexibility to achieve commercially acceptable results, such as freeing up capital.

B. DISADVANTAGES

- The inherent risk for consumer and claimant issues increases, requiring stronger regulatory monitoring and controls for protection. For some alternative mechanisms, there is no guarantee that appropriate fairness will take place.
- Alternative mechanisms for troubled insurers might become a tool for solvent carriers to transfer value away from policyholders.
- As to reinsurance, restructuring might affect the value of the future reinsurance claim or offset rights, arbitration rights, and reinsurance collateral.
- The cost of efficiency or company enticements may come at the expense of policyholders or insureds.
- Difficult decisions arise with a troubled insurer that is not clearly solvent or insolvent, and significant ramifications could follow with certain choices.
- Companies may seek to continue run-off or restructuring activities even after it becomes clear that the company is hopelessly insolvent, resulting in preferential payments made at the expense of outstanding claims.
- Compensation incentives may restrict future claims-paying ability.
- Voluntary restructuring schemes may deny policyholders and consumers the substantive and procedural safeguards otherwise available for their protection in court-supervised receivership proceedings.
- Run-off and restructuring schemes may be used to circumvent state priority and preference rules in order to discount claims at the expense of policyholders and other claimants. They may also be used to circumvent other consumer protection laws, including state receivership and guaranty association laws as well as commutation and assumption transfer laws.
- May allow the company to terminate coverage and extinguish liabilities over the objections of policyholders and other creditors by majority cram-down vote.
- Run-offs and restructuring schemes may result in substantially reduced payments to policyholders. State receivership laws typically require a showing that a rehabilitation plan is fair and equitable, complies with priority rules, and provides no less favorable treatment of claims than would occur in liquidation. Run-offs and alternative mechanisms, such as

those addressed herein, may have the ability to sidestep these equitable standards and permit broad discretion in discounting claim values. In fact, the success of a plan may be dependent on the ability to impose deep discounts on claims, and there may be no rules or mandatory standards in place to protect policyholders or claimants.

- There is a risk that similarly situated creditors will be treated differently or that they will receive payments that are less than they would receive in an insolvency proceeding.
- Alternative mechanisms adopted in any given state may not be enforceable across state lines, leaving the company at risk of further exposure, litigation, and ongoing collection activity that may disrupt efforts to implement a restructuring plan.
- Alternative mechanisms are not appropriate for compromising the claims of consumer policyholders due to lack of sophistication and the existence of extensive consumer protections built into insolvency laws.
- In the absence of strong regulatory involvement, there is a risk that policyholders and creditors will not receive adequate or accurate information on which to base their decisions.
- The interests of management may not be the same as the interests of policyholders and creditors.

III. TYPES OF ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

MECHANISMS AVAILABLE TO INSURERS WITHIN THE UNITED STATES AND RELATED TERRITORIES

A. RUN-OFF OF TROUBLED INSURER

1. DESCRIPTION

A troubled company run-off is usually a voluntary course of action where the insurer ceases writing new business on all lines of business, but continues collecting premiums and paying claims as they come due on existing business. Due to state cancellation laws, the insurer may be required to renew business, which can be particularly challenging for insurers running-off personal lines risks. The insurer may seek to run-off business in the traditional sense—paying claims in full in the ordinary course of business—or management of the insurer might seek to end or limit their exposure on insurance business before policy terms expire by utilizing reinsurance, assumption transfers, negotiated settlements, and/or voluntary policy commutations. These transactions should not have a negative impact on policyholders, as close regulatory monitoring is normally maintained throughout the process. The goal is to completely close operations while remaining solvent.

In order to succeed in run-off, assets and income must be maintained at sufficient levels to cover the remaining claims and administrative costs of handling those claims. However, solvent run-offs may have little revenue other than investment income, and run-offs may develop into insolvencies that could require receivership proceedings—for example, if the insurer is unable to collect reinsurance, makes errors in estimating recoverable assets, experiences a decline in asset values and investment income, and/or encounters other cash flow issues at any point in the process.

Although run-off mechanisms can generally be applied to property/casualty, life, health, title, or fraternal insurers, it is of general consensus that personal lines should not be included in any commutation plan incorporated as a component of any run-off plan.

a. STATUTORY BASIS FOR SUPERVISED RUN-OFF PLANS

Run-off of a troubled company may be subject to regulatory supervision under applicable state law. (See, e.g., NAIC Risk-Based Capital (RBC) For Insurers Model Act, Section 6.B(2).) Regulatory supervision of a troubled company run-off may be triggered in order to enhance the regulatory oversight and monitoring of the financial performance, consumer protections, and market conduct related to implementation of the run-off plan. Enhanced regulatory oversight may include increased financial and regulatory reporting requirements, regulatory approval of transactions and claim settlement practices, and on-site regulatory supervision. Supervision of the run-off plan is conducted in order to ensure that policyholders, consumers, and other creditors fare no worse under the run-off plan than in receivership.

For example, the Illinois Insurance Code, based on the NAIC Model Act, provides the Illinois Director of Insurance with a discretionary alternative mechanism for handling troubled property and casualty companies and health organizations whose RBC Reports indicate a mandatory control level event. Section 35A-30(c) of the Illinois Insurance Code, 215 ILCS 5/35A-30(c), provides:

In the case of a mandatory control level event with respect to a property and casualty insurer, the Director shall take the actions necessary to place the insurer in receivership under Article XIII or, **in the case of an insurer that is writing no business and that is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Director.** (Emphasis added)

A mandatory control level event is defined under the statute as an RBC Report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC. Under this statutory mechanism, if there is a mandatory control level event at a company that has ceased writing new business and the company is engaged in a voluntary run-off, the Director has the discretion to either seek a receivership order or to allow the company to continue its run-off under the Director's supervision.⁶⁹ In order to persuade the Director to exercise the supervised run-off option, the company must prepare and present a comprehensive run-off plan, including financial projections, that establishes that the plan is viable, that there is a high probability that the run-off can be conducted without putting policyholders at greater risk, and that all claim obligations will be satisfied.

The specific content of the run-off plan may vary depending upon the nature of the business being run-off and the financial circumstances of the troubled company. (See a sample outline for a run-off plan at VII. *Appendix C*.) However, the primary goals of the plan should include and achieve consumer protection, satisfaction of all policyholder obligations, and the maintenance of positive surplus and sufficient liquidity. Typically, the components of such a plan would include substantial cost-cutting measures, commutations of reinsurance agreements, collection of outstanding premium, recovery of statutory deposits, policy buy-backs, novations, and claim settlements.⁷⁰ A key element of such a plan would be a discussion of the benefits to the policyholders of a run-off rather than a receivership, including the impact of any state guaranty fund or guaranty association coverage.

The nature and scope of the Director's supervision may be delineated in a comprehensive corrective order, which would include and reference such things as the run-off plan, periodic reporting requirements, on-site monitoring, procedures relating to the approval of transactions, claim settlement practices, and other related matters. The corrective order, which may be amended from time to time, would likely be confidential under state law. Because the company is involved in a supervised run-off, it may be appropriate to negotiate certain adjustments (e.g., discount reserves, allow prepaid expenses, remove schedule F penalty) to its statutory financial statements, but, as adjusted, the financial statements should still comply with Generally Accepted Accounting Principles. Any such adjustments should be based upon credible forecasts and other available information.

⁶⁹ Section 35A-30(d), 215 ILCS 5/35A-30(d), of the Illinois Insurance Code provides the Director with a similar supervised run-off option with respect to troubled health organizations.

⁷⁰ In 2005, the Illinois voidable preference statute was amended to provide that in the case of a company involved in a supervised run-off, a transaction involving transfer of cash or other assets by the company (buy-back, settlements, etc.) that was approved by the Director in writing cannot later be found to constitute a voidable transfer, 215 ILCS 5/204 (m)(C). This provision provides policyholders and other parties to buy-back, novation, commutation and other approved transactions with protection from the voidable preference statute in the event that the company ultimately goes into liquidation. In the absence of this protection, policyholders and others may be reluctant to enter into such transactions.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Voluntary run-offs may enable commercial parties to achieve commercially acceptable results in arm's-length transactions that reflect customary market practice.
- Timely defense and payment of policyholder claims in full not otherwise always covered by guaranty funds or associations.
- Potentially more favorable environment for the negotiation of disengagement transactions and commutations with reinsurers.
- Continuity of management information systems.
- Some business entities may be willing to acquire insurance companies in run-off and inject additional capital or reduce overhead expense. This consolidation and management expertise could provide some efficiency for regulators in regard to their monitoring processes.
- Typically involve commutations and other solutions reflective of the consent of the contracting parties.
- There is evidence that it appears to be a robust method, given that there are accumulators of seasoned run-off companies.
- Strategic decisions can be made quickly and efficiently working with appropriate state regulators.

DISADVANTAGES

- Preferential treatment issues might arise when dealing with business-to-business structures, if both large and small policyholders exist, as deals tend to focus on settling with large carriers first. In addition, more complicated commutations may be structured in the run-off plan to be handled last.
- Preferential payments may arise with respect to creditors whose priority of payment in the event of liquidation would be classified below that of policyholder and consumer claims.
- Policyholders and consumers may be compelled to accept less than the fair value of their claims.
- Potential negative impact of adverse claim development.
- Attempts to commute or settle with policyholders (complete policy buy-backs) can result in reinsurers resisting payment.
- To the extent the estate assets are reduced by paying claims earlier, the estate assets remaining to pay remaining policyholder and guaranty association claims will be reduced, costing the industry more.
- Larger insureds may have better leverage to negotiate better settlements.
- Absent regulatory oversight—there is no guarantee that settlements will be at consistent or even fair levels.
- The absence of court oversight and mandatory rules and standards (such as priority rules and rehabilitation plan standards) increases the likelihood that policyholder claims will be sharply discounted and that bargained-for benefits and protections will be lost.
- Guaranty funds may be disadvantaged in a subsequent receivership if non-guaranteed creditors were paid more than the ultimate distribution from the receivership.

B. NEW YORK REGULATION 141

1. DESCRIPTION

In 1989, at the request of the New York Superintendent of Insurance, the New York Legislature enacted New York Insurance Law § 1321. Section 1321 authorized the Superintendent to permit an impaired or insolvent New York domestic insurer (or an impaired or insolvent United States branch of an alien insurer entered through New York) to commute reinsurance agreements to eliminate the company's impairment or insolvency.

Until the Legislature enacted NYIL § 1321, commutation agreements with troubled New York domestic insurers were subject to challenge as potential preferences pursuant to the Insurance Law's voidable transfer provisions. When the Legislature enacted Section 1321, it extended the voidable transfer period from four to 12 months (NYIL § 7425(a)). The Legislature also amended the insurance law to provide that commutation agreements executed pursuant to NYIL § 1321 "shall not be voidable as a preference" (NYIL §7425(d)).

Section 1321 required that any commutation proposed under the new statute be approved by the Superintendent "in accordance with standards prescribed by regulation." In 1990, the acting New York Superintendent promulgated Regulation 141 (Regulation No. 141, Commutation of Reinsurance Agreements, N.Y. Compo Codes R. & Regs. tit. 11, Section 128 (1989) (11 NYCRR Section 128)). Regulation 141 sets out the "applicable standards that the superintendent will use in determining whether such commutations entered ... will be approved."

Regulation 141 applies to all New York-domiciled insurers (and U.S. branches) "other than a life insurance company" as defined in NYIL § 107(a)(2). However, the regulation excludes impaired or insolvent life insurers and solvent insurers. The Regulation sets out how a troubled insurer may propose and implement a Regulation 141 plan. Among other things, the Regulation's procedures add the requirement that any company seeking the benefits of Regulation 141 must stipulate that the troubled insurer will consent to an order of rehabilitation or liquidation if its proposed commutation plan does not restore policyholder surplus to the required minimum amounts (or such surplus as the Superintendent deems adequate).

The troubled insurer must provide the New York Department with a draft commutation agreement and a proposed commutation offer that will be extended to "each and every ceding insurer to which the impaired or insolvent insurer has obligations." The reinsurer must also provide a balance sheet showing both the insurer's impairment or insolvency as determined by the Superintendent and a pro forma balance sheet reflecting the troubled company's financial condition subsequent to the plan's implementations.

The proposed commutation offer must include an offer to pay a percentage of the cedent's losses. The impaired insurer must advise its cedents that the commutation offer remains subject to the Superintendent's determination that the total of all accepted commutation offers has restored policyholder surplus either to a statutory minimum or an amount that the Superintendent deems adequate.

Regulation 141 requires that offers to commute assumed reinsurance obligations be made to "each and every ceding insurer to which the impaired insurer or insolvent insurer has obligations." The Regulation broadly defines the term "obligations" to include paid losses, loss reserves, incurred but not reported (IBNR), all loss adjusting expenses (paid, case, and IBNR), reserves for unearned premiums, and "any

other balances due under the reinsurance agreements.” The terms of all proposed commutation agreements must be the same.

For example, the same discount must be offered to each cedent—e.g., 90% of paid losses, 60% of case reserves, and 30% of IBNR. No cedent may be favored with different discounts. Discounts for different lines of business may be proposed, but these discounts must be “reasonable, actuarially sound, and supported by documents justifying such a variance.” To date, none of the Regulation 141 plans approved by New York Superintendents of Insurance has incorporated different discounts by line of business.

Any proposed Regulation 141 plan submitted to the Superintendent must include an exhibit setting forth the obligations due each cedent to which the troubled company has obligations and the consideration (commutation offer) to be paid each cedent. Within 10 days of the plan’s approval, the troubled company must deliver its proposed commutation agreements to its cedents. No cedent may be compelled to commute its “obligations.” The terms of the proposed commutations and the amount offered “shall not be subject to negotiation.” Each cedent makes its own determination with respect to whether the cedent wishes to accept the proposed commutation or refuse to commute and run the risk that the Regulation 141 plan will not succeed.

The results of an approved plan must be returned to the Superintendent within a period specified by the Superintendent. The plan results must include: copies of all executed commutation agreements; copies of all rejected commutation agreements; “correspondence pertaining to all ... offers made to the ceding insurers”; a pro forma balance sheet showing the effect of the accepted/rejected offers; any other components of the plan to restore surplus to policyholders; and copies of any agreements that modify, commute, or assign any retrocession agreements.

If the Superintendent determines that the proposed commutation agreements and any other plan components sufficiently restore policyholder surplus, the commutation agreements take effect. The Superintendent may specify, when he or she approves the Regulation 141 plan, that cedents that agree to commute be paid within so many business days.

If the Superintendent determines that surplus has been restored, the Superintendent may proceed against the troubled company armed with the company’s stipulation consenting to entry of any order of rehabilitation or liquidation.

The primary procedural safeguards for an approved Regulation 141 plan include: the state regulator’s full discretion to accept, reject, or modify any proposed plan; explicit requirements that the same commutation terms be offered to every ceding company whose obligations appear on the troubled company’s books and records; the absence of any “cram down” provisions that would allow the Superintendent to approve the commutation of a cedent’s contracts over a cedent’s objections; timeframes for the submission of a plan and payment of agreed commutation amounts within days after the plan’s results have been approved; and provisions calling for the preservation and production of all communications between the troubled company and its cedents.

In addition, and as previously noted, the commutation agreements executed pursuant to an approved Regulation 141 plan will not take effect “unless ... the plan shall eliminate the insurer’s impairment or insolvency” and restore surplus to policyholders to levels required under the insurance law or an amount that the Superintendent deems “is adequate in relation to the insurer’s outstanding liabilities or financial needs.”

Although the troubled company's directors must consent to an order of rehabilitation or liquidation if the company's surplus has not been restored to the required minimum, the Superintendent need not consider any plan proposed pursuant to Regulation 141 "in lieu of taking any other action" against the company. This gives the Superintendent full discretion to decide whether to allow the troubled company to propose a plan or to take other action against the company, including supervision, rehabilitation, or liquidation.

Thus far, three professional reinsurers have successfully implemented New York Superintendent-approved commutation plans pursuant to Regulation 141: 1) Rochdale Insurance Company; 2) Paladin Reinsurance Company; and 3) Constellation Reinsurance Company. In addition, the Insurance Company of the State of New York (INSCORP) obtained the Superintendent's approval for a Regulation 141 plan and submitted its commutation plan results to the Superintendent. However, as a result of the continued adverse development, INSCORP's policyholder surplus could not be improved to an acceptable level, and INSCORP was placed in rehabilitation.

See VII. Appendix D – Reference List of NAIC Model Laws and State Selected Related Statutes for review of the Regulation.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- No cedent can be outvoted and compelled to accept a commutation offer.
- All communications to and from the ceding insurer must be preserved and provided to the regulator.
- Although the regulation was designed for professional reinsurers, the plan also works if the troubled insurer is engaged in assumed reinsurance and also wrote direct business.
- No court approval is required.
- The plan must show how the proposed commutations will affect its retrocessional program, thus reducing the risk that the commutation plan will bind or negatively affect retrocessionaires.
- The Superintendent has ultimate oversight, flexibility, and control, to the extent that the Superintendent may approve, disapprove, or modify a plan, and the Superintendent may also review all the communications exchanged relating to the offer to ensure that no unfair offsets were arranged or that offers to commute did not otherwise favor or disfavor particular cedents.
- Regulation 141 also allows for other components to be added to the plan to restore policyholder surplus, including surplus notes and capital contributions.

DISADVANTAGES

- As an offer under this regulation is based on the assuming reinsurer's books at a given date, discrepancies between the ceding and assuming insurers' books are likely to occur.
- Timing could become problematic if the regulator does not enforce strict deadlines regarding the consideration and execution of offers.
- Regulation 141 does not require an audited balance sheet to confirm the extent of the troubled insurer's financial condition.
- Many subjective considerations must be used by the troubled insurer to determine in advance what percentage of approval is needed for the plan to work.

C. RHODE ISLAND STATUTE AND REGULATION FOR VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS

1. DESCRIPTION

Rhode Island's Title 27, Chapter 14.5⁷¹ provides for voluntary restructuring of solvent insurers. The statute was intended to provide an alternative to a traditional run-off by bringing "solvent schemes of arrangement" (which are discussed further in the next section) to the United States. It allows solvent companies that are in run-off to reach a court-ordered (and department of insurance supervised) agreement with all of its creditors in order to accelerate completion of the run-off, bringing certainty of payment to creditors and reducing administrative costs often associated with lengthy run-offs.

The statute sets forth a structure for court-ordered review, approval and implementation of what the statute refers to as a "commutation plan." The process may only be utilized by reinsurers and commercial property and casualty insurers domiciled in Rhode Island and in run-off (R.I. Gen. Laws § 27-14.5-1(6)). In addition, the insurer must be solvent and adequately reserved in accordance with all applicable Rhode Island statutes and regulations, as well as in compliance with all other department solvency standards.

A company considering the process must first prepare and submit their proposed commutation plan to the insurance department for review⁷² (Insurance Regulation 68(4)(a)(i)). A commutation plan is very broadly defined as a plan for extinguishing the outstanding liabilities of a commercial run-off insurer. After the plan is reviewed by the department and all issues are resolved, the company may apply to the court for an order agreeing to classes of creditors and calling for a meeting of creditors (Insurance Regulation 68(4)(a)(iii)). At this point, the company is required to give notice of the application and proposed commutation plan to all parties pursuant to fairly broad requirements set forth in the statute (R.I. Gen. Laws §§ 27-14.5-3 and 27-14.5-4(b)(1)).

All creditors and interested parties (such as Guaranty Funds) are granted full access to the plan and all information related to the plan. Both creditors and interested parties are given an opportunity to file comments or objections to the plan with the court (R.I. Gen. Laws § 27-14.5-4(b)(3)). Ultimately, all creditors must be given an opportunity to vote on the commutation plan, and approval of the plan requires consent of at least i) 50% of each class of creditors, and ii) the holders of 75% in value of the liabilities owed to each class of creditors (R.I. Gen. Laws § 27-14.5-4(b)(4)). However, it is important to note that only the claims of creditors present or voting through proxy at the meeting of the creditors are counted toward determining whether the requisite majorities have been achieved. (See Insurance Regulation 684(e)(i).)

Upon approval of the commutation plan by the creditors, the company must petition the court to enter an order confirming the approval and allowing implementation of the plan (R.I. Gen. Laws § 27-14.5-4(c)(1)). The implementation order must enjoin all litigation in all jurisdictions between the applicant and creditors, as well as release the applicant of all obligations to its creditors upon payment

⁷¹ The Rhode Island statute was adopted in 2002 and amended in 2007. See R.I. Gen. Laws § 27-14.5-1 *et seq.*, "Voluntary Restructuring of Solvent Insurers," and R.I. Insurance Regulation 68 (Commutation Plan regulations).

⁷² Plan approval is done by the court; however, the department has the statutory authority to intervene in any proceeding brought under this statute. According to the Rhode Island Division of Insurance Regulation, it is highly unlikely that the court would approve a plan over the Division's objection.

of the amounts specified in the plan (R.I. Gen. Laws § 27-14.5-4(c)(2)). The court may only issue an implementation order if it determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders (R.I. Gen. Laws § 27-14.5-(c)(1)(ii)). The court does have a responsibility to ensure that all policyholders and creditors have been treated fairly. Once the implementation order is entered, distribution to creditors may begin.

After implementation and upon completion of the commutation plan, the court can issue an order of discharge or dissolution. As a result of this order, the company is either i) dissolved or ii) discharged from the proceeding without any liabilities. At this point, any residual assets are distributed to the company owners (R.I. Gen. Laws § 27-14.5-4(d)).

One of the key aspects of the process is that the court's implementation order releases the insurer from all obligations to its creditors upon payment of the amounts specified in the commutation plan. This brings about a court-ordered finality to the run-off that would not be possible utilizing traditional run-off options. To this end, the order actually binds the insurer and all of its creditors and owners, whether or not a particular creditor or owner is affected by the plan or has accepted the plan, or whether or not the creditor or owner ultimately receives money under the plan. The order is also binding whether or not creditors had actual notice (R.I. Gen. Laws § 27-14.5-3(b)).

It is also important to note that because the restructuring mechanism provided for by the statute would not be appropriate or practical for companies with a large number of small creditors with very diverse interests, the statute is restricted to use by reinsurers and commercial property and casualty insurers. It includes express limitations on the lines of business that can be included in a commutation plan, and specifically excludes all life insurance, workers' compensation and personal lines (See R.I. Gen. Laws § 27-14.5-1(21)). However, in cases where a company does have excluded lines, the statute provides for a bifurcated process for disposing of all lines of business within the context of the run-off scheme. Commercial lines would be included in the commutation plan, and, if possible, excluded lines would be transferred to an eligible insurer through court-ordered and department-sanctioned assumption reinsurance (See R.I. Gen. Laws § 27-14.5-1(6) and R.I. Gen. Laws § 27-14.5-4(d)(2)(ii)). Again, the process is available only to solvent companies—the theory being that the restructuring would permit all liabilities to be paid in full.

The definition of "Commercial Run-off Insurer" under the statute was expanded by amendment in 2007 to include companies newly formed or re-activated under Rhode Island law solely for the purpose of accepting transferred business for restructuring pursuant to the statute (See R.I. Gen. Laws § 27-14.5-1(6)). The purpose of this amendment was to expand the population of insurers that might qualify for the process. The amendment permits an insurer to transfer some or all of its commercial liabilities (a very controversial process) to a newly formed run-off entity for the sole purpose of implementing a commutation plan pursuant to the statute. The original insurer would be allowed to continue writing business with no further obligations under the transferred policies. Any such transfer would require prior approval of the department.

Since the statute's enactment in 2002, no insurer has availed itself of the statute, and no other U.S. state has adopted a similar law.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Might provide a better solution for policyholders and investors than traditional run-off options (creditor democracy).
- Provides certainty of payment to creditors of present and future claims.
- Avoidance of a lengthy run-off with the associated ongoing administrative costs, adverse claim development and deteriorating reinsurance collections.
- Provides certainty of payment by reinsurers.
- Accelerated release of capital to shareholders at the conclusion of the process, allowing for more efficient deployment of capital to non-run-off operations.
- Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism for these companies will create an active market for investment in run-off companies.

DISADVANTAGES

- Permits an insurer to terminate coverage and extinguish liabilities over the objections of policyholders and creditors who are in the minority.
- Creditors are bound by the plan whether they had notice or not, and only those present or voting through proxy are counted toward establishing the requisite majority, which may create incentives to manipulate notice (though the department and court could take steps to prevent such manipulation).
- Although the process is limited to solvent insurers and the intent therefore is that full value will be paid to all creditors, there are no guarantees that all policyholders will receive full value, or even present value for their claims (especially those with IBNR claims).
- There is no reference to segregating and preserving reserve assets for excluded lines, or any explanation as to how policies and claims would be administered and paid during the interim period prior to completion of the plan.
- Questions concerning the enforceability of any such plan across state lines may leave companies exposed to further risk, litigation and disruption or termination of a plan—i.e., even if the Rhode Island court did approve the plan, it is possible that policyholder or claimant actions could arise in other states' courts, (or perhaps federal courts), resulting in enforcement and implementation issues for the company attempting the restructuring.⁷³
- Although the Rhode Island plan is available only to commercial insurers and reinsurers in run-off, the plan is not exclusively limited to “troubled” companies; thus, any commercial run-off insurer could conceivably use this mechanism to cease operations and eliminate ongoing claims payment liability.
- Despite the fact that there is significant statutorily delineated regulatory guidance included in the Rhode Island framework (unlike UK solvent schemes), parties may view Rhode Island's “commutation plan” statute as simply a domestic version of the UK's solvent schemes and attribute all of the disadvantages associated with UK-like solvent schemes of arrangements (listed below in D-2) to the Rhode Island system.
- Because the Rhode Island statute allows for the formation or reactivation of a domestic company and the transfer of assets and liabilities to that company, certain parties view this as allowing a “ring-fence” of assets, unfairly shielding assets from creditors.

⁷³ For a detailed discussion on the issue of enforceability, see David Wright, “A Question of Enforceability,” Run Off Business, Issue 12, Spring 2005, pp. 20-22.

MECHANISMS AVAILABLE TO INSURERS OUTSIDE THE UNITED STATES AND RELATED TERRITORIES

D. UK-LIKE SOLVENT SCHEMES OF ARRANGEMENTS

1. DESCRIPTION

A scheme of arrangement is essentially a statutory compromise or arrangement between a company and its creditors. The process is allowed under Part 26 of the United Kingdom Companies Act 2006 that requires majority creditor approval representing at least 75% in value of obligations; confirmation by the UK Financial Service Authority (FSA) of no objections; and court sanction. If approved, the process will bind all creditors, but does not necessarily bind reinsurers. The process has evolved over the years and includes a process for insolvent and solvent insurers.

The FSA maintains a very active role in reviewing the schemes with a review document containing approximately 30 questions. In July 2007, the FSA issued a process guide related to decisions made with schemes that included the following:

- Stresses that the scheme must comply with principles for businesses (e.g., treating policyholders fairly and communicating in clear terms).
- Established an FSA schemes review committee.
- Stated that the run-off should be at least five years old.
- Distinguishes between individual retail and small commercial policyholders, large commercial policyholders and other risk carriers.
- Distinguishes between insolvent risk carrier, marginally solvent risk carrier and substantially solvent risk carrier.
- In case of substantially solvent risk carrier, the FSA is likely to object to a scheme unless the risk carrier offers benefits designed to ensure that policyholders are not in a worse position than in a solvent run-off.
- Provides for a role of policyholder advocate.
- The FSA may not object to a scheme, even if it fails to satisfy the criteria stipulated, if the risk carrier can demonstrate that the scheme treats policyholders fairly (e.g., through suitable additional benefits for policyholders and/or safeguards for dissenting procedures).

As of September 2008, there have been approximately 174 solvent schemes of UK non-life business. However, in every instance when policyholders have mounted serious opposition, the UK courts have ruled in the policyholders' favor. In particular, objecting policyholders have successfully challenged the British Aviation Insurance Co. Ltd. (BAIC), Willis Faber Underwriting Management (WFUM) and Scottish Lion solvent schemes in the UK courts. These are the only solvent schemes involving direct policyholder coverage that have been challenged to date, and all three have resulted in the court rulings favorable to the policyholders. To date, no UK court has agreed to sanction a solvent scheme involving direct coverage (as opposed to reinsurance) in the face of a policyholder legal challenge to the scheme.

Claims being paid can include IBNR, and most schemes have the ability to pay for IBNR based on estimation methodology. Additionally, schemes will allow a creditor's methodology to be used, if reasonable.

Chapter 15 of the U.S. Bankruptcy Code may be used to assist with a scheme of arrangement in the United States. The effect is to grant a U.S. bankruptcy court authority to enforce the scheme and protect the company's assets from creditors. However, although no UK solvent scheme has yet been challenged under Chapter 15 of the U.S. Bankruptcy Code, there is a possibility that such challenges may arise, and the U.S. bankruptcy courts could reject solvent schemes.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Some advocates state that solvent scheme mechanisms, in particular, have proven to be very effective in the UK and other jurisdictions to permit closure of companies that have reduced their liabilities to fairly minimal levels and that can reasonably estimate their future liabilities.
- Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism from these companies will create an active market for investment in run-off companies.
- Companies using UK schemes of arrangements have statistically improved their net asset position by approximately 5%.
- Some insurers have made payments to creditors at or near 100%.
- Schemes may allow a creditor's claim estimation methodology to be used, if reasonable.

DISADVANTAGES

- Schemes may undermine the value of insurance contracts by not honoring contractual obligations.
- Lost coverage may hurt policyholders at the expense of American citizens and the economy.
- Schemes could pose a formidable collective action problem.
- Schemes could undermine the reliability of insurance institutions.
- Schemes may allow for the reduction or cancellation of contractual obligations outside the scope of the current receivership system by not adhering to the statutory priority of distribution rules. Under such a scheme, a troubled company could force certain policyholders to commute (or buy-back) mutually agreed-upon insurance coverage despite their objections.
- The use of terms "debtor" and "creditor" used in the restructuring arena may tactically create a new environment for insurance where risk transfer is not necessarily part of the product purchased.
- Enforceability across state lines.
- Schemes could be used by companies to simply reorganize their corporate structure to move reinsurance operations unencumbered by old claims under a different name.
- In its latest proposal, the Reinsurance (E) Task Force had a provision where an insurer engaging in solvent schemes would not be allowed to take a reduction of collateral.
- Chapter 15 is a relatively new provision of the Bankruptcy Code with relatively little case law to support it, thus leaving the ability for judges' discretion and leeway in its application.
- Schemes can involve reinsurers, where the reinsurance contract with an insurance company is negatively affected.
- Schemes could provide an opportunity for solvent insurers to avoid insurance and reinsurance obligations and return the risk to insureds of ceding companies who purchased

- the coverage in good faith.
- Schemes force creditors to trade insurance coverage for payments based on estimations of future claims that are inexact and possibly unfair.
- The individuals chosen to adjudicate claims under a scheme may lack expertise in the necessary legal issues.
- There is no oversight of solicitation by the company of scheme acceptances. Thus, some accepting creditors may have already achieved favorable settlements, while dissenting creditors are left to litigate their claims in an unfavorable forum.
- Schemes do not allow dissenting policyholders to opt out of the scheme.
- Schemes do not ensure continuation of coverage.
- Schemes do not include a safety net of guaranty association protection.
- Schemes do not allow a policyholder to seek judicial review of its claims against the insurer.

E. PART VII PORTFOLIO TRANSFERS

1. DESCRIPTION

Part VII of the Financial Services and Markets Act 2000 (FSMA) allows for a transfer of insurance business under a statutory and court process. The transfer allows a reinsurer to move all or certain of its reinsurance business (assets and liabilities) to another reinsurer without the consent of each and every policyholder but with the sanction of the UK High Court. The main statutory requirements are: 1) policyholder notification; 2) a report by an independent expert; 3) UK High Court approval; and 4) no objection by the FSA or other regulators and interested parties, including policyholders.

The court is involved in the process with the directions hearing, which is when court will grant leave to proceed. The court is also involved in the hearing to sanction the transfer (or final hearing). The relevant legislation and requirements can be found in VII. Appendix D4.

The transferee must be an insurance company established in a European Economic Area (EEA) state. However, the transferor can be authorized in the UK, an EEA branch of a UK firm, a UK branch of an EEA firm, an EEA firm with no UK branch, or a non-EEA that is permitted to carry on business in the UK.

Per the FSA Web site, the following are reasons why reinsurance firms undertake Part VII transfers:

- Rationalization—combine similar business from two or more subsidiaries, putting all into a single regulated entity.
- Efficiency—transfer business between third parties, separating old liabilities in run-off from new business, putting each into separate firms.
- Capital reduction—transfer business to a new firm and extract any surplus shareholders' funds.
- Exit—transfer business such as employers' liability that cannot be schemed.

The legal effect of a Part VII transfer is a statutory unilateral novation of the affected contracts of insurance or reinsurance, including any rights attaching to those contracts.

The two primary aspects for the protection of affected parties are as follows: 1) the independent expert's report, which needs only to consider the effect on policyholders; and 2) the court is required

to be satisfied that the transfer as a whole is fair as between the interests of different classes of persons affected by the transfer.

Per the FSA Web site, the FSA and the court are concerned whether a policyholder, employee, or other interested person or any group of them will be adversely affected by the scheme. This is primarily a matter of actuarial and regulatory judgment involving a comparison of the security and reasonable expectations of policyholders without the scheme with what would be the result if the scheme were implemented. The court will pay close attention to any views expressed by the FSA regarding whether individual policyholders or groups of policyholders may be adversely affected, though this does not necessarily mean that the transfer is to be rejected by the court.

The key question is whether the transfer as a whole is fair as between the interests of the different classes of persons affected. However, it is not the function of the court to produce what, in its view, is the best possible scheme. With regard to different transfers, the court may deem all fair, but it is the company's directors' choice to select the transfer to pursue. Under the same principle, the details of the scheme are not a matter for the court, provided that the scheme as a whole is found to be fair. Thus, the court will not amend the scheme, because individual provisions could be improved upon.

Overall, a loss portfolio transfer is a means of transferring outstanding net or gross legal liability from one insurer to another insurer. It has been viewed as a form of retrospective reinsurance. The transfers must be sanctioned by the court, and are subject to review and opinion by an independent expert that is approved by the FSA. Notice of the proposed transfer is usually required to be sent to all policyholders of the parties unless the court decides otherwise. A detailed report must also be provided setting out all the details and the independent expert's opinion. The FSA and any party who feels adversely affected by the transfer can make representation to the court for consideration.

The FSA is also required to assess a number of aspects (e.g., whether policyholders will be worse off moving from one place to another, or if there is any potential risk posed by the transfer). Rating agency ratings or the effect on ratings could be a component as part of the FSA's considerations, as well as other regulatory bodies.

There have been over 100 Part 7 transfers, and the majority dealt with internal reorganization within holding groups. Over 50% were performed in the life industry. Very few Part 7 transfers have seen business go from a company to a third party; however, they are becoming increasingly popular. The receiving company's motives for entering into these arrangements may stem from tax advantages to potential profits based on one's claims handling experience.

COMPARISON OF PART 7 TRANSFERS WITH U.S. ALTERNATIVES (*BINGHAM TABLES*)

	Part 7 Transfers	Assumption Reinsurance Solvent	Assumption Reinsurance Insolvent	Rehabilitation Proceedings
Creditor Voting	No	Yes	No	No
Regulatory Review	Yes	Yes	Yes	Yes
Creditor Input	Low	High	Low	Medium
Transparency	Low	High	Low	Medium
Court Review	Yes	No	No	Yes
Hold-ups & Hold-outs	No	Yes	No	No

	Schemes of Arrangement	Run-off with Commutations	Rehabilitation Proceedings
Who Runs the Case	Management	Management	Regulator
Stay of Proceedings	Yes	No	Yes
Hold-ups and Hold-outs	Yes	Yes	No
Creditor Votes	Yes	Yes	No
Regulatory Involvement	Review	Ongoing Monitoring	Control
Claims Adjudication	Management Appointee	Variety of Courts	Receivership Court

The foregoing tables compare schemes of arrangement and Part 7 transfers with analogous mechanisms available under U.S. law. While it appears that the mechanisms are similar in many respects, in practice they have proven to be quite different. Under UK schemes of arrangement, policyholders have been forced to accept payouts based on estimations of their claims so that equity holders can recapture the capital of the company. Under UK Part 7 transfers, policyholders have been forced to accept the credit of another insurer in order to permit the insurer from whom they bought the policy to exit business and recapture its capital. Current U.S. practice, with the possible exception of the Rhode Island statute, would not enable these results. Policyholders are only required to accept payment based on estimation in the U.S. where the company is insolvent and shareholders will not receive a return of their capital. Also, under current U.S. practice, policy transfers to a new insurer are not made involuntarily except where there is an insolvency of the transferor. While UK regimes certainly have safeguards in the form of voting (in the case of schemes) and court review (in the case of schemes and Part 7 transfers), the ultimate risk is left on the policyholder.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Permits more efficient management of transferred books of business, allows dedicated capital and focused solutions to be applied to run-off liabilities, and promotes efficient use of capital for ongoing business.
- Options can be explored to strengthen policyholder protections and reach regulator approval, such as altering deductibles, strengthening reserves, obtaining reinsurance, and other arrangements to share the risk.
- Might attract new capital to insurance businesses insofar as it can be invested directly in run-off liabilities, and strengthens ongoing companies by permitting the separation of those

liabilities.

- Can reduce risk of exposure.
- A recent amended UK rule introduces a simpler alternative where no court sanction is required for pure reinsurance business transfers if all the policyholders affected by the transfer consent to the proposal.
- Substantial regulatory oversight is required.

DISADVANTAGES

- Could transfer obligations from the entity the creditor dealt with: to one that is completely unknown; to one with whom the creditor would have never willingly chosen to deal; from a differing country subject to different regulation; and to a less secure debtor.
- A Part VII-like transfer to an alien reinsurer from a U.S. domestic reinsurer may cause the primary insurer to lose its credit for reinsurance.
- Very difficult to quantify trapped capital in these scenarios.
- Problems could arise for a ceding company, if the Part VII transfer goes to a reinsurer with a lower rating, because the rating agency could lower the ceding company's rating.
- Could present unique accounting and reporting anomalies on both a statutory and GAAP basis.
- The regulator is not required to publicly explain its decision-making process.

IV. OBSERVATIONS AND CONSIDERATIONS BEFORE USING ALTERNATIVE MECHANISMS

A. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. STATE RECEIVERSHIP/GUARANTY FUND LAWS

Delinquency proceedings (receiverships) are instituted against an insurance company by an insurance department for the purpose of conserving, rehabilitating, or liquidating an insurance company. All require a court order, and the domiciliary state court will take jurisdiction over matters involving the resulting receivership estate. The court's role is to ensure transparency and due process and to be an independent arbiter of any disputes that may arise. The nature, timing, and extent of regulatory action in any given troubled insurer situation depend on the circumstances of the particular situation.

The U.S. Constitution in Article I, Section 10 states that "No state shall ... pass any ... law impairing the obligation of contracts." However, during certain delinquency proceedings, states may, on rare exceptions, impair contracts, but only where there is a legitimate public purpose behind the law.

It should be noted that the language in the rehabilitation statutes for most states is very broad and provides that anything that will restructure, revitalize, or reform the insurer can be proposed in a plan.

2. PRIORITY DISTRIBUTION STATUTES/PREFERENTIAL TREATMENT

One of the key consumer protections in the existing state delinquency proceedings are the priority distribution statutes that require payment of policyholder-level claims before the payment of any other claimants, including non-policy claims of the United States government, claims of other insurers and reinsurers, and general creditors. These same priority distribution statutes also require members of the same class or group of creditors to be treated similarly. The priority distribution statutes ensure that the needs of consumers, who might not be sophisticated in insurance matters, are placed ahead of non-policyholder level claimants and that everyone with the same level or type of claim is treated the same.

If assets are not sufficient to cover the remaining claims and administrative costs of an insurer using one of the alternative mechanisms, then all claims paid prior to that point have been given a preference at the expense of the claims to be paid in the future. As a result, the receiver could be statutorily required to attempt to recover these preferential payments.

B. CONSUMER PROTECTIONS AND PUBLIC POLICY CONSIDERATIONS

In order to ensure some baseline of protections for policyholders and consumers, there are certain core principles that regulators should strive to maintain with any alternative mechanism for troubled insurers. The first among these, a requirement that the company honor its contractual obligations to policyholders, is considered the primary and overriding principle. This first principle translates into no impairment of policy benefits and claims without the express, informed, voluntary consent of the policyholder. The others are corollary principles, all supporting that primary goal of honoring contractual obligations to policyholders. Any alternative mechanism for run-off or restructuring of a troubled insurance company's obligations should strive to establish parameters consistent with these principles.

Core Principles:

1. Honor Contractual Obligations to Policyholders. Alternative mechanisms should not be a way for an insurance company to sidestep its contractual obligations to policyholders. There should be no involuntary restructuring of policies or impairment of policy benefits or claims permitted outside of receivership. This would preclude any changes to policies, or reductions to policy claims or benefits, without the express, informed, voluntary consent of individual policyholders. Accordingly, there should be no cram-down approval of a mechanism by majority vote over the objection of policyholders; no involuntary transfer of risk back to policyholders through forced commutation of claims or otherwise; and no cancellation, termination, or non-renewal of coverage, except as permitted under the express terms of the policy. In short, every policyholder should be entitled to continue coverage and to receive all policy benefits for the full term of their policy.
2. Meaningful Notice and Information Sharing. This contemplates accurate, consistent, and timely notice and disclosures to all policyholders, creditors, and guaranty associations of meaningful information (including financial information, status plans, and any proposed assumption reinsurance or other significant transactions) at inception and on an established schedule thereafter. Disclosures should also identify creditors (at least below the policy level) in order to permit some meaningful, organized discussion among creditors.
3. Adherence to Priority Scheme. Alternative mechanisms should require adherence to statutory liquidation priority schemes. They should not provide a mechanism for circumventing the distribution priority to benefit the company, its shareholders, employees, other stakeholders, or specific groups of policyholders at the expense of other classes of policyholders. Controls on preferences and the outflow of assets are needed, and will require regular ongoing review. The company and/or equity shareholders should not be permitted to retain assets unless all claims having priority, as measured under state liquidation laws, have been satisfied in full.
4. Coherent, Comprehensive Financial Planning. Any alternative mechanism should be based on a fully developed and comprehensive financial plan that includes complete and meaningful financial data, and projections based on reasonable and realistic financial assumptions. There should be full disclosure and transparency in financial planning, monitoring, and reporting as a condition to approval of any such plan and throughout implementation. In addition, any such mechanism should provide a global solution addressing all in-force policies and pending policy claims. There should be no ring-fencing or piecemeal disposition of assets and liabilities that may result in unequal treatment of policyholder claims, and give rise to preference and priority concerns. Moreover, the fairness and reasonableness of any mechanism cannot be reasonably assessed on a transaction-by-transaction basis without consideration of the overall impact on other policyholders and creditors.
5. Procedural Safeguards. Any alternative mechanism should provide substantive procedural safeguards, including clear standards for disclosure, reporting, and external review; appropriate and timely notice; access to information and the opportunity for informed participation for all stakeholders; court and/or regulatory approval for all significant actions to be taken; and meaningful compliance monitoring and reporting.

V. OBSERVATIONS AND CONSIDERATIONS WHEN USING ALTERNATIVE MECHANISMS

C. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. USE OF PERMITTED PRACTICES

There have been situations where an insurer would be able to maintain operations for 20 years, but to date, since liabilities barely exceed assets based on NAIC accounting practices and procedures, the insurer is nearly or technically insolvent. A carefully thought-out permitted practice could allow a troubled insurer time to dramatically restructure in order to provide better results for consumers in terms of timely claims payments.

2. MODIFICATIONS TO EXISTING STATUTORY AUTHORITY

In some circumstances, state insurance regulators may want to consider modifying laws and regulations to provide for a more favorable environment for certain alternative mechanisms. For example, the Illinois Division of Insurance strongly supported the General Assembly's adoption of 215 ILCS 5/204 in the Illinois Insurance Code's provision on Prohibited and Voidable Transfers and Liens to protect transfers made during the Division's supervision of a solvent run-off. The language reads as follows:

m) The Director as rehabilitator, liquidator, or conservator may not avoid a transfer under this Section to the extent that the transfer was: ***

(C) In the case of a transfer by a company where the Director has determined that an event described in Section 35A-25 [215 ILCS 5/35A-25] or 35A-30 [215 ILCS 5/35A-30] has occurred, specifically approved by the Director in writing pursuant to this subsection, whether or not the company is in receivership under this Article. Upon approval by the Director, such a transfer cannot later be found to constitute a prohibited or voidable transfer based solely upon a deviation from the statutory payment priorities established by law for any subsequent receivership.

D. SURVEILLANCE MONITORING BY STATE INSURANCE REGULATOR

State insurance regulators need to consider whether the state has appropriate expertise on staff or whether the state needs to hire outside consultants of particular functions, such as claims assessment, reserves, reinsurance, etc. Please refer to the *Troubled Insurance Company Handbook* for a description of competency and skills of personnel assigned to conduct surveillance on troubled insurers.

1. SUPERVISION ORDERS/CONSENT AGREEMENTS/LETTER OF UNDERSTANDING

Regulators may want to consider various methods to articulate the regulator's expectations with an alternative mechanism, as well as the possible recourse that may occur with the insurer as a result of certain actions or behaviors. Such communication methods can be informal, such as a letter of understanding with the insurer, or formal, such as voluntary consent agreement or a confidential supervision order.

If a supervision order is taken under the commissioner's administrative provisions, the insurer's management will generally remain in place subject to restrictions in the supervision order and the direction of the supervisor. The supervision can be voluntary or involuntary and confidential or public. Confidential supervisions are becoming more infrequent, as disclosures of such regulatory actions have become more necessary under federal law for insurers within publicly traded groups. Some states may require court approval, as well.

2. FINANCIAL REPORTING/ANALYSIS/EXAMINATION

All active insurers that are not in liquidation proceedings should be filing quarterly financial statements to the NAIC Financial Data Repository to provide regulators, policyholders, creditors, and claimants meaningful information. Enhanced monitoring, such as monthly financial statements and claims/exposure reports, should also be considered.

All states should conduct analysis and examination practices in compliance with Part B of the Financial Regulation Standards and Accreditation Program.

3. COMMUNICATIONS

As a result of utilizing various alternative mechanisms, regulators should attempt to coordinate the situation and supervisory plan with other affected insurance departments/jurisdictions, other regulatory agencies, and guaranty associations. Coordination may be useful to avoid actions that may be counterproductive. Interdepartmental and intradepartmental communication is also important to ensure that key departmental officials possess all relevant information to permit decisions to be made on a timely basis.

E. BENEFITS, RISKS AND CONTROLS: FOR U.S. CLAIMANTS/POLICYHOLDERS WHEN A NON-U.S. INSURER OR REINSURER RESTRUCTURES

1. INTRODUCTION

This section considers the impact upon U.S. policyholders and creditors of the restructuring of non-U.S. insurers and reinsurers. It will not consider the impact upon U.S. policyholders and creditors of the restructuring of the U.S. branch of a non-U.S. insurer, because that will be governed largely by familiar U.S. laws and procedures. However, it should be noted that the extent to which the U.S. branch may realize economic support from its non-U.S. parent and/or affiliates is likely to be governed primarily by the laws of the jurisdiction(s) in which the latter are domiciled.

What this section examines is the possible impact on U.S. policyholders and creditors of the restructuring of a non-U.S. insurer or reinsurer outside the U.S. The restructuring of a non-U.S. insurer or reinsurer may be governed simultaneously by the laws of several jurisdictions. For example, as Solvency II becomes the norm in the European Union, an insurer or reinsurer doing business in many member jurisdictions may be subject to their various laws to varying degrees. However, the jurisdiction in which the parent is domiciled (or the group supervisor, if different) may be particularly influential even over the fate of subsidiaries in other jurisdictions. The continued evolution of group supervision as an integral part of Solvency II is likely to enhance the influence of the parent's domicile. Less predictable will be the management of the restructuring of insurers doing business simultaneously in EU and non-EU jurisdictions. There remains a wide disparity in the core principles underlying insurance regulatory

systems throughout the world—some attributable to the pace of economic development, others to fundamental cultural differences, and still others to specific national public policies.

This section endeavors to identify the key considerations that should be evaluated from the perspective of U.S. policyholders and creditors when their non-U.S. insurer or reinsurer is restructured. It seeks also to provide a sampling of illustrations of how those considerations might evolve in specific circumstances. Pre-purchase evaluation of how these considerations are addressed in a particular jurisdiction may enable the astute policyholder to avoid purchasing coverage that is apparently reliable but for which there is little effective protection upon restructuring.

2. POTENTIAL ADVANTAGES AND RISKS OF RESTRUCTURING MECHANISMS

In many non-U.S. jurisdictions, mechanisms are available for the restructuring of insurers and reinsurers short of formal rehabilitation or liquidation proceedings. A distinction should be drawn between restructuring in the face of potential insolvency (the focus of this paper) and restructuring as a business strategy not in response to immediate solvency concerns. In the latter case, there is little justification for compromising policyholder interests, and regulatory schemes typically do not permit that result. It is in the face of a potential insolvency that restructuring can present a meaningful dilemma.

On the one hand, restructuring mechanisms can be advantageous when compared to rehabilitation or liquidation proceedings in three key respects:

- a. Such mechanisms typically offer at least a realistic prospect of a faster resolution of the underlying financial challenge.
- b. Often, these mechanisms are cheaper and therefore consume fewer scarce resources in the implementation of the process itself.
- c. Often these mechanisms serve to preserve coverage that might otherwise have to be terminated in the context of formal proceedings.

On the other hand, there can be some serious draw-backs in these alternative schemes. The next subsection considers key factors in more detail. However, the principal concerns that may arise in the context of these alternatives include:

- a. Reduced regulatory and judicial oversight resulting in diminished policyholder protection.
- b. Greater likelihood that policyholder interests will be compromised for the sake of other constituencies, such as owners, managers, and other creditors.
- c. The probability that policyholders will have less influence in the process and a diminished ability to protect themselves from potentially adverse outcomes.

3. KEY CONSIDERATIONS

In the U.S., state insurance regulators are accustomed to the fundamental principle that the interests of policyholders (used here as including insureds), especially consumers, should take precedence over

those of unsecured non-policyholder creditors. This principle is not mandated in non-insurer bankruptcies in the U.S. and may not have the same importance in non-U.S. jurisdictions. It is helpful to identify the likely principal interests of policyholders (including insureds), as they may be affected in insurer restructuring.

In addition, this subsection will identify key considerations for reinsureds and creditors when a non-U.S. reinsurer restructures. The treatment of reinsureds is the primary consideration; however, a proper restructuring plan will keep tax authorities and other creditors informed as well. While the nature of the reinsured/reinsurer (sometimes referred to as cedent/assuming company) relationship invokes many of the same key considerations—because typically reinsureds are sophisticated business entities rather than individual consumers—slight differences may arise.

a. RIGHT OF PAYMENT

Not surprisingly, the principal interest of policyholders is likely to be assurance that claims (perhaps including those for return of unearned premium) will be paid promptly and in full. With the arguable exception of continuation of coverage, it is likely that policyholders' other interests (discussed below) are derivative of and ancillary to payment concerns.

The ability to obtain full payment of claims may turn on many factors, only some of which may be attributable to the nature of the proceeding. For example, the debtor's financial condition will always be a key consideration, regardless of the nature of the proceeding. The nature of the claim will also be an important consideration. For example, policyholders making claims based on IBNR must rely on actuarial estimates, which can vary widely. Such policyholders face a risk that any payment under a restructuring plan would be insufficient to meet future liabilities. This section does not address such considerations, which—however important—are unrelated to the nature of the proceeding or the regulatory or supervisory scheme under which it operates.

b. CONTINUATION OF COVERAGE

Under a variety of circumstances, it may be difficult for a policyholder to find acceptable coverage to replace that provided by the restructuring insurer. In the U.S., this interest is typically given more weight in the insurance rather than reinsurance context, and in the case of life accident and health insurance rather than in the context of property and casualty insurance.

c. CLAIM PRIORITIES

As noted, we are accustomed in the U.S. to the supremacy of policyholders over other unsecured creditors. This priority is critically important when available assets may not suffice to discharge fully all liabilities of the insurer. Of course, in insurer insolvencies, typically the category of general creditors includes most notably reinsureds. Thus, the interests of reinsureds and policyholders, treated as congruent in much of this section, may be very divergent in particular circumstances. Policyholder priority may not be observed as strictly, or at all, in other jurisdictions.

d. GUARANTY ASSOCIATION COVERAGE

Over the last four decades the U.S. insurance sector has implemented nearly universal guaranty fund mechanisms, providing at least basic protection for the insureds of most failed insurers. There are, of

course, notable exceptions like HMOs, risk retention groups, surplus lines carriers and certain lines (separate account annuities, fiduciary bonds, etc.) in the main; however, this “safety net” serves to soften the impact of insurer failure and effectively provides a standard against which are measured the anticipated results of restructuring. Most non-U.S. jurisdictions have not implemented nearly as comprehensive an insolvency protection scheme. The guaranty association mechanism is typically not available to reinsureds in the U.S. or elsewhere.

e. RIGHT TO VOTE

Although largely foreign to U.S. insurer restructuring and insolvency proceedings, in other jurisdictions, policyholders may have a right to vote on the restructuring plan. Most often, however, that right exists when the plan does not require that policyholder contracts be fulfilled in their entirety. In such plans, policyholders whose claims consist of incurred but not reported losses may have different rights from policyholders who have unsettled paid claims or outstanding losses.

f. CRAM DOWN

In certain jurisdictions, it is possible for policyholders and reinsureds to be compelled to accept a restructuring plan that requires that they make economic concessions. The plan may require approval upon the votes of creditors, or it may simply require regulatory or court approval. This should be contrasted with U.S. laws, which typically do not permit restructuring plans in which policyholders’ interests are compromised for the benefit of non-policyholder creditors.

g. VOICE IN REPLACEMENT

The restructuring plan may entail coverages being transferred to other insurers or reinsurers with whom policyholders and reinsureds had no relationship. In some cases (including instances in the U.S.), policyholders and reinsureds may have little discretion in the transaction (except potentially non-payment of premium and forfeiture of coverage).

h. TRANSPARENCY

The ability of creditors, including policyholders or reinsureds, to obtain information about the proceeding, and the financial factors upon which key decisions will be based, varies considerably from jurisdiction to jurisdiction. Access to relevant information, however, is often the essential first step in policyholders’ ability to protect their interest in a restructuring.

i. ACCOUNTABILITY

The individual or entity responsible for managing the restructuring may be a private practitioner engaged by the restructuring entity’s management, a group of creditors, or a regulatory authority. Alternatively, the process may be placed in the hands of a public official. The degree to which the individual or entity in charge of the process is accountable to a superior or independent authority can be critically important in ensuring the fairness and efficacy of the process. In those instances in which oversight consists principally of court supervision, the independence of the tribunal is important, as is the degree to which interested parties have access to that tribunal.

j. REGULATORY PROTECTION

In some jurisdictions (including the U.S.) statutory or common law (judicial decision) standards govern the manner in which an insurer may be restructured. They range from fundamental constitutional protections against the taking of property without due process to specific thresholds that must be satisfied before a Rehabilitation Plan can be approved. The availability of such protections and of viable enforcement mechanisms (such as an empowered administrative agency) are generally key to the prospect of a meaningful recovery or protection for policyholders and reinsureds.

k. ENFORCEMENT IN THE UNITED STATES

Non-U.S. restructuring plans have been enforced by the U.S. courts under Chapter 15 of the United States Bankruptcy Code. Chapter 15 governs cross-border insolvencies and is a framework whereby representatives in corporate restructuring procedures outside the U.S. can obtain access to U.S. courts. Chapter 15 permits a U.S. bankruptcy court to cooperate with a foreign procedure in which assets and affairs of the debtors are “subject to control or supervision by a foreign court, for the purpose of reorganization or liquidation.” Recent Bankruptcy Act amendments resulting in the current form of this provision were intended in part to bring U.S. law into greater harmony with the provisions adopted by the United Nations Commission on International Trade Law (UNCITRAL) and observed throughout much of the world. Applicability of these rules can be complex and often commences with a determination of which jurisdiction’s proceeding will control. The emerging trend is to defer to the jurisdiction in which lies the Center of Main Interest (COMI). However, it is important to note that the COMI may not necessarily be the domiciliary jurisdiction of the insolvent, and cases applying this principle sometimes reach puzzling results. While further discussion of these issues is beyond the scope of this section, the subject merits careful attention when applicable.

l. STANDING TO APPEAR

The ability to appear before the tribunal or agency conducting or overseeing the proceeding may be an important component of creditor protection. Of course, the fairness and impartiality of such a tribunal or agency are of critical importance. Moreover, the right to appear may be far less important when the individual managing or overseeing the process is charged principally or in material part with protection of policyholders and reinsureds and takes that responsibility seriously.

m. SET-OFFS, CLAIMS ACCELERATION AND ESTIMATION, PREFERENCES, AND VOIDABLE TRANSFERS

Insolvency proceedings can trigger a number of unique technical rules that are common in U.S. jurisdictions but may not receive the same treatment in other regimes. Among these are provisions that govern set-offs of claims and credits, acceleration and estimation of claims, when payments before commencement of a proceeding may be deemed to be reversible preferences, when such payments may constitute fraudulent or voidable transfers, and other such rules.

The issue of claims acceleration and estimation is illustrative of this difference in rules. Reinsurers have repeatedly expressed opposition to any system that could result in the accelerated and involuntary payment of their obligations based on any estimation of policyholder claims. Reinsurers oppose compelled payment of reinsurance recoverables based on IBNR on the basis that they are theoretical losses with theoretical values allocated in a theoretical fashion. Because reinsurance is a contract of indemnity, reinsurers assert that they cannot be required to pay losses, such as IBNR losses, which are unidentified or unknown.

While it is beyond the scope of this section to consider the details of each of these “technical” issues, it is important for the affected party to identify those that may be important in the particular case and determine how they are addressed in the specific proceeding. It should be noted that the application of these rules may not always be immediately evident. For example, if only part of a company’s business is subject to the restructuring plan, reinsurers may be concerned that they will lose existing set-off rights. This concern by reinsurers may affect the ability of reinsureds to receive full payment.

n. POLITICS

Finally, it should never be forgotten that “all politics are local.” In the U.S., the degree to which political considerations control an outcome is somewhat mitigated by cultural and legal constraints. These constraints, however, may not be as applicable in non-U.S. jurisdictions. Familiarity with the local environment is essential in order to avoid unpleasant surprises. And political considerations may not relate just to governmental entities—they may relate to the industry as well. For example, when the reinsured is also a reinsurer, it may be unwilling to help one of its potential competitors with a restructuring. The presence of existing disputes or investigations may also affect how a reinsured views a restructuring plan.

VI. CONCLUSION

Overall, although alternative mechanisms for troubled insurers can provide cost savings or greater efficiency over the current system, these mechanism can also pose unique risks for consumers and require specialized surveillance monitoring, practices, and procedures, particularly where the activities may occur outside of court-supervised receivership proceedings. In this context, regulators are encouraged to consider implementing standards and best practices responsive to these risks in order to preserve important consumer protections, increase transparency, and provide appropriate procedural safeguards.

First and foremost, it is the responsibility of regulators to protect insurance consumers. Thus, proponents of alternative mechanisms for troubled insurers should be pressed to prove to the regulator's satisfaction that the claims of greater efficiency or flexibility will not be used to strip policyholders and claimants of their policy rights so that value can be returned to investors. And regulators should ensure that all alternative mechanisms for troubled insurers place the interests of consumers ahead of other competing interests, coupled with a clear statement of goals and objectives and a meaningful oversight mechanism.

VII. APPENDIX

A. CASE STUDIES

This appendix describes troubled insurance company situations to illustrate some of the alternative concepts and techniques discussed earlier in this paper. The names of the insurers have intentionally been omitted. These case studies are not intended to reveal all problems or situations that may arise during the restructuring of a troubled reinsurance company. Additionally, the proposed actions with respect to the subject company may not be appropriate in all jurisdictions in light of changing market conditions and the possible differences in statutes, regulations, and implementing tools and resources.

1. RESTRUCTURED TROUBLED REINSURANCE COMPANY

Company characteristics, circumstances, and concerns:

- A property/casualty reinsurance company (treaty and individual risk basis).
- Primary reinsured lines included allied lines, commercial multiple peril, accident & health, workers' compensation, liability, and non-proportional reinsurance.
- Immediate parent and primary reinsurer of a direct property/casualty insurer.
- Non-U.S. ultimate parent.
- Parent refused to provide further financial support to its subsidiary.

BACKGROUND. Restructured Troubled Reinsurance Company (RTRC) was an established property/casualty reinsurer that appeared to be reporting significantly improving financials since two years earlier, accomplished through active re-underwriting and non-renewal of underperforming business. RTRC was a large reinsurer licensed or accredited in 27 states. Growth was moderate over the years, and the company remained adequately capitalized until significant adverse development constrained resources. Almost all property/casualty lines of reinsurance were written by RTRC with primary focus on workers' compensation, accident & health, liability, and proportional reinsurance. The group restructured through a series of transactions and separated its third-party assumed reinsurance business into an independent corporate structure. RTRC received a surplus note contribution from its ultimate parent that provided for semi-annual interest payments.

CAUSES OF TROUBLE. The Insurance Department had no information immediately on hand that would have raised a question regarding the solvency of RTRC. The financial statements reported much improved underwriting results, as well as ratios that were also continuing to show improvement. Approximately six months after the financial examination, but a few months prior to the restructuring, management met with the Department to discuss the rising amount of reinsurance recoverable related to its "Unicover" business. RTRC conducted a detailed internal review of its prior years' U.S. casualty business and found that significant reserve strengthening was necessary in its general liability and specialty liability lines, causing a substantial surplus strain and the triggering of the Department's hazardous financial condition regulation.

PRELIMINARY ACTIONS. The Department had several telephone conferences with RTRC management whereby the Department was informed that a capital contribution from RTRC's ultimate parent would be forthcoming as a result of the significant adverse development discussed above. Management then contacted the Department for a meeting on the premise that the Chairman was in town and wanted a face-to-face meeting to discuss what was going on at the group. During that meeting, the Department was informed that RTRC and its direct subsidiary would be placed in run-off and neither would it receive

a capital infusion as originally discussed. A firm was hired by RTRC's parent to assist in the development of a strategic plan for a solvent run-off.

CORRECTIVE ACTIONS. The Department sought to institute more rigorous financial monitoring. RTRC entered into a confidential letter agreement with the Department that required the Department's approval prior to, among other things, making any material changes to management; moving books and records; making any withdrawals from bank accounts outside the ordinary course of business; incurring any debt; writing or assuming any new business; or making dividend payments or other distributions. It also provided that the Department would receive a monthly report of commutation activity (which, as can be seen below, was the bedrock of the run-off plan); a copy of the final reserve analysis report prepared by an outside firm; and any additional reports the Department reasonably determined were necessary to monitor the financial condition. Finally, the agreement provided that senior management would meet with Department staff weekly, in person or by conference call.

RTRC hired outside actuaries to conduct an external audit. In addition to the reserve strengthening was a non-admission of its deferred tax asset.

A cash flow analysis was commissioned by the Department to conclude whether RTRC could, in fact, have a solvent run-off. RTRC developed a Business Plan/Run-off Plan, which combined commutations with expense cuts (staff and facilities reduction). Quarterly RBC filings were required. Employment levels were reduced commensurate with the Plan, and a retention plan was implemented to help retain talented, necessary staff and management. Surplus note interest payments were disapproved. The Department requested NAIC staff to set up a conference call for regulators to inform states of the situation and provide them time to ask questions or air concerns.

Ultimately, an RBC plan was approved by the Department. Subsequently, a revised Business Plan/Run-off Plan was filed and approved, and the agreement was extended for an additional year.

As commutations continued and improvements began to take hold, the company and its subsidiary were eventually sold. A new plan was developed, as—under new ownership with substantial resources—emphasis was no longer on an aggressive commutation strategy but was now on an aggressive asset management strategy. Monthly calls with management were temporarily put into place to ensure the Department would be aware of any changing circumstance. A less restrictive agreement was implemented as the Department was more comfortable with the possibility of a positive outcome. Ultimately, the subsidiary was again sold—another positive development for RTRC. The frequency of reserve reporting was reduced to an annual basis as long as there was no change in Chief Actuary, and RTRC was released from the agreement.

2. NEW YORK REGULATION 141 PLAN

Company characteristics, circumstances, and concerns:

- Professional property and casualty reinsurers and insurers that write such business and also assume reinsurance of property and casualty business.
- All property and casualty lines, but not life business.
- Member of a holding company group or stand-alone entity.
- Other members of the holding company would not or could not provide further financial help.

BACKGROUND. ABC Reinsurance Company (ABC) was a professional reinsurer incorporated in New York in 1977. ABC became capital-impaired and ceased underwriting in 1985. ABC's management sought approval to commute certain assumed contracts, but the New York Superintendent of Insurance maintained that these commutations would prefer certain creditors over others and that the Superintendent lacked statutory authority to approve such commutations under then-existing New York insurance laws.

CAUSES OF TROUBLE. The parent company refused to add capital. The Department, lacking the authority to authorize the commutations, moved to place ABC in rehabilitation pursuant to New York Insurance Law Article 74. In 1987, the Superintendent moved in Supreme Court, New York County, for an order of liquidation. ABC remained in liquidation until 1992.

During those five years, ABC's liquidator approved some cedents' claims, but paid none. In 1990, however, the New York Insurance Department introduced, and the legislature adopted, an amendment of NYIL 1321 to permit an impaired or insolvent New York insurer to commute reinsurance agreements and, with the Superintendent's approval, eliminate the risk that those agreements could be avoidable as a preference.

In May 1992, the Superintendent, in his role as ABC's liquidator, petitioned the court to approve a plan of reorganization based on a 100% quota share of ABC's portfolio of outstanding losses on all business that ABC wrote before its liquidation. XYZ Reinsurance Company of New York (XYZ) proposed the reorganization plan and provided the reinsurance cover.

After a July 1992 hearing, the court approved ABC's reorganization plan and entered a final order and judgment that terminated the liquidation proceeding. The XYZ quota share contained a \$305 million limit and an expansion of the quota share's limit that expanded based on a formula that included, among other things, paid losses, reinsurance recoveries, and interest income. ABC resumed operations with new directors and officers, but the plan also provided for a manager to administer ABC's run-off.

When the Superintendent petitioned the court in 1992 to approve the reorganization plan, ABC's projected liabilities were, as of December 31, 1990, \$295.3 million. By 1993, ABC and its quota share reinsurer had paid more than \$302.8 million to its ceding insurers. In 2002, ABC substantially increased its asbestos-related IBNR reserves, as did much of the industry. As reported on its 2002 annual statement, ABC's capital became impaired by more than \$12.7 million.

PRELIMINARY ACTIONS. As a result of its 2002 impairment, and pursuant to New York Insurance Law § 1321 and Insurance Regulation 141 (11 NYCRR Part 128) (Regulation 141), ABC submitted to the New York Insurance Department a plan to eliminate capital impairment pursuant to Regulation 141. As required under Regulation 141, ABC's board and the company's sole shareholder stipulated that if ABC's implementation of the Regulation 141 Plan failed to restore ABC's surplus to policyholders to the minimum required as determined in accordance with Regulation 141, ABC would not oppose a petition to again liquidate the company pursuant to New York Insurance Law Article 74.

Under Regulation 141, no commutation of ABC's assumed reinsurance could become effective, and no consideration for any such commutation agreement could be paid, until the Superintendent determined that a sufficient number of fully executed commutation agreements had been returned to restore ABC's surplus to the required minimum (11 NYCRR § 128.5). Regulation 141 also required that ABC provide the Superintendent with copies of all e-mail, correspondence, and other communications between ABC

and its ceding insurers relating to the current Regulation 141 commutation offers, including any such communications rejecting the offer.

The proposed 141 Plan and Regulation 141 also required that ABC offer the same, non-negotiable commutation terms to all of its ceding companies. The 141 Plan further required that an offer to commute reinsurance agreements be made to every ceding insurer for which ABC had paid losses and LAE (Paid Losses) or known case losses and LAE (Case Reserves) on its books as of June 30, 2003.

Under its Regulation 141 Plan, ABC offered to pay 100% of Paid Losses and 60% of Case Reserves to commute obligations under the reinsurance agreements. Cedents were required to respond to this offer within 90 days.

CORRECTIVE ACTIONS. In January 2004, the Superintendent approved the 141 Plan and allowed ABC to extend commutation offers to its cedents. Shortly thereafter, ABC mailed commutation offers pursuant to the Plan to about 580 cedents. In October, ABC delivered to the Superintendent more than 300 executed commutation agreements along with copies of all correspondence with cedents relating to the Plan. The Superintendent subsequently determined that these commutation agreements would, upon his approval, eliminate ABC's impairment.

With the Superintendent's approval, ABC paid \$22,558,221 to those ceding insurers that accepted its Regulation 141 commutation offers. The post-Plan ABC balance sheet showed a positive surplus of \$3,675,366 and the elimination of its 2002 impairment.

The completed Regulation 141 Plan left ABC with many cedents. No cedents were compelled to accept the 141 commutation offers, and the Superintendent's approval of the Plan was premised on ABC's sufficient surplus to policyholders to complete its run-off. At the same time, Regulation 141 gave the Superintendent the statutory authority to permit commutation with a troubled company—avoid a protracted receivership—while also respecting every cedent's right to reject the proposed commutation offers and run the risk that ABC would lack sufficient capital to complete its run-off.

3. COMMERCIAL INSURANCE COMPANY RUN-OFF

Company characteristics, circumstances, and concerns:

- A property/casualty insurance company, writing primarily commercial lines on a national basis.
- Primary lines included commercial multiple peril, accident & health, workers' compensation, general liability.
- Member of a large multinational property/casualty insurance and reinsurance group with a non-U.S. ultimate parent.
- Parent sought to provide sufficient capital support to its subsidiary.

BACKGROUND. Restructured Troubled Insurance Company (RTIC) was an established property/casualty insurer pursuing a business model outsourcing most of its underwriting and claims functions to managing general agents (MGAs) and third-party administrators (TPAs), respectively. RTIC was licensed and operated in 50 states and wrote directly and through six subsidiary companies. The company had been operating for over 50 years and independent for approximately six years prior to being purchased by its current parent. Following the acquisition, RTIC pursued a modified business strategy for three years before being placed into run-off. RTIC wrote most lines of commercial liability insurance with primary

focus on workers' compensation, accident & health, and general liability insurance.

CAUSES OF TROUBLE. Although the parent company installed new management and sought to reverse the business decline at RTIC following the acquisition, continued underwriting losses and adverse development from past years resulted in a ratings downgrade at the company. In addition, the California Insurance Department had been monitoring RTIC for some time due to the poor underwriting results and concern over the company's capitalization. The parent determined that the business model for the company was not appropriate for the then-current market and was not likely to result in a return to profitable business for the company. The parent also determined that the profitable lines of business RTIC was writing could be pursued through restructured and separately capitalized subsidiary companies, while the potential for continued adverse development in certain lines written by RTIC— particularly workers' compensation—would require substantial new capital for RTIC to regain its ratings. Accordingly, the parent determined to place RTIC into run-off.

PRELIMINARY ACTIONS. The parent developed a run-off plan that called for the capital and operational restructuring of RTIC. Representatives of the parent, RTIC, and the run-off manager met with the Department to present a detailed plan for RTIC in run-off. The plan included a restructured capital base intended to provide sufficient flexibility and liquidity for the run-off. A principal component of this restructuring was the merger of a subsidiary of the parent already in run-off into RTIC. This contributed company had been in solvent run-off for a number of years and held sufficient excess capital to support RTIC in run-off. The resulting merged entity was to be placed under the management team of the contributed company, a dedicated professional team with 10 years of experience in the operation of run-off companies.

Over the course of a three-month period, the Department and the company representatives met frequently to refine the run-off plan. The Department was receptive to a solvent run-off under the control of the parent, provided that the parent could demonstrate sufficient capitalization within RTIC, the establishment of certain financial standards for RTIC, and enhanced financial and operational reporting by the company. Upon approval by the Department of the run-off plan and the merger, RTIC was formally placed in run-off.

CORRECTIVE ACTIONS. The Department, the parent, and RTIC entered into an agreement that required RTIC to maintain a minimum RBC standard of 200%, a net-reserves-to-surplus ratio of no greater than 3-to-1, and a specified minimum surplus amount. The parent guaranteed that RTIC would meet these standards. RTIC also agreed to provide frequent and detailed reporting to the Department on the progress of the run-off.

Based upon the company's actuarial analysis and a separate review by the Department, RTIC strengthened reserves in certain lines. The run-off plan also included a restructuring of the capital of RTIC which, in addition to the merger, included the contribution of a three-year term note from the parent to insure liquidity and sufficient capital, and the transfer of the stock of certain affiliated companies from RTIC into a trust in favor of RTIC. Certain subsidiaries of RTIC were purchased by the parent to continue writing certain lines outside of the run-off. RTIC reduced staff, and certain operations were subsequently transferred directly to the run-off manager. A retention plan was created to help retain knowledgeable, talented staff and management for the run-off. RTIC met separately with the domestic regulators of its subsidiary insurance companies to inform them of the plan and obtain their approval where necessary. RTIC and the Department also coordinated with NAIC staff to inform all interested states of the situation at an NAIC regulator meeting and to provide

regulators with the opportunity to ask questions or air concerns.

With the Department's agreement, RTIC began to terminate its MGA and most of its TPA agreements and assumed direct control of most of its claims. The company then began to aggressively settle claims, reduce its overall exposures, and commute certain reinsurance contracts where protection was uncertain or disputed. The investment manager restructured RTIC's investment portfolio to better address the anticipated cash flow and capital requirements of the run-off.

PROGRESS OF THE RUN-OFF. The Department's cooperation with management and establishment of clear operating guidelines, the capital support at RTIC provided by the parent, and singular focus of management on the satisfaction of RTIC's obligations and responsible management of the company's assets have resulted in a stable and successful run-off. Five years into the run-off, RTIC had reduced open claims by approximately 85%, reduced reserves by approximately 40%, and increased surplus by over 70%. The stabilization of RTIC, its successful execution of the run-off plan, and gains in its investment portfolio have resulted in the Department's agreement to terminate the trust arrangements created for the affiliated company investments, deferral, and subsequent forgiveness of the third installment of the parent note and the return of excess capital from RTIC to the parent. RTIC continues to adhere to the established financial standards, maintaining a comfortable margin over the minimum requirements established by the Department. RTIC management and the Department continue to meet approximately quarterly to review the progress of the run-off.

4. RESTRUCTURED TROUBLED LONG-TERM CARE COMPANY

Company characteristics, circumstances, and concerns:

- A stock life, accident and health company.
- Part of a large national life and A&H group.
- Primary line of business is a closed block of predominately long-term care in force.
- Ceased writing new business five years prior to restructuring.
- Received large capital contributions from parent for many years.
- Continuous premium rate increase requests.
- Adverse claim development and reserve strengthening.
- Low RBC ratio.

BACKGROUND. Restructured Troubled Long-Term Care Company was a writer of predominately long-term care business, operating in most of the 46 states, D.C., and the U.S. Virgin Islands. It had held a firm niche position in the long-term care market with profitable operations and a conservative balance sheet. The long-term care block of business was written by the Company and its predecessor companies prior to being acquired by the Company in the 1990s.

CAUSES OF TROUBLE. Shortly after the acquisition of long-term care blocks in the 1990s, the Company reported a reserve deficiency. The Company phased in a new reserve valuation basis for long-term care policies, requested and implemented premium rate increases, and implemented tighter underwriting standards. The cause of trouble was under-pricing and under-reserving that became evident as the company experienced claim costs and utilization that exceeded expectations. The original pricing assumptions on long-term care assumed a 4% to 5% lapse rate, while the actual lapse rate was only 1% to 2%. Additionally, the Company's investment return assumptions were much higher than actual returns.

Over the course of more than a dozen years, the Company received capital contributions to offset losses. The Company reported an increasingly larger reserve deficiency each year from 1998 to 2007, several years in excess of \$100 million deficient. The Company reported net losses in each year from 1997 to 2007.

PRELIMINARY ACTIONS. In 2003, Company management decided to stop marketing insurance products and to place the Company in run-off. The insurance department began monitoring the Company monthly and meeting with Company management on a quarterly basis as a result of continued poor operating performance, reserve deficiencies, and multi-year rate increase requests. A study was conducted of the Company's incurred claims experience. As a result, the Company updated the claim cost assumptions underlying the contract reserves and unearned premium reserves for the long-term care policies. The change was made using the "pivot" method, such that the change in claim costs would be accrued into the reserve balance over time. Multiple premium rate increases were sought. Over the course of 15 years, the Company received over \$900 million in capital contributions from the parent. The parent company indicated that no future capital contributions would be forthcoming.

The Company also came under scrutiny for market conduct issues, including claims administration and complaint handling practices. The Company underwent a market conduct examination to get a further understanding of the market conduct problems within the Company and, as a result, a settlement agreement was reached, recommendations for corrective measures were made, and an improvement plan was developed. The settlement included a monetary penalty for violations; a contingent penalty for non-compliance with improvements, including systems upgrades and improved claims administration; and restitution and remediation regarding the reevaluation of denied claims.

CORRECTIVE ACTIONS. With the approval of the insurance department, the Company's parent transferred the stock of the Company to a non-profit independent trust. In connection with the transfer, the parent contributed additional capital to the Company to fund future operating expenses. The capital was in the form of senior notes payable, invested assets, cash, and the forgiveness of unpaid dividends. The trust is intended to operate the Company for the exclusive benefit of the long-term care policyholders, without a profit motive. It is governed by a board of trustees under the oversight of the insurance department, as outlined in the Form A Acquisition Order.

5. LIABILITY OF INSURERS TRANSFERRED TO THIRD PARTY – EUROPE

BACKGROUND. The European market is a provider of insurance and reinsurance to insureds and cedents worldwide.

Events that took place in Europe during the 1990s provide an example of an extreme case of a market coming to the brink of collapse, only to be saved by a series of transactions that were simple in concept but, of necessity, very complex in their implementation. Those transactions amounted to what has become a famous event in the history of insurance. Most recently the final transaction took place, which had the effect of removing the outstanding liabilities of the re/insurers in question.

CAUSES OF TROUBLE. In the early 1990s there was an unexpected, huge increase in long-tail liability claims (typically asbestos, pollution and health hazard) made against certain European market insurers. Many of these insurers faced collapse, as the liabilities swamping the market and the difficulty in estimating the IBNR and calculating an appropriate reinsurance premium were so great. The effect was that several troubled European insurers were without protection and remained exposed to the incoming claims.

CORRECTIVE ACTIONS. The situation was so dire that immense efforts were made to bring about a solution. One solution, in particular, allowed certain troubled European insurers to pay a premium (which varied according to exposure) and have all the liabilities for the exposed years 1992 and earlier to be reinsured by a specially formed company, ABC Reinsurer. Claims handling and all other aspects of the run-off were transferred to XYZ insurer (a wholly owned subsidiary of ABC Reinsurer). XYZ also reinsured ABC Reinsurer under a retrocession agreement. Certain rights of the original troubled insurers as reinsureds of ABC Reinsurer were held on trust for policyholders: In this way, the benefit of all reinsurance recoveries were applied in paying the liabilities due to policyholders. The intervening 10 years to 2006 found XYZ working to plan with a controlled program of inwards and outwards commutations as a means of dealing with the run off of these liabilities. In all practicality the original troubled insurers had finality—i.e. they were no longer financially exposed personally so long as XYZ remained solvent. However, as a matter of law, they did remain personally liable to policyholders for any excess liability over and above that paid by XYZ.

By early 2006, the market in the purchase of portfolios in run-off had taken off. XYZ was the world's largest business in run-off, so large that the number of likely purchasers was very limited. However, fortunately by the end of 2006, the two-stage deal with a large conglomerate—XOX—was announced, the stages being:

- 1) XYZ retroceded to XOX's subsidiary, BOB, its liabilities to ABC Reinsurer arising under the agreement. Cover was limited to approximately \$6 billion (U.S.) over and above existing reserves of approximately \$9 billion, as of March 2006. The premium was all of XYZ's assets less approximately \$340 million, plus a \$145 million contribution from some of the original troubled insurers. Staff and operations were transferred to another XOX subsidiary, RRR.
- 2) A "Part VII transfer" of all the liabilities of the original troubled European insurers (and the protection of the ABC Reinsurer–XYZ–BOB reinsurance chain) to a third-party company. Provided the transfer was to take place before December 2009, XYZ would be entitled to purchase further reinsurance from BOB of up to \$1.3 billion if XYZ's net undiscounted reserves had not deteriorated by more than \$2 billion from their March 31, 2006, position.

Part VII of the UK Financial Services & Markets Act 2000 (FSMA) provides a statutory novation of business (i.e., reinsureds' obligations to their policyholders) by a transferor re/insurer to the transferee re/insurer, provided that strict procedures are complied with. The novation is effected by court order. The court order has the effect of vesting the transferor's business in the transferee without the need for consent of the policy holders/reinsureds. The court can and usually does order assets attributable to the underlying business to be transferred—i.e., including the outwards reinsurance contracts. There are strict definitions of business that are subjected to a Part VII transfer. Put broadly, it applies to transfers of business carried on in the UK or elsewhere within the European Economic Area (EEA) with a UK connection as defined and where the transferred business is to be carried on from an establishment of a transferee in an EEA state. There are various conditions and exclusions.

The unusual position of these particular re/insurers, should they wish to avail themselves of Part VII, was recognized at the time Part VII first became law. However, additional changes to the legislation had to be made to facilitate this transaction, and they became law in 2008. In particular, the Part VII provisions in the FSMA were extended to a further cohort of these particular re/insurers.

Under the Part VII transfer procedure, there are two court applications. The first gives directions as to notices to be served and other technical requirements allowing any opposing reinsureds or outwards reinsurers to object to the transfer. In the case of the XYZ Part VII, certain requirements were dispensed with taking into account the high volume of notices that would have to be given to individual names and other relevant parties. An essential part of the procedure is the report provided by an independent expert whose identity is approved by the Financial Services Authority (FSA). Furthermore, the FSA itself provides a report indicating its views that is made available to those interested in the transfer. Time is allowed for any objectors to produce their own case in the context of the independent expert report and the FSA's report. In the case of the XYZ transfer, the FSA indicated that it would not object to the transfer.

The second and final stage of the process is the application for sanction by the court. The court has discretion whether to sanction the transfer scheme but may not do so unless it considers it appropriate in all the circumstances of the case. Under case law on the statutory provisions, the court is concerned as to whether a policyholder, employee or other interested person will be adversely affected by the transfer scheme. The hearing took place in mid-year 2009, and the judge concluded that the Part VII transfer scheme should go ahead.

During the hearing, the judge was satisfied that other requirements protecting policyholders of the business being transferred had been fulfilled, such as that certificates of solvency for the transferee company were obtained confirming the adequacy of the transferee's solvency for the purpose. Presentations explaining the import of the transfer had been carried out in the UK and in the jurisdiction of XOX to transferring policyholders, the original troubled insurers, and their representatives. Help lines and a Web site had been set up. Numerous telephone calls, e-mails or letters had been sent in response by the Part VII advisers, with less than 10 people raising substantive issues.

ENFORCEMENT IN OTHER JURISDICTIONS. Part VII of the FMSA originates from EU Directives. The sanction order is thereby recognized throughout the EEA. A further step would be needed to ensure enforcement in the United States and other countries where policyholders were located. However, the shape of the scheme is such that enforcement in the United States and other jurisdictions is most probably unnecessary. Policyholders would be entitled to drawdown on trust funds located in the United States, Canada, Australia and South Africa, providing them with security for amounts accruing due to them over time should there be any default payment.

PROGRESS. With the sanction of this transfer scheme granted during mid-year 2009, the two-stage transaction provided by the XOX group was completed in time. Because the transfer was affected prior to December 2009, it is believed that the further amount of \$1.3 billion (U.S.) reinsurance cover will be available to secure future payment of all policyholder claims.

B. SAMPLE DOCUMENTS

1. SAMPLE SUPERVISION CONSENT ORDER

----- §
 In the Matter of: §
 The Administrative Supervision of §
 RESTRUCTURED TROUBLED §
 REINSURANCE CORPORATION, a § Docket No. EX xx-xx
 Connecticut domiciled property and casualty insurance company. §
 ----- §

CONSENT ORDER

This Consent Order is entered into by and between Restructured Troubled Reinsurance Corporation (RTRC) and the Insurance Commissioner of the State of Connecticut (the Commissioner) to provide supervision and regulatory oversight of RTRC in the run-off of its insurance and reinsurance obligations in force.

WHEREAS, the Commissioner hereby finds, and RTRC agrees, as follows:

1. The Commissioner has jurisdiction over the subject matter and of RTRC.
2. RTRC is a Connecticut-domiciled property and casualty insurer and reinsurance company having its principal office at XXX Street, Anywhere, XX 00000, and holds a certificate of authority to transact the business of insurance and reinsurance in Connecticut and is licensed or accredited in a number of other states.
3. RTRC is a wholly owned direct subsidiary of Restructured Troubled Corporation (RTC), a Delaware corporation and an indirect subsidiary of Restructured Troubled (Barbados) Ltd., a Barbados corporation which is a wholly owned direct subsidiary of Restructured Troubled Group Ltd. (RTG), a Bermuda corporation.
4. Due to the significant deterioration of RTG’s financial condition in 20XX, on December 3, 20XX, RTRC entered into a “letter of understanding” with the Connecticut Insurance Department (Department) as part of the Department’s continuing financial monitoring of RTRC pursuant to which RTRC agreed that it would not take certain actions without the prior written approval of the Connecticut Insurance Commissioner or her designee, including, among others, disposing of any assets, settling any intercompany balances or paying any dividends.
5. RTRC has submitted to the Department a risk-based capital report, (the RBC Report) pursuant to CONN. AGENCIES REGS. § 38a-72-2. The RBC Report indicates that RTRC was at the “Regulatory Action Level Event” as of December 31, 20XX. On July 30, 20XX, RTRC filed with the Department an updated RBC Report which estimates that RTRC was at the “Authorized Control Level Event” as of June 30, 20XX.
6. RTRC has ceased underwriting activities and has determined that it is in the best interests of its

policyholders and creditors to run-off the existing operations of RTRC in such a manner as would maximize the availability of funds to satisfy the interests of policyholders, creditors, and other constituents.

7. RTRC has retained the services of a firm with expertise and experience in run-off management to review the operations of RTRC and its subsidiaries in run-off, to supplement its internal resources, and to accelerate the successful completion of the run-off, all pursuant to a comprehensive run-off plan (including therein, among other items, a plan to effectuate commutation of existing reinsurance obligations). The run-off management consultant will develop and submit, along with a more extensive run-off engagement agreement retaining their services to manage the run-off, to the RTRC Board of Directors for approval and, if such plan and agreement are approved, to the Commissioner, creditors of RTC, and other constituencies for approval.

8. On April 15, 20XX, the Department commenced a targeted examination of the financial condition of RTRC pursuant to CONN. GEN. STAT. § 38a-14. The examination was called based on RTRC's submission of a Cash Flow Projection Model to demonstrate that RTRC has sufficient assets and cash flow to pay both claims and operating expenses as those obligations become due.

9. On August 20, 20XX, RTG and RTC filed for protection under Chapter 11 of Title 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware.

10. RTRC is in such condition that regulatory control of the insurer is appropriate to help safeguard its financial security and is in the best interests of the policyholders and creditors of the insurer and of the public as RTRC administers the run-off of its existing business.

IT IS THEREFORE ORDERED AND AGREED THAT:

11. RTRC hereby consents to and shall be placed under the administrative supervision of the Commissioner pursuant to CONN. GEN. STAT. § 38a-962b and under the terms herein.

12. RTRC hereby knowingly and voluntarily waives receipt of written notice under CONN. GEN. STAT. § 38a-962b of grounds for the Commissioner to effectuate administrative supervision by the Commissioner.

13. The period of administrative supervision by the Commissioner shall commence upon execution of this Consent Order. The period of supervision pursuant to this Consent Order shall be coterminous with the run-off of RTRC's existing business, unless the Commissioner takes action pursuant to Paragraph 27 hereof.

14. The determination that RTRC shall be subject to administrative supervision by the Commissioner may be abated and thereby released from administrative supervision by the Commissioner if RTRC complies with the orders of supervision provided herein and, during the period of supervision, RTRC shall have attained sufficient liquidity, surplus, and reserves necessary to exceed and maintain Company Action Level RBC, as defined in CONN. AGENCIES REGS. § 38a-72-1, or the Commissioner in her sole discretion determines the supervision of RTRC is no longer necessary for the protection of policyholders, claimants, creditors, or is no longer in the public interest.

15. During the period of supervision, RTRC shall not undertake, engage in, commit to accept, or renew

any insurance obligations including without limitation, insurance or reinsurance policies or any similar arrangements or agreements of indemnity or, without the prior written approval of the Commissioner, make any material change in any insurance or reinsurance agreement which would increase the financial obligations of RTRC in any material respect. Moreover, RTRC shall not engage in activities beyond those that are routine in the day-to-day conduct of its business in run-off and are otherwise consistent with its comprehensive business run-off plan (Run-off Plan) to be filed with, and found acceptable by, the Commissioner, without the prior approval of the Commissioner or her designee. The routine day-to-day conduct of RTRC's business in run-off includes but is not limited to: (a) paying claims and operating expenses as such obligations become due and in accordance with the applicable law and the settlement and commutation of claims and insurance and reinsurance obligations, unless otherwise provided in the following paragraph or otherwise directed or approved by the Commissioner or her designee; (b) defending RTRC and persons insured or claiming to be insured by RTRC against claims arising from or related to insurance policies and reinsurance agreements previously issued, assumed, or ceded by RTRC; (c) settling or otherwise resolving or attempting to adjust and resolve such claims; (d) engaging, directing, discharging, and compensating counsel (including reasonable costs incurred) with respect to such claims or other matters; (e) paying settlements or judgments with respect to such claims; and (f) investing the assets of RTRC and liquidating such assets in an appropriate manner as required to pay claims, operating expenses, settlements, commutations, and other charges in the ordinary course of business and subject to the provisions of this Consent Order.

The routine day-to-day conduct of RTRC's business in run-off also includes but is not limited to: (a) submitting information to reinsurers with respect to RTRC's reinsured losses and loss adjustment expenses; (b) advising reinsurers of all sums due to RTRC under their respective reinsurance contracts and treaties with RTRC (including settlement and commutation thereof, provided, however, that RTRC shall not enter into commutation of liabilities (either inward or outward including obligations of others to RTRC) or settlements of claims other than for amounts not in excess of \$250,000 except as otherwise provided in the Run-off Plan or otherwise approved by the Commissioner or her designee); and taking all actions necessary and appropriate to recover all sums due to RTRC from reinsurers and others.

The following activities, to the extent not necessary for the adjusting and payment of losses and expenses associated with claims adjusting and settlement or commutation of reinsurance agreements are understood to be outside the day-to-day conduct of RTRC's business in run-off, and in no event shall RTRC engage in or undertake the following activities without the prior approval of the Commissioner or her designee:

- (a) Dispose of, convey, or encumber any of its assets or its business in force.
- (b) Withdraw any of its bank accounts.
- (c) Lend any of its funds.
- (d) Invest any of its funds.
- (e) Transfer any of its property.
- (f) Incur any debt, obligation, or liability.
- (g) Merge or consolidate with another company.
- (h) Write new or renewal business.
- (i) Enter into any new reinsurance contract or treaty.
- (j) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except for nonpayment of premiums due.
- (k) Release, pay, or refund premium deposits, unearned premiums, or other reserves on any insurance policy, certificate, or contract.

- (l) Make any material change in management.
- (m) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

RTRC shall make a recommendation with the reasons therefore in writing to obtain the prior approval of the Commissioner as to any of the foregoing actions.

16. The Commissioner shall have the final authority to approve or disapprove the initiation, settlement, or withdrawal by RTRC of any action, dispute, arbitration, litigation, or proceeding of any kind involving RTRC that is not in the ordinary course of business or would require payment in excess of \$250,000. RTRC shall prepare a written report to the Commissioner with a recommendation for approval or disapproval with the reasons therefore.

17. Without the prior written approval of the Commissioner, RTRC shall not (i) add any individual who is not currently a senior executive officer of RTRC, or one of its affiliates, to the board of directors of RTRC or (ii) move the principal offices or records of RTRC to a location outside of Connecticut.

18. RTRC shall file with the Department a monthly financial statement consisting of a balance sheet and income statement on the 25th day of each month as of the end of the prior month.

19. At least annually, RTRC shall submit an actuarial analysis prepared by a qualified actuary as defined in CONN. AGENCIES REGS. § 38a-53-1 of the loss and loss adjustment expense reserves.

20. RTRC shall submit a report on a quarterly basis containing detailed information on all commutations of reinsurance treaties and related activities which have occurred year-to-date, including specific impact on RTRC's statutory financial statement.

21. RTRC shall submit to the Department any additional reports that the Department reasonably determines as necessary to ascertain the financial condition of RTRC.

22. RTRC shall submit any and all reports or items required by this Consent Order, and all requests for the Commissioner's action or approval to:

_____ (name)
Connecticut Insurance Department
P.O. Box 816
Hartford, Connecticut 06142-0816
(860) 297-3823
(860) 566-7410 FAX

23. The Commissioner may retain, at RTRC's expense, such experts (including, but not limited to, attorneys, actuaries, accountants, and investment advisors) not otherwise a part of the Commissioner's staff, as the Commissioner reasonably believes is necessary to assist in the supervision of RTRC.

24. RTRC hereby knowingly and voluntarily waives all rights of any kind to challenge or to contest this Consent Order, in any forum now available to it, including the right to any administrative appeal pursuant to CONN. GEN. STAT. § 4-183.

25. This Consent Order of supervision, and proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the administrative supervision by the Commissioner of RTRC are subject to the confidentiality provisions of CONN. GEN. STAT. § 38a-962c and § 38a-8.

26. RTRC shall continue to comply with all obligations under law, including applicable financial, regulatory, and tax reporting requirements.

27. Nothing in this Consent Order shall preclude the Commissioner from taking further action as the Commissioner in her sole discretion deems appropriate and in the best interest of RTRC's policyholders and the public, including commencement of further legal proceedings if and as necessary under Chapter 704c of the Connecticut General Statutes.

28. This Consent Order shall supersede in all respects the "letter of understanding" between RTRC and the Department referenced to in Paragraph 4 of this Consent Order, which letter shall have no further force and effect.

29. The Board of Directors of RTRC, at a specially called meeting or by unanimous written consent, has simultaneously, with the entry of this Consent Order, approved and provided resolutions complying with the terms of this Consent Order, which is effective upon entry of this Consent Order.

The foregoing Consent Order for Restructured Troubled Reinsurance Corporation is entered and shall be effective at 3:00 p.m. on this _____ day of September 20XX.

(name)
Insurance Commissioner

Agreed and Consented to by RESTRUCTURED TROUBLED REINSURANCE CORPORATION on this _____ day of September 20XX.

By: _____
(name)
President

(Corporate Seal)

On this _____ day of September 20XX, before me, the subscriber, personally appeared

_____, the President of Restructured Troubled Reinsurance Corporation, who I am satisfied is the person who has signed the preceding Consent Order, and he did acknowledge that he signed, sealed with the corporate seal, and delivered the same as such officer aforesaid and that the Consent Order is the voluntary act and deed of such company made by virtue of the authority vested in him by its Board of Directors.

(name), (Title)

2. SAMPLE REINSURER LETTER AGREEMENT

November , 20XX

President
Restructured Troubled Reinsurance CompanyXXX Street
Anywhere, XX 00000

Dear _____:

The Any State Insurance Department (Department) continues its financial monitoring of Restructured Troubled Reinsurance Corporation (RTRC or Company).

The Company's parent, Restructured Troubled Group Ltd. (RTG) reported an operating loss of \$245 million for the third quarter of 2002 and an operating loss of \$252.6 million for the first nine months of 2002. The loss resulted principally from approximately \$100.7 million of loss reserve increases recorded by the operating subsidiaries and a \$64.5 million loss related to the establishment of a deferred tax valuation reserve. The operating results for the first nine months of 20XX included approximately \$33 million of loss development related to the September 11th terrorist attacks recorded in the first quarter of 20XX. On October 18, 20XX, A.M. Best Company lowered the ratings of the operating subsidiaries of RTG from A- to B+. Subsidiary Insurance Company was lowered from A- to B. The downgrade constituted an event of default under RTG's bank credit facility, under which banks had issued \$336 million in letters of credit to support RTG's underwriting at its Lloyd's operation. On November 1, 20XX, with the approval of the Department, the Company entered into an Underwriting and Reinsurance Arrangement with Facility Re, Inc., whereby new business is underwritten by Facility Insurance Company, a member of the Facility Group. On November 14, 2002, A.M. Best again lowered the ratings of the operating subsidiaries of RTG from B+ to B-. Subsidiary Insurance Company was lowered from B to C++.

In order to protect the existing quality and integrity of RTRC's assets, reserves, and management to protect policyholders/reinsureds and the public, it is requested that the Company agree to the following:

1. RTRC shall not take any of the following actions without the prior written approval of the Insurance Commissioner or her designee:
 - a. Dispose of, convey, or encumber any of its assets or its business in force.
 - b. Withdraw any of its bank accounts except in the ordinary course of business.
 - c. Settle any intercompany balances.
 - d. Lend any of its funds.
 - e. Transfer any of its property.
 - f. Make any investments other than cash equivalents.
 - g. Incur any debt, obligation, or liability, except liabilities in the ordinary course of business.
 - h. Make any material change in management.

- i. Make any material change in the operations of the Company.
 - j. Move any books and records from its office in Stamford, Connecticut.
 - k. Pay any dividends, ordinary or extraordinary.
 - l. Enter into any affiliated reinsurance contracts, affiliated commutation agreements, or settlement agreements.
 - m. Enter into any unaffiliated insurance or reinsurance contracts that would constitute new or renewal business, or any unaffiliated commutation agreements or settlement agreements in excess of \$1 million not in the ordinary course of business.
 - n. Enter into affiliated transactions of any nature.
2. Senior management shall meet with the Department, in person or by conference call, with such frequency as may be deemed necessary by the Insurance Commissioner or her designee, to provide updates on the status of the parent and any changes in the status of the Company.
 3. A monthly financial statement consisting of a balance sheet and income statement shall be filed with the Department on the 25th day of each month as of the prior month end.
 4. The above-described terms shall continue in effect until such time as the Insurance Commissioner shall deem they are no longer necessary or issues an order that supersedes this agreement.
 5. RTRC acknowledges that nothing contained herein shall in any way limit any power or authority given the Insurance Commissioner under the laws of the State of Connecticut, including the right to initiate any further actions as she deems in her discretion to be necessary for the protection of RTRC's policyholders/reinsureds and the public.

I have enclosed two originals of this letter to your attention. Please sign and date both originals, retain one for your file, and return one executed original to me.

Sincerely,

_____, Chief Examiner
Financial Analysis & Compliance

AGREED TO this _____ day of November, 20XX, by a duly authorized representative of RTRC.

C. SAMPLE OUTLINE FOR RUN-OFF PLANS

The following is a sample outline for a run-off plan.

I. Introductory Overview

- A. Executive Summary: Providing an executive level summary of the history, current business conditions, recent significant transactions, and proposed run-off solution.
 - 1. Status
 - 2. Mission
 - 3. Business (Guiding) Principles
- B. Plan Objectives: Describing the ability of the plan to fully and timely settle all valid policyholder claims in compliance with the liquidation priorities of state distribution scheme.
- C. Advantages
- D. Benefits

II. Corporate History

- A. Summary
- B. Recent Happenings: Description of business plans, significant transactions, prior restructuring plans, and financial performance related thereto.
 - 1. Mergers & Acquisitions
 - 2. Employment
 - 3. Internal Growth
 - 4. External Factors
 - 5. Current Position
- C. Business Description: Including a comprehensive description of organizational and corporate structure, lines of insurance, nature of policyholder and other risks, and claim-handling function associated with the run-off.
 - 1. Lines
 - 2. Programs
 - 3. Markets
- D. Reserve Development
 - 1. Environmental Issues
 - 2. Underwriting Issues
 - 3. Adverse Development
 - 4. Reserves by Line – Summary

E. Financial Condition: Summary of recent financials

1. Summary
2. Statutory Surplus
3. Consolidated Financial Statement(s)
4. Operating Expenses
 - a. Staffing
 - b. Insurance
 - c. Real Estate
 - d. Fixed Costs
 - e. Information Technology
5. Taxes

F. Operations: Description and historical comparison of staffing, real estate, expenses, insurance and information technology, and other pertinent operations associated with run-off.

1. Claims Handling
2. Reinsurance
 - a. Outstanding Balances
 - b. Disputes
 - c. Solvency Issues
 - d. Uncollectables
 - e. Write-offs
 - f. Collateral
 - g. Lines of Business
 - h. Programs
 - i. Processes & Systems

III. Run-off Plan: Description of initiatives and priorities, including demonstration of Run-Off Plan serving the best interests of policyholders and other claimants.

A. Summary

B. Financial Projections: Including description of surplus-enhancing initiatives and transactions, loss development, liquidity and expense projections.

1. Key Factors
2. Assumptions
3. Revenues

4. Expenses
 5. Surplus Projection
 6. Liquidity Projection
- C. Initiatives
1. Surplus Enhancing
 - a. Policy Buybacks
 - b. Expense Reductions
 - i. Operating Expenses
 - a. Staffing
 - b. Real Estate
 - c. Fixed Costs
 - d. Insurance/Benefits
 - e. Information Technology
 - ii. Allocated Loss Adjustment Expenses
 - c. Reinsurance Commutations
 2. Liquidity
 - a. Asset Portfolio Assessment
 - b. Encumbered Assets
 - c. Unencumbered Assets
 - d. Statutory Deposits
- D. Risk Factors: Description and projection of risks associated with Run-Off Plan, including regulatory concerns, preferences, and risks associated with policyholders, and guaranty funds/associations, including identification of critical elements for plan success.
1. Define Uncertainties
 - a. Business
 - b. Economic
 - c. Regulatory
 2. Additional Adverse Loss Reserve Development
 3. Increased Reinsurance Disputes
 4. Unexpected Liabilities
 5. Drastic Asset Value Changes
 6. Financial Market – Investments

- E. Voluntary Run-off vs. Receivership: Analysis and comparison between the alternative mechanisms from best interests of policyholders, claimants, and guaranty funds/associations.
- F. Regulatory Reporting: Description of proposed regulatory supervision and reporting requirements—e.g., monthly statutory basis financial statements (balance sheet, statement of income and statement of cash flow), including comparison of actual results to Plan projections; quarterly reports demonstrating reinsurance recoverables and premium receivables past due, in dispute, litigation or arbitration; report demonstrating material credit exposures, related collateral held, and identity of credit impaired transactions; unpaid losses on state-by-state basis; weekly cash flow report; periodic review of loss reserves and amortization of any permitted loss reserve discounting, including appropriate actuarial certification; copies of all internal and external audit reports within five business days of issue; approval of all transactions exceeding pre-determined thresholds; and identification of prohibited transactions.
- G. Corporate Governance: Description of proposed governance and internal controls.

D. RELEVANT NAIC MODEL LAWS & REGULATIONS AND STATE STATUTES

This appendix section provides current and relevant NAIC Model Laws and Regulations, as well as specific state statutes that pertain to an insurance department's authority and responsibilities in dealing with troubled insurers. The sections are not intended to be all-inclusive, but rather a reference source.

1. NAIC MODEL LAWS & REGULATIONS

- Administrative Supervision Model Act
- Insurers Receivership Model Act
- Model Regulation to Define Standards and Commissioners' Authority for Companies Deemed to be in a Hazardous Financial Condition
- Criminal Sanctions for Failure to Report Impairment Model Bill

2. RULES AND REGULATIONS OF THE STATE OF NEW YORK – TITLE 11 INSURANCE DEPARTMENT – CHAPTER IV FINANCIAL CONDITION OF INSURER AND REPORTS TO SUPERINTENDENT – SUBCHAPTER D REINSURANCE – PART 128 COMMUTATION OF REINSURANCE AGREEMENTS (REGULATION 141)

(Text is current through February 15, 2008.)

Section 128.0. Purpose.

Section 1321 of the Insurance Law authorizes the Superintendent of Insurance to permit an impaired or insolvent domestic insurer or an impaired or insolvent United States branch of an alien insurer entered through this state to commute reinsurance agreements as a means of eliminating such an impairment or insolvency. This Part sets forth applicable standards that the superintendent will use in determining whether such commutations will be approved.

Section 128.1. Applicability.

This Part shall be applicable to any domestic insurer or United States branch of an alien insurer entered through this state, other than a life insurance company as defined in section 107(a)(28) of the Insurance Law.

Section 128.3. General provisions.

- (a) Nothing in this Part shall require the superintendent to give prior consideration to a plan which contains the commutation of reinsurance agreements in lieu of taking any other action against an impaired or insolvent insurer in accordance with the Insurance Law, including proceeding against such insurer pursuant to article 74 of the Insurance Law.
- (b) All the terms and conditions of any plan which contains the commutation of reinsurance agreements are subject to approval by the superintendent and no such plan will be approved by the superintendent unless the effect of the plan shall eliminate the insurer's impairment or insolvency and restore the insurer's surplus to policyholders to the greater of the minimum amount required to be maintained pursuant to the applicable provisions of the Insurance Law or to the amount the superintendent determines is adequate in relation to the insurer's outstanding liabilities or financial needs. The determination regarding the adequacy of the insurer's surplus to policyholders shall be made in accordance with the factors set forth in section 1104(c) of the Insurance Law.

Section 128.4. Requirements.

- (a) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall provide that:
 - (1) the offer to commute reinsurance agreements is made to each and every ceding insurer to which the impaired or insolvent insurer has obligations;
 - (2) the terms of the commutation agreement to be offered to each and every ceding insurer are the same, except that the percentage by which the impaired or insolvent insurer proposes to discount obligations due to each

ceding insurer may vary in regard to the type of business being commuted. Any variance by type of business shall be reasonable, actuarially sound and supported by documentation justifying such a variance; and

- (3) the impaired or insolvent insurer agrees to enter into a stipulation with the superintendent consenting to an order of rehabilitation or liquidation in the event that the implementation of the plan by the insurer does not result in restoring the insurer's surplus to policyholders to the minimum required as determined in accordance with section 128.3(b) of this Part.
- (b) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall include:
 - (1) a balance sheet that reflects the insurer's impairment or insolvency as determined by the superintendent, a pro forma balance sheet reflecting the financial condition of such insurer subsequent to the effective date of the plan, and a reconciliation between both balance sheets;
 - (2) an exhibit setting forth the obligations due to each and every ceding insurer as of the proposed effective date of such plan and the consideration to be offered each and every ceding insurer for the commutation of such obligations. The obligations shall be offered in accordance with the categories contained in the definition set forth in section 128.2(c) of this Part; and
 - (3) details regarding any retrocessionaire's participation in the plan.

Section 128.5. Procedures.

- (a) Any plan which contains the commutation of reinsurance agreements shall be submitted to the superintendent by the impaired or insolvent insurer within a period designated by the superintendent, which shall not be more than 90 days from the determination of the insurer's impairment or insolvency.
- (b) If the superintendent has no objection to any of the plan's terms and conditions and determines that the impaired or insolvent insurer's surplus to policyholders will be restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the proposed plan shall be approved and the insurer shall offer the commutation proposals to its ceding insurers. No commutation agreement shall become effective and no consideration for any commutation agreement shall be paid by the impaired or insolvent insurer until the superintendent determines that, as a result of the commutation proposals agreed to and executed by the ceding insurers, along with the effect of any other components of the plan, the impaired or insolvent insurer's surplus to policyholders is restored to the minimum required.
- (c) Within 10 days after the superintendent approves the plan, the impaired or insolvent insurer shall deliver the proposed commutation agreements to each ceding insurer. The terms of any commutation agreement shall not be subject to negotiation between the impaired or insolvent insurer and the ceding insurer.
- (d) The impaired or insolvent insurer shall submit to the superintendent, within a designated period as determined by the superintendent, copies of the executed commutation agreements from those ceding insurers agreeing to the proposed terms, copies of rejections of the commutation agreements by those ceding insurers not agreeing to the proposed terms and copies of any other correspondence pertaining to all such offers made to the ceding insurers. This submission shall include a balance sheet that reflects the effect of the executed agreements, together with any other components of the plan, upon the insurer's impairment or insolvency as determined by the superintendent. The insurer shall also submit copies of executed agreements with any retrocessionaires which either modify, commute or assign any retrocession agreement.
- (e) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the executed commutation agreements shall become effective.
- (f) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is not restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the superintendent may proceed against the insurer in accordance with the stipulation executed pursuant to section 128.4(a)(3) of this Part.

Section 128.6. Reporting requirements.

Any impaired or insolvent insurer which eliminates such impairment or insolvency using commutations approved by the superintendent in accordance with the provisions of this Part shall exclude all historical data pertaining to such

commutations from the loss development schedules contained in future financial statements filed in accordance with applicable provisions of the Insurance Law. The historical data pertaining to the business commuted shall be reported on a supplemental loss development schedule in a form consistent with the schedule contained in statutory financial statements as filed with this department. The supplemental schedule shall show the aggregate experience of such business as of the effective date of commutation agreement.

3. RHODE ISLAND STATUTE AND REGULATION – VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS TITLE 27 CHAPTER 14.5 AND REGULATION 68

§ 27-14.5-2 Jurisdiction, venue, and court orders.

- (a) The court considering applications brought under this chapter shall have the same jurisdiction as a court under chapter 14.3 of this title.
- (b) Venue for all court proceedings under this chapter shall lie in the superior court for the county of Providence.
- (c) The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this chapter. No provision of this chapter providing for the raising of an issue by a party in interest shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of process.

§ 27-14.5-3 Notice.

- (a) Wherever in this chapter notice is required, the applicant shall, within ten (10) days of the event triggering the requirement, cause transmittal of the notice:
 - (1) By first class mail and facsimile to the insurance regulator in each jurisdiction in which the applicant is doing business;
 - (2) By first class mail to all guarantee associations;
 - (3) Pursuant to the notice provisions of reinsurance agreements or, where an agreement has no provision for notice, by first class mail to all reinsurers of the applicant;
 - (4) By first class mail to all insurance agents or insurance producers of the applicant;
 - (5) By first class mail to all persons known or reasonably expected to have claims against the applicant including all policyholders, at their last known address as indicated by the records of the applicant;
 - (6) By first class mail to federal, state, and local government agencies and instrumentalities as their interests may arise; and
 - (7) By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in any other locations that the court overseeing the proceeding deems appropriate.
 - (b) If notice is given in accordance with this section, any orders under this chapter shall be conclusive with respect to all claimants and policyholders, whether or not they received notice.
 - (c) Where this chapter requires that the applicant provide notice but the commissioner has been named receiver of the applicant, the commissioner shall provide the required notice.

§ 27-14.5-4 Commutation plans.

- (a) *Application.* Any commercial run-off insurer may apply to the court for an order implementing a commutation plan.
 - (1) The applicant shall give notice of the application and proposed commutation plan.
 - (2) All creditors shall be given the opportunity to vote on the plan.
 - (3) All creditors, assumption policyholders, reinsurers, and guaranty associations shall be provided with access to the same information relating to the proposed plan and shall be given the opportunity to file comments or objections with the court.
 - (4) Approval of a commutation plan requires consent of: (i) fifty percent (50%) of each class of creditors; and (ii) the holders of seventy-five percent (75%) in value of the liabilities owed to each class of creditors.
 - (1) The court shall enter an implementation order if: (i) the plan is approved under subdivision (b)(4) of this section; and (ii) the court determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders.
 - (2) The implementation order shall:

Commented [RAW54]: This needs to be updated. According to a quick internet search, there have been some changes since this was copied. We should use an official source, but this is probably fairly reliable:
<https://casetext.com/statute/general-laws-of-rhode-island/title-27-insurance/chapter-27-145-voluntary-restructuring-of-solvent-insurers/section-27-145-3-notice>

- (i) Order implementation of the commutation plan;
 - (ii) Subject to any limitations in the commutation plan, enjoin all litigation in all jurisdictions between the applicant and creditors other than with the leave of the court;
 - (iii) Require all creditors to submit information requested by the bar date specified in the plan;
 - (iv) Require that upon a noticed application, the applicant obtain court approval before making any payments to creditors other than, to the extent permitted under the commutation plan, payments in the ordinary course of business, this approval to be based upon a showing that the applicant's assets exceed the payments required under the terms of the commutation plan as determined based upon the information submitted by creditors under paragraph (iii) of this subdivision;
 - (v) Release the applicant of all obligations to its creditors upon payment of the amounts specified in the commutation plan;
 - (vi) Require quarterly reports from the applicant to the court and commissioner regarding progress in implementing the plan; and
 - (vii) Be binding upon the applicant and upon all creditors and owners of the applicant, whether or not a particular creditor or owner is affected by the commutation plan or has accepted it or has filed any information on or before the bar date, and whether or not a creditor or owner ultimately receives any payments under the plan.
- (3) The applicant shall give notice of entry of the order.
- (1) Upon completion of the commutation plan, the applicant shall advise the court.
- (2) The court shall then enter an order that:
- (i) Is effective upon filing with the court proof that the applicant has provided notice of entry of the order;
 - (ii) Transfers those liabilities subject to an assumption reinsurance agreement to the assumption reinsurer, thereby notating the original policy by substituting the assumption reinsurer for the applicant and releasing the applicant of any liability relating to the transferred liabilities;
 - (iii) Assigns each assumption reinsurer the benefit of reinsurance on transferred liabilities, except that the assignment shall only be effective upon the consent of the reinsurer if either:
 - (A) The reinsurance contract requires that consent; or
 - (B) The consent would otherwise be required under applicable law; and
 - (iv) Either:
 - (A) The applicant be discharged from the proceeding without any liabilities; or
 - (B) The applicant be dissolved.
- (3) The applicant shall provide notice of entry of the order.
- (e) *Reinsurance.* Nothing in this chapter shall be construed as authorizing the applicant, or any other entity, to compel payment from a reinsurer on the basis of estimated incurred but not reported losses or loss expenses, or case reserves for unpaid losses and loss expenses.
- (f) *Modifications to plan.* After provision of notice and an opportunity to object, and upon a showing that some material factor in approving the plan has changed, the court may modify or change a commutation plan, except that upon entry of an order under subdivision (d)(2) of this section, there shall be no recourse against the applicant's owners absent a showing of fraud.
- (1) The commissioner and guaranty funds shall have the right to intervene in any and all proceedings under this section; provided, that notwithstanding any provision of title 27, any action taken by a commercial run-off insurer to restructure pursuant to chapter 14.5, including the formation or re-activation of an insurance company for the sole purpose of entering into a voluntary restructuring shall not affect the guaranty fund coverage existing on the business of such commercial run-off insurer prior to the taking of such action.
 - (2) If, at any time, the conditions for placing an insurer in rehabilitation or liquidation specified in chapter 14.3 of this title exist, the commissioner may request and, upon a proper showing, the court shall order that the commissioner be named statutory receiver of the applicant.
 - (3) If no implementation order has been entered, then upon being named receiver, the commissioner may request, and if requested, the court shall order, that the proceeding under this chapter be converted to a rehabilitation or liquidation pursuant to chapter 14.3 of this title. If an implementation order has already been entered, then the court may order a conversion upon a showing that some material factor in approving the original order has changed.

- (4) he commissioner, any creditor, or the court on its own motion may move to have the commissioner named as receiver. The court may enter such an order only upon finding either that one or more grounds for rehabilitation or liquidation specified in chapter 14.3 of this title exist or that the applicant has materially failed to follow the commutation plan or any other court instructions.
- (5) Unless and until the commissioner is named receiver, the board of directors or other controlling body of the applicant shall remain in control of the applicant.

RI Regulation 68 – www.dbr.state.ri.us/documents/rules/insurance/InsuranceRegulation68.pdf

Section 2 *Purpose*

The purpose of this Regulation is to outline the procedural requirements for insurance companies applying for the implementation of a Commutation Plan pursuant to R.I. Gen. Laws § 27-14.5-1, *et seq.* and related matters.

4. PART VII OF THE FINANCIAL SERVICES AND MARKETS ACT 2000 (FSMA)

www.opsi.gov.uk/acts/acts2000/ukpga_20000008_en_1

<http://fsahandbook.info/FSA/html/handbook/SUP/18>

<http://fsahandbook.info/FSA/html/handbook/PRIN>

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KPMG Run-Off Survey – Non-Life Insurance (October 2008).

No. 165 of 2005, In the High Court of Justice Chancery Division Companies Court, In the Matter of the British Aviation Insurance Company Limited and In the Matter of the Companies Act 1985, Witness Statement of Susan Power Johnston, NY: 479913-7.

Wright, David. “A Question of Enforceability,” *Run Off Business*, Issue 12, Spring 2005, pp. 20-22.

LUANN PETRELLIS
lpetrellis@outlook.com
(610) 304-4524

BY E-MAIL

November 30, 2021

Superintendent Elizabeth Kelleher Dwyer
Commissioner Glen Mulready
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group

Attention: Dan Daveline (ddaveline@naic.org)

Re: The Restructuring Mechanisms (E) Working Group Draft White Paper

Dear Superintendent Dwyer and Commissioner Mulready,

I appreciate the opportunity to comment on the Draft White Paper of the Restructuring Mechanisms (E) Working Group.

The draft white paper of the Restructuring Mechanisms Working Group provides a comprehensive summation of activities leading to the development of insurance business transfer (IBT) and corporate division (CD) laws. In its review the Working Group concludes that each state will have different needs and approaches to these restructuring mechanisms and it is best left to the states to decide what is required for their purposes.

The recently concluded Allstate Division transaction in Illinois provides a good illustration of how these restructuring tools can be successfully implemented. While each transaction is unique depending on the specific proposals, the Allstate Division provides a solid framework for the division process in Illinois and other states with similar CD legislation and serves as a model for all transactions going forward.

Allstate Division

On February 2, 2021, Allstate Insurance Company filed the first plans of division in the U.S. market to restructure its insurance operations. The Allstate plans of division were filed with the Illinois Department of Insurance (the "Department") pursuant to the Illinois Domestic Stock Company Division Law.¹ The plans involved eight insurance company subsidiaries under the Allstate, Esurance, and Encompass brands, (the "Dividing Companies")² with each filing a plan of division with the Illinois Director of Insurance ("Director").

¹ In 2018, the Illinois General Assembly passed the Illinois Domestic Stock Company Division Law 215 ILCS 5/156-5/172 ("Division Law").

² The "Dividing Companies" are: (i) Allstate Insurance Company ("AIC"); (ii) Allstate Indemnity Company; (iii) Allstate Property and Casualty Insurance Company; (iv) Allstate Fire and Casualty Insurance Company ("AFCIC"); (v)

The eight plans of division allocated certain portions of each company's inactive Michigan automobile insurance business (the "Specified Policies") to eight (8) new insurance companies created in the division process ("New Companies"). Immediately following the divisions, the eight New Companies merged into three newly formed Illinois domestic insurers pursuant to the Illinois Merger Law, so that there was one surviving insurer for each of the Allstate, Esurance and Encompass brands (the "Merger Companies") Following the mergers all the assets, liabilities, contracts, and required surplus associated with the Specified Business allocated to the New Companies passed by operation of law to the Merger Companies. Upon the closing of the transaction, the Merger Companies continued to be wholly owned, indirect subsidiaries of Allstate, which is the ultimate controlling person of each of the Merger Companies.

Division Transaction review and implementation

Central to any successful restructuring transaction is the effective program management of all the subsidiary projects and tasks involved. Keeping the program and all the relevant staff and advisers focused and on track is fundamental. Arguably the most important roles in delivering a successful transfer on time are those of the project manager, legal advisers, financial advisors and other experts. These key appointments must be considered carefully by the parties to the transfer.

There are a number of key elements to a restructuring transaction using either the IBT or CD legislation that include:

- a) Information gathering
- b) Selection and appointment of advisers
- c) Assessment of capital adequacy and solvency
- d) Assessment of notice requirements
- e) Assessment of the impact on affected policyholders
- f) Contingency planning

For IBT and CD transactions, an important consideration for the regulator is the scale of the transaction. Scale is defined by gross liabilities, obligations to policyholders, other creditors, reinsurance and other assets. Scale will affect the cost of the transfer, and what the parties must do to satisfy the regulatory review. Generally, a regulator will adopt a principle of proportionality, namely the bigger, more complex or controversial a transaction is, then the greater the degree of regulatory scrutiny.

The Allstate transaction was a large, relatively complex transaction and the first of its kind in the U.S. As a result, both the Department and Allstate went above and beyond the legislative

Encompass Indemnity Company; (vi) Encompass Property and Casualty Company; (vii) Esurance Insurance Company; and (viii) Esurance Property and Casualty Insurance Company. Each Dividing Company is an Illinois domestic insurer, holding a license from the IL DOI, and is licensed as a foreign insurer in Michigan.

requirements of the Illinois Division law in connection with the financial review and notice requirements.

For the Allstate Division, the Department engaged me as project manager to assist in the implementation of the legislation. In addition to my engagement, the Department also engaged Stephen Schwab of DLA Piper as outside counsel to represent the Department. To support the financial review, the Department retained Risk & Regulatory Consulting ("RRC") as its independent actuarial consultant to focus on reserves and capital. RRC conducted an independent reserve analysis and evaluated the initial capital levels of the Merger Companies.

The Department's review focused on policyholder and claimant protection and prudent financial analyses. The key areas considered under the financial evaluation scope included:

- Capital adequacy
- Loss reserves
- Financial modelling and projections

Allstate conducted its own internal analysis to determine the capital adequacy of the Merger Companies. Allstate utilized several tools and methodologies, including: (1) Allstate's estimate of required capital using A.M. Best's BCAR framework; (2) the NAIC RBC ratio; and (3) a peer company review.

In addition to Allstate's internal analyses, Allstate retained outside consultants including A.M. Best, a rating agency, to provide an independent rating analysis and a preliminary credit assessment for the Merger Company group. Allstate also retained Lazard, a financial advisory and asset management firm, to analyze the capital adequacy of the Merger Companies. As part of its mandate, Lazard was charged with preparing a report analyzing the business and financial condition of the Merger Companies and assessing this information against certain financial aspects of the Division Law's requirements. Specifically, Lazard analyzed pro forma financial metrics as provided by Allstate. Lazard also performed a peer benchmarking analysis, comparing key pro forma financial metrics of the Merger Companies to public information regarding selected comparable companies. After consideration of all findings presented, the Department concluded that the initial capital levels were reasonable.

Early engagement with the Department was key to the success of the Allstate transaction. Allstate worked closely with the Department providing detailed information regarding the business to be divided, the assets to be allocated to support the business, how the companies were to be capitalized, and how policyholder considerations were to be addressed. Allstate's comprehensive planning identified potential sources of areas of objection, and, prior to the hearing, Allstate took the necessary actions to address these concerns. All parties worked together to complete the project and obtain necessary approvals within Allstate's requested timeline. The collaborative working environment enabled this transaction to be completed on Allstate's time schedule notwithstanding that it was executed during a Pandemic and was the first transaction of its kind in the U.S.

Notice and Hearing

The Illinois Division Law requires a hearing only if the Director deems it to be in the public interest or if requested by the Dividing Company. **Also** notice is not required unless the Director deems it to be in the public interest. Because of the significance of this being the first division transaction undertaken in the United States and Allstate's desire for transparency, Allstate requested a public hearing. Allstate's division plans also included a Communication Plan that provided notice to affected policyholders, guaranty funds, the Michigan regulator and other relevant stakeholders. Allstate also provided broad public notice through ads published twice in each of The Chicago Tribune and The Detroit Free Press.

The Department closely reviewed and approved Allstate's Communication Plan and the notice of hearing that was provided to the affected policyholders and claimants, and other stakeholders. In addition, Allstate requested that the Hearing Officer, Judge MaryAnne Mason (ret.), review the notice of hearing. The hearing was held virtually by Zoom and provided the opportunity for any person to submit a comment or intervene in the proceedings.

Any interested person was able to attend the hearing via a Zoom link. No objections or other comments were submitted to the Hearing Officer. On March 19, 2021, based on the Hearing Officer's Findings of Fact and Conclusions of Law, the Director issued an order approving the eight Plans of Division.

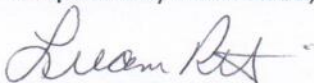
Conclusion

The key "lessons learned" from this transaction include the following:

- Early engagement with the regulator is essential
- Careful selection of project manager, consultants and experts is key
- Communication and transparency are important
- A collaborative working environment facilitates timely execution

Allstate's Division transaction is a landmark transaction for the insurance industry to successfully implement the Illinois Division legislation in a complex transaction structure. Importantly, the transaction was achieved by Allstate and the Illinois Department working together with their consultants and representatives to put forth a transaction structure that allowed Allstate to accomplish its corporate objectives and better position itself for the future while ensuring that the interests of policyholders and claimants were properly protected.

Respectfully submitted,



Luann Petrellis



ENSTAR (US) Inc.

December 1st, 2021

Comments to Restructuring Mechanisms Working Group draft white paper

Dear Superintendent Dwyer and Commissioner Mulready:

Thank you to the entire working group and NAIC staff for the time and effort directed into the development of this white paper. As you have recognized, the need for restructuring transactions within the insurance industry continues to grow. The growth of the runoff industry reflects the success this market has achieved to improve the capital and managerial efficiencies of the insurance industry. We appreciate your leadership and recognition of the importance of preparing US regulators for the continued need for these types of transactions.

Enstar is a publicly traded global insurance group and market leader in the active runoff management industry. We recognize that it is often difficult to quantify and differentiate between active runoff management insurers, active insurers that also hold business in runoff, and companies that have transitioned from active insuring to managing their own runoff. As the working group continues to pursue its charges, we would appreciate the opportunity to address how these differences may be relevant to the recommendations of the working group. We believe that these distinctions may give additional insight into the purposes and value of the restructuring transactions identified within the white paper. These distinctions are likely to be developed further by the Restructuring Mechanisms Subgroup in pursuit of its charges, and we hope that this pending work will be added to the white paper once completed.

We appreciate that the white paper recognizes the importance of state licensing on companies looking to aggregate runoff business into a single company. We agree that it is in the interests of policyholders, regulators, and insurers for companies to be able to obtain insurance licenses despite operating a business model that would not necessarily require a license to be granted. We hope that the working group will consider taking on a

charge or referral on this issue and will make a place in this white paper for any additional insights developed during this process.

We have valued and enjoyed the opportunities offered to us to share our perspective on the runoff industry with the working group, and we remain available should there be any further opportunities for us to assist the working group and its subgroups with their charges.

Sincerely,

A handwritten signature in blue ink, appearing to read "R. Redpath".

Robert Redpath
US Legal Director



December 1, 2021

VIA Electronic Delivery

Restructuring Mechanisms (E) Working Group
National Association of Insurance Commissioners
Attn: Mr. Dan Daveline
Attn: Mr. Casey McGraw
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Re: Comment on Draft Restructuring Mechanisms White Paper

Dear Restructuring Mechanisms (E) Working Group:

The Virginia State Corporation Commission's (the "Commission") Bureau of Insurance (the "Bureau") appreciates the efforts of the Restructuring Mechanisms (E) Working Group (the "Working Group") to compile its thoughtful draft white paper on the complex topic of Restructuring Mechanisms (the "White Paper"). The Bureau submits this comment to bring to the attention of the Working Group both § 38.2-136 of the Code of Virginia (the "Code"), which is in essence an anti-novation statute, and how that section of the Code governed the Commission's approach to a prior Insurance Business Transfer ("IBT") involving Virginia policies.

The Bureau respectfully proposes that the White Paper should include a discussion of anti-novation statutes, like § 38.2-136 of the Code, because these statutes and analogous legal principles will influence the sections on "Assumption Reinsurance," "Guarantee Association Issues," and "How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States."

Background:

Assumption Reinsurance Model Act. As the White Paper notes, ten states have enacted the NAIC Assumption Reinsurance Model Act ("Model Act"). Under the Model Act, individual policyholders are notified of a proposed transfer of their policy and "have the right to reject the transfer and novation of their contracts of insurance." Model Act §§ 4, 5. This core requirement of policyholder consent, however, is not only found in states that have adopted the Model Act. While the details will vary, a state may also require such consent through independent anti-novation statutes or the application of common law principles. In Virginia, the principle of policyholder consent is codified in § 38.2-136 of the Code.

Section 38.2-136 of the Code. In relevant part, § 38.2-136 of the Code prohibits the assumption of policy obligations on risks located in Virginia as direct obligations unless (1) the

policyholder consents and (2) the assuming insurer is properly licensed in Virginia. *See* § 38.2-136 (B) of the Code. Absent policyholder consent, such a transaction requires an order from the Commission approving the transaction. The Commission *may* enter such an order whenever (i) the Commission finds a licensed insurer to be impaired or in hazardous financial condition, (ii) a delinquency proceeding has been instituted against the licensed insurer for the purpose of conserving, rehabilitating, or liquidating the insurer, or (iii) the Commission finds, after giving the insurer notice and an opportunity to be heard, that the transfer of the contracts is in the best interests of the policyholders. *See* § 38.2-136 (C) of the Code. Additionally, if granting an approval order, the Commission is required to ensure that policyholders do not lose any rights or claims afforded under their original policies by the Virginia Property and Casualty Insurance Guaranty Association or the Virginia Life, Accident and Sickness Insurance Guaranty Association. *Id.*

Virginia’s Application of § 38.2-136 of the Code to IBTs. As noted in the section of the White Paper on “Transactions Completed to Date:”

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company’s (“PWIC”) IBT plan. The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company [(“Yosemite”)]. (White Paper at 12.)

The transferred business, however, included a number of Virginia workers’ compensation policies. As such, the Bureau informed PWIC and Yosemite that the IBT—as to the Virginia policies—required policyholder consent under § 38.2-136 (B) of the Code because it involved the cessation or assumption of policy obligations on risks located in Virginia. In response, PWIC and Yosemite requested that the Commission waive the policyholder consent requirement by finding that the transfer of the Virginia policies was in the best interests of the policyholders pursuant to § 38.2-136 (C)(iii) of the Code.¹ The Commission found that the transfer of Virginia policies was subject to the requirements of § 38.2-136 (B) of the Code (*i.e.* policyholder consent and proper licensure), but approved the transfer pursuant to § 38.2-136 (C)(iii) of the Code (*i.e.* best interests of the policyholders). *See* Order Approving Application, Case No. INS-2021-00055 (June 17, 2021).²

Effect on the White Paper:

The existence of § 38.2-136 of the Code and its application to the PWIC / Yosemite IBT raise important considerations with respect to three sections of the White Paper.

First, in the section on Assumption Reinsurance, the Bureau would encourage the Working Group to not only discuss states with the Model Act, but to also consider jurisdictions—like Virginia—that have independent anti-novation provisions or principles. That addition will prevent any misimpression that the important issues raised in this section only exist in the ten states that have adopted the Model Act.

¹ While requesting this order, PWIC and Yosemite did not concede that such an order was necessary.

² Included with this comment for reference are (1) a copy of the text of § 38.2-136 of the Code and (2) the Commission’s order regarding the PWIC / Yosemite IBT.

Furthermore, this section could be clarified as to whether it is (a) only raising the issue of how statutory restructuring mechanisms would interact with the Model Act if both were included within a single jurisdiction’s laws or (b) also addressing how one state’s statutory restructuring mechanism would interact with the Model Act or an independent anti-novation statute or principle in another jurisdiction. If the White Paper is only addressing the former, the Bureau would propose also flagging the even more complex issue raised by a multi-jurisdictional analysis (*e.g.* if State A had an IBT statute and State B had the Model Act or an anti-novation statute, how would those statutes interact if State A attempted to approve the transfer of policies located in State B). Understanding the complexity of that multi-state scenario will likely be important for regulators weighing the persuasiveness of the suggestion by some stakeholders noted in the White Paper that the “statutes coexist.” (White Paper at 15.)

The interaction of these statutes can also raise thorny legal and factual issues worth highlighting in the White Paper. Most notably, there are varying standards for approving a transaction. As explained by the White Paper, various IBT statutes require that there be “no material adverse impact on affected policyholders.” (White Paper at 10.) For Virginia to approve an IBT authorized by another jurisdiction with respect to Virginia policyholders, however, the Commission must find the transfer of the Virginia policies to be “in the best interests of the policyholders.” § 38.2-136 (C)(iii) of the Code.³ Simply put, those pursuing novel statutory restructuring mechanisms should be aware that other jurisdictions—like Virginia—may hold the transfer to a higher standard.⁴

Finally, the White Paper’s observation in this section that “[t]he issue has not yet been addressed by any court nor raised in the proceedings on restructurings,” could be updated to reflect that the Commission, which acts as a court of record, applied Virginia’s anti-novation statute to the PWIC / Yosemite IBT. (White Paper at 15.)

* * *

Second, in Virginia and any states with a similar statute, the guaranty association concerns identified in the White Paper’s section on “Guarantee Association Issues” take on added importance. The Bureau certainly agrees with the White Paper’s position that “guaranty association coverage should not be reduced or eliminated by the restructuring.” (White Paper at 13.) Under Virginia law, however, the bar is higher for a transaction that is dependent on an approval order pursuant to § 38.2-136 (C) of the Code due to the lack of policyholder consent. Such an order could not be issued and, therefore, such a restructuring could not occur unless the Commission determined that policyholders would not lose any rights or claims afforded under their original policies by the Virginia guaranty associations.⁵ As a result, the language in this

³ In certain circumstances, the Model Act also permits the “transfer and novation” of policies “notwithstanding the provisions of [the Model Act]” if such a transfer “is in the best interest of the policyholders.” Model Act § 7.

⁴ As a practical matter, this difference in standards (“no material adverse impact” v. “best interests”) may result in the record from an IBT proceeding standing alone not satisfying the heightened standard found in another state.

⁵ With respect to the PWIC / Yosemite IBT, which involved two insurers who were both licensed in Virginia and guaranty coverage from the Virginia Property and Casualty Insurance Guaranty Association, the Commission determined “[b]ased upon the Bureau’s review of the Application and the Applicants’

section and the corresponding recommendation in Section 6 could be strengthened to reflect that unless and until guaranty association coverage can be *ensured*, transactions involving policies in states with anti-novation statutes will not be possible.⁶

* * *

Third, Virginia’s treatment of the PWIC / Yosemite IBT should potentially be referenced in the section on “How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States.” The Commission’s order is one concrete example not just of how another jurisdiction *might* respond to an IBT, but how another jurisdiction did *in fact* respond. Regulators approving IBTs and insurers looking to utilize them should be aware that if policies from a state with an anti-novation statute or principle are involved, they are likely to see a response from those jurisdictions similar to Virginia’s response to the PWIC / Yosemite IBT.

* * *

The Bureau again thanks the Working Group for its work on this complex issue and appreciates the opportunity to comment on the draft White Paper. If you have any questions regarding this comment, the Bureau’s staff would be happy to discuss the matter with you and/or provide additional information regarding the above referenced proceedings before the Commission.

Sincerely,



Scott A. White
Commissioner of Insurance

representations” that “the Virginia policyholders will not lose any rights or claims afforded under their original contracts.” Order Approving Application, Case No. INS-2021-0005, at 3.

⁶ For example, the recommendations section currently advises that “regulators should very carefully consider how plans presented address the guaranty association issues to assure that consumers are not harmed by the transaction.” (White Paper at 19.) This advice could be expanded to also advise states to consider whether a transfer of policies in other jurisdictions will even be possible due to the uncertainty around guaranty association coverage in certain circumstances.

§ 38.2-136. Reinsurance

A. Except as otherwise provided in this title, any insurer licensed to transact the business of insurance in this Commonwealth may, by policy, treaty or other agreement, cede to or accept from any insurer reinsurance upon the whole or any part of any risk, with or without contingent liability or participation, and, if a mutual insurer, with or without membership therein.

B. No insurer licensed in this Commonwealth shall cede or assume policy obligations on risks located in this Commonwealth whereby the assuming insurer assumes the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution for the obligations of the ceding insurer to the payees, unless: (i) the policyholder has consented to the assumption and (ii) the assuming insurer is licensed in this Commonwealth to write the class or classes of insurance applicable to the policy obligations assumed.

C. Notwithstanding the provisions of subsection B, the transfer of risk under any reinsurance agreement may be effected by entry of an order by the Commission approving the transaction whenever (i) the Commission finds a licensed insurer to be impaired or in hazardous financial condition, (ii) a delinquency proceeding has been instituted against the licensed insurer for the purpose of conserving, rehabilitating, or liquidating the insurer, or (iii) the Commission finds, after giving the insurer notice and an opportunity to be heard, that the transfer of the contracts is in the best interests of the policyholders. In granting any such approval, the Commission shall ensure that policyholders do not lose any rights or claims afforded under their original policies pursuant to Chapter 16 (§ 38.2-1600 et seq.) or 17 (§ 38.2-1700 et seq.) of this title. Prior to granting an approval under clause (iii), the Commission shall consider whether there is a reasonable expectation that the ceding insurer may not be able to meet its obligations to all policyholders; whether the ceding insurer's continued operation in this Commonwealth may become hazardous to policyholders, creditors and the public in this Commonwealth; or whether the ceding insurer may otherwise be unable to comply with the provisions of this title.

Code 1950, §§ 38-160, 38-519; 1952, c. 317, § 38.1-26; 1986, c. 562; 1993, c. 158.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

AT RICHMOND, JUNE 17, 2021

SCC-CLERK'S OFFICE
DOCUMENT CONTROL CENTER

2021 JUN 17 P 4:00

2021 JUN 17 P 4:00

APPLICATION OF

YOSEMITE INSURANCE COMPANY
AND PROVIDENCE WASHINGTON
INSURANCE COMPANY

CASE NO. INS-2021-00055

For approval of the transfer of certain
insurance policies pursuant to
§ 38.2-136 (C)(iii) of the Code of Virginia

ORDER APPROVING APPLICATION

By Application filed with the State Corporation Commission ("Commission") of the Commonwealth of Virginia ("Virginia") dated April 14, 2021, Yosemite Insurance Company, an Oklahoma-domiciled insurer ("Yosemite"), and Providence Washington Insurance Company, a Rhode Island-domiciled insurer ("PWIC" together with Yosemite, "Applicants"), requested approval of the transfer of 251 Virginia workers' compensation policies from PWIC to Yosemite ("Virginia Transfer") pursuant to § 38.2-136 (C)(iii) of the Code of Virginia ("Code").¹ Yosemite and PWIC are affiliates within the Enstar Group ("Enstar") and both are licensed to transact the business of insurance in Virginia and are in good standing.

The transfer of these Virginia workers' compensation policies is part of an Insurance Business Transfer ("IBT") that PWIC filed with the Oklahoma Insurance Department on November 13, 2019 pursuant to Oklahoma's Insurance Business Transfer Act. On November 26, 2019, the Commissioner of the Oklahoma Insurance Department approved the IBT after

¹ PWIC previously obtained the Virginia policies in question from Reciprocal of America, in receivership, pursuant to a Loss Portfolio Transfer Agreement approved by an order of the Commission on June 16, 2014. *See Final Order*, Case No. INS-2013-00190 at 9 (June 16, 2014) (adopting Hearing Examiner's recommendations and finding that the "Deputy Receiver has met all the requirements of § 38.2-136 (C) of the Code.").

concluding it would not have a material adverse impact on the interests of the policyholders. On October 15, 2020, the District Court of Oklahoma County approved the IBT following an approval hearing.

The Commission's Bureau of Insurance ("Bureau") informed Yosemite and PWIC that the IBT required policyholder consent under § 38.2-136 (B) of the Code to the extent that it involved the cessation or assumption of policy obligations on risks located in Virginia whereby the assuming insurer assumes the policy obligations of the ceding insurer as direct obligations.

Pursuant to § 38.2-136 (C)(iii) of the Code, the Applicants have requested that the Commission waive § 38.2-136 (B) of the Code's policyholder consent requirement for the Virginia Transfer by finding that the transfer of these policies is in the best interests of the policyholders.² The Applicants have waived the right to a hearing under § 38.2-136 (C)(iii) of the Code in their application.

In support of the Application, Yosemite and PWIC state, *inter alia*, that during the Oklahoma IBT proceedings notice of the Virginia Transfer was mailed to the Virginia policyholders and that no policyholder objected prior to or during the approval hearing held before the District Court of Oklahoma County.

Following submission of the Application, Yosemite and PWIC informed the Bureau on May 14, 2021 that Enstar is in the process of selling PWIC and had entered into a stock purchase agreement with Everspan Insurance Company ("Everspan"). As a result, if the Virginia Transfer were not to occur, the Virginia workers' compensation policies in question would leave Enstar and go to Everspan with PWIC.

² While requesting an order pursuant to § 38.2-136 (C)(iii) of the Code, the Applicants do not concede that such an order is necessary for the Virginia Transfer. *See* Application at 4.

The Bureau, based upon the Application, the record in the Oklahoma IBT proceedings and the information available in this matter, has recommended that the Virginia Transfer is in the best interests of the Virginia policyholders. Based upon the Bureau's review of the Application and the Applicants' representations, the Virginia policyholders will not lose any rights or claims afforded under their original contracts pursuant to Chapter 16 of Title 38.2 of the Code.

NOW THE COMMISSION, having considered the Application, the recommendation of the Bureau that the Virginia Transfer is in the best interests of the Virginia policyholders, and the law applicable hereto, is of the opinion that the Virginia Transfer is subject to the requirements of § 38.2-136 (B) of the Code, and that the Application should be approved.

Accordingly, IT IS ORDERED THAT the Application of Yosemite Insurance Company and Providence Washington Insurance Company for the approval of the transfer of 251 Virginia workers' compensation policies from PWIC to Yosemite pursuant to § 38.2-136 (C)(iii) of the Code be, and it is hereby, APPROVED.

A COPY hereof shall be sent by the Clerk of the Commission by electronic mail to: Scott J. Sorkin, Esquire, Bland & Sorkin, P.C., at ssorkin@blandsorkin.com, 5398 Twin Hickory Road, Glen Allen, Virginia 23059; Robert Redpath, Senior Vice President and U.S. Legal Director, Enstar (US) Inc., at robert.redpath@enstargroup.com, 475 Kilvert Street, Suite 330, Warwick, Rhode Island 02886; and a copy shall be delivered to the Commission's Office of General Counsel in care of Attorney, Thomas J. Sanford and the Bureau of Insurance in care of Deputy Commissioner Douglas C. Stolte.

Wayne Mehlman
Senior Counsel
(202) 624-2135
waynemehlman@acli.com

December 1, 2021

Superintendent Elizabeth Kelleher Dwyer, Co-Chair
Commissioner Glen Mulready, Co-Chair
Restructuring Mechanisms Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108

RE: Draft White Paper on Restructuring Mechanisms

Superintendent Dwyer and Commissioner Mulready:

The American Council of Life Insurers (ACLI) would like to thank you for this opportunity to comment on the Restructuring Mechanisms Working Group's draft *White Paper on Restructuring Mechanisms*.

ACLI believes that certain guardrails, including important process, review, and consumer and company solvency protections, must be in place before a proposed insurance business transfer (IBT) or corporate division transaction can be approved by a state regulator (and in the case of an IBT, by a state court).

Accordingly, in 2019, ACLI's Board of Directors adopted a comprehensive set of *Principles and Guidelines on Insurance Business Transfer & Corporate Division Legislation* that ACLI and its members would refer to when evaluating potential legislation, regulations and models. As you finalize this White Paper, we strongly encourage the Working Group to incorporate the following Principles and Guidelines:

Policyholders and Other Impacted Stakeholders Must Have Access to the Process

- All transactions must be subject to a public hearing.
- Individual policyholders, reinsurers, applicable state regulators, guaranty associations, and any other persons determined by the regulator must receive notice of the proposed transaction.

The Regulatory Review Process Must Be Robust

- The Commissioner's review process must include certain findings, including:
 - The financial condition of an involved insurer will not jeopardize the financial stability of the insurers, or prejudice the interest of its policyholders or reinsurers;

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 95 percent of industry assets in the United States.

- An involved insurer will not have plans or proposals to liquidate another involved insurer, sell its assets, or consolidate or merge or to make any other material change in its business or corporate structure or management, that are unfair or unreasonable to policyholders, reinsurers or the public;
- The involved insurers will be solvent at the time of the transaction;
- The assets allocated to the involved insurers will not be, at the time of the transaction, unreasonably small in relation to the business and transaction;
- The terms of the transaction will not be unfair or unreasonable to any involved insurer's policyholders or reinsurers;
- The competence, experience and integrity of the persons who would control the operation of an involved insurer are such that it would be in the interest of the involved insurers' policyholders and reinsurers and the general public to permit the transfer;
- The transaction is not likely to be hazardous or prejudicial to the insurance-buying public;
- The interest of the policyholders of an involved insurer that may become policyholders of another insurer will be adequately protected; and
- The transaction is not being made for purposes of hindering, delaying or defrauding any policyholders or reinsurers.
- In determining whether to approve the transaction, the regulator must consider, among other things, all assets, liabilities, cash flows and the nature and composition of the assets proposed to be transferred including, without limitation:
 - An assessment of the risks and quality (including liquidity and marketability) of the proposed transfer portfolio, and
 - Consideration of asset/liability matching and the treatment of the material elements of the portfolio for purposes of statutory accounting.

Independent Experts Must be Utilized as Part of the Process

- An independent expert is required for all transactions and the expert's report must address:
 - Business purposes of the proposed transaction;
 - Capital adequacy and risk-based capital (including consideration of the effects of asset quality, non-admitted assets and actuarial stresses to reserve assumptions);
 - Cash flow and reserve adequacy testing (including consideration of the effects of diversification on policy liabilities);
 - The impact, if any, of concentration of lines of business following the transaction;
 - Business plans; and
 - Management's competence, experience and integrity.

Court Approval is Required for Insurance Business Transfer Transactions, but Not Necessarily for Corporate Division Transactions

- For insurance business transfer transactions, court approval is required.
- For corporate division transactions, court approval is not required, provided the Principles relating to public hearing, notice, and independent expert report(s) are included in the analysis.

Policyholders and the State-Based Guaranty Association System Should Be Protected

- Involved insurers must be licensed such that policyholders maintain guaranty association coverage in the same state in which they had it immediately prior to the transaction.

In addition, we have some specific comments and suggestions:

- On Pages 4 and 10, Arkansas has not yet enacted corporate division legislation, while Colorado, Georgia and Nebraska have.
- On Page 5, in the first paragraph, the types of runoff business mentioned in the third sentence should also refer to life insurance business.

- On Page 6, in the second full paragraph, it should read: “subject to approval of a court and an independent expert review”.
- On Page 9, in the third full paragraph, it should refer to “UK’s Part VII” instead of “UK’s Part IV”.
- On Page 10, the second paragraph should refer to an “independent expert report”.
- On Page 10, (2) should read: “the resulting insurer would not be eligible to receive a license in the same state(s) as the dividing insurer”.
- On Page 11, in the last paragraph, it should be noted that Colorado’s and Iowa’s corporate division statutes contain independent expert requirements.
- On Pages 13 and 14, it should refer to “guaranty associations” instead of “guarantee associations”.
- On Page 15, at the end of the second paragraph under “Separate Issues in Long-Term Care”, we suggest adding the following sentence: “That being said, there should be increased scrutiny for any block transfers, not just those relating to long-term care insurance, that are currently in a projected deficit situation”.
- On Page 17, the last paragraph should refer to “Allianz” instead of “Allainz”.
- On Page 18, in the Subgroup’s charge, the sentence “Complete by the 2021 Summer National Meeting” should be deleted.
- On Page 19, in the first paragraph under “Guaranty Association Issues”, it states that “A number of states – Connecticut, California, and Oklahoma – have enacted statutory solutions to these issues.” We are not aware of any such solutions and ask that this sentence either be clarified or deleted. In addition, it should mention that some states, such as Colorado and Illinois, and to a certain degree, Arkansas, require an assuming or resulting insurer to be licensed in the the same state(s) as the transferring or dividing insurer.
- On Page 19, under “Statutory Minimums”, we suggest adding the following after the first paragraph:
The American Council of Life Insurers (ACLI) has developed a set of Principles and Guidelines on Insurance Business Transfers and Corporate Division Legislation which includes the following principles:
 - Policyholders and other impacted stakeholders must have access to the process.
 - The regulatory review process must be robust.
 - Independent experts must be utilized as part of the process.
 - Court approval is required for insurance business transfer transactions, but not necessarily for corporate division transactions.
 - Policyholders and the state-based guaranty association system should be protected.
- On Page 19, at the beginning of the second paragraph under “Statutory Minimums”, it should read: “None of the restructuring mechanisms are based on an NAIC model.”
- On Page 20, after the first sentence that ends with “without a history with the insurer”, we suggest adding the following sentence: “Some stakeholders, however, believe that the expert should not be an employee of the department that is reviewing the proposed IBT or CD transaction and should be independent of the insurer or sponsor who is proposing the transaction.”

Thanks again for this opportunity to provide comments. If you have any questions, feel free to contact me at waynemehlman@acli.com or 202-624-2135.

Sincerely,

Wayne A. Mehlman

Wayne Mehlman
Senior Counsel, Insurance Regulation

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December 1, 2021

Re: NAIC Restructuring Mechanisms Working Group White Paper

Thank you for the opportunity to comment on the NAIC's Draft Restructuring Mechanisms White Paper. Swiss Re appreciates the ongoing effort the NAIC is making to identify and address the critical issues in the restructuring mechanisms arena. Our hope is that the White Paper serves as a basis for continuing discussions about these issues and that the NAIC devote time and effort to answering the questions identified and developing any guidance necessary to meet state insurance regulators' financial solvency and consumer protection objectives.

Overall, the White Paper accurately identifies areas in need of additional scrutiny and attention. In addition to the issues delineated, an assessment of the use of protected cells in connection with an insurance business transfer was previously deferred but is still among the issues to be reviewed by the Working Group.

As the NAIC has done with other issues, the creation of specific, technical ad hoc groups representing all stakeholders' interests could be a useful approach that would bring the necessary resources to aid in completing the NAIC's work. Ultimately, a more fulsome discussion of the issues and concerns, pro and con, will benefit regulators, policyholders, and insurers.

Swiss Re supports additional work being done in the areas identified in the White Paper – financial standards, guaranty funds, statutory minimum requirements, and licensure.

Financial Standards

The NAIC Restructuring Mechanisms Subgroup is already tasked with developing best practices to be used in considering the approval of proposed restructuring transactions. Providing clarity

on what decision-making criteria should be applied to insurance business transfers and corporate divisions will establish a known baseline on which all stakeholders can rely in evaluating the merits of any proposed transaction. In addition to the areas of reserves, capital, and liquidity already identified, the Subgroup may want to consider whether different standards should be applied to intragroup versus third-party transfers, including the role, if any, of third-party guarantees or reinsurance.

Guaranty Funds

In addition to perfecting guaranty fund statutory language to address the possibility of bulk orphan policyholders and clarify that no coverage will be eliminated, or new coverage created, as the result of a restructuring transaction, the NAIC should discuss whether guaranty fund considerations should also be evaluated in the costing/value of a transaction.

Statutory Minimum Requirements

When discussing and developing statutory minimum requirements, the NAIC should consider whether review procedures should differ by line or type of business – consumer P&C, life and health, specialty lines, reinsurance, commercial lines, surplus lines, etc. However, even if such differing requirements are warranted by line or type of business, the NAIC should consider whether statutory minimums should be applied to both insurance business transfers and corporate divisions with some degree of parity. Arguably regulators do not want to create a situation that encourages regulatory arbitrage between the two mechanisms, where a transaction is accomplished under one statute when it would not meet the statutory minimum standards under the other.

Licensure

Licensing of insurers seeking to engage in restructuring transactions should be considered in parallel with other issues. In addition to reviewing the appropriate application of licensing rules, the Working Group should consider licensure in the other workstreams involving financial standards, guaranty funds, and statutory minimums.

Swiss Re looks forward to the continuing dialogue on restructuring mechanisms. If you have any questions, please contact me.

Yours sincerely,



Matthew Wulf
Head State Regulatory Affairs Americas
Swiss Re

BY E-MAIL

December 1, 2021

Elizabeth Kelleher Dwyer
Glen Mulready
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group

Attention: Dan Daveline (ddaveline@naic.org)
Casey McGraw (cmcgraw@naic.org)

Re: Comments on Draft White Paper dated October 22, 2021 (“White Paper”)

Dear Superintendent Dwyer and Commissioner Mulready:

The undersigned companies support the important work being done by the Restructuring Mechanisms (E) Working Group and are grateful for the opportunity to deliver these comments on the draft White Paper. The United States insurance marketplace is highly competitive and we strongly believe that policyholders choose their insurers for very specific reasons, including the insurer’s financial strength and market reputation. A process that substitutes a new insurer for the client’s chosen insurer, without consent, is a significant event that needs to be approached with great respect and with the best interest of the policyholder in mind.

Need for Urgency on the Development of National Accreditation Standards.

As the White Paper highlights, several states have enacted insurance business transfer (“IBT”) and corporate division (“CD”) statutes. Indeed, some states have already approved transactions. As we have emphasized in our prior comment letters (attached for reference), IBT and CD statutes raise significant consumer protection and insurance regulatory framework issues that should be addressed in a nationally uniform manner before any additional transactions are approved, especially for long-duration business such as life, annuity, and long-term care insurance. As we have seen with Senior Health Insurance Company of Pennsylvania (“SHIP”, which was formed in 2008 as a result of what many consider to be one of the first US insurance restructuring transactions), even the best intentioned proposals that receive expert regulatory review have the potential to go awry. The fact is that isolating capital-intensive long-duration business that must endure many different economic cycles is inherently risky. Although best practices and accreditation standards cannot guarantee that every approved restructuring transaction will result in long-term success, the existence of those tools will help ensure consistency across all states, instill confidence in the process, and best ensure that only those proposals that have the highest likelihood of long-term success will be approved. Further, these tools will allow the state-based system to defend its processes if an insurer involved in a restructuring transaction ultimately becomes insolvent.

The Restructuring Mechanism Subgroup has been charged with developing best practices for approving restructuring transactions, including, among other things, the expected level of reserves and capital and the adequacy of long-term liquidity – topics not addressed in the White

Paper. Although COVID understandably delayed many work streams, we note that the initial deadline for this work was Summer 2021. We respectfully request that the White Paper make clear that the work of the Subgroup will be completed by the Summer 2022 NAIC national meeting so that these best practices can be implemented. Our prior comment letters include several specific recommendations for the Subgroup to consider.

It is also important to note that proponents of restructuring laws point to Part VII of the UK Financial Services and Markets Act of 2000 (“Part VII”), and its success to date, to support state adoption of IBT and CD laws, yet safeguards in US laws enacted to date often fall significantly short of UK Part VII. If IBT and CD laws are to be affected in the US, we agree that Part VII, in its entirety with all safeguards, should be used as a regulatory baseline for US laws. Accordingly, we further believe that the White Paper should recommend the development of accreditation requirements that substantially incorporate, at a minimum, the UK Part VII’s robust regulatory and court review process. Accreditation standards would provide uniformity, consistency, and less uncertainty for the industry and consumers, and would preclude forum shopping by insurers seeking approval for an IBT or CD transaction.

Focus on Potential Adverse Consequences to Policyholders of Long Duration Products and Development of Accreditation Requirements.

Although the White Paper discusses the advantages of restructuring to both companies and consumers, we believe that it should more fully discuss the potential adverse consequences to policyholders of longer duration personal lines insurance products and policyholders of companies that fund the guaranty association system. In a worst-case scenario, the acquiring or resulting insurer that accepts the existing liabilities would become insolvent while the original insurer remains strong. In that situation, there are several negative consequences that can be anticipated, and the White Paper should propose specific solutions for those consequences.

First and foremost, any insurer failure will be a new strain on the guaranty association system that consumes resources to both manage and fund the liabilities. The burden to provide these resources will fall on member companies of the guaranty associations and their policyholders. Accordingly, the possibility of those burdens should be acknowledged in the White Paper.

Further, many policyholders of a failed company will not receive the full benefits of their policies because coverage under guaranty association laws is limited. And, if the policyholders are not covered by the same guaranty association as they were prior to the restructuring transaction (and instead receive coverage via the insurer’s domestic guaranty association), the domestic guaranty association may not have the necessary assessment capacity to pay claims on a timely basis, nor offer the same level of guaranty association coverage as the previous guaranty association, further harming policyholders. Given these concerns, and the importance of a strong guaranty association safety net, the White Paper should take into account these strains and recommend an accreditation requirement that policyholders must have coverage under the same guaranty association both before and after the transaction, which will require licensing of the acquiring or resulting insurer in each of the jurisdictions where customers of the existing insurer reside.

If an acquiring or resulting insurer were to fail, it would be very damaging to the reputation of the state regulatory system, especially because of the strong public interest in the many issues involved with these transactions. Consequently, the transparency and public trustworthiness of the restructuring approval process must be as sound and defensible as possible. We believe that the White Paper should require restructuring laws to include certain safeguards as accreditation requirements to help instill public confidence in the process:

- For transactions under Part VII, the approving UK regulator has national jurisdiction. In addition, Part VII requires at least the implicit approval of several other national regulators before a transaction is approved. The US insurance regulatory framework, obviously, does not have a national regulator. Accordingly, to provide the equivalent of this protection in the US, every state regulator that has policyholders impacted by the transaction should be consulted so that all concerns are satisfactorily addressed before a transaction is approved.
- As required by Part VII, the US framework should require the use of an independent expert. Restructuring transactions are significant events, and having the independent expert report will be an important data point if a transaction goes awry many years into the future. We appreciate that some regulators have expressed concern with making this a mandatory requirement. We would like to provide additional context for our position:
 - The requirement to have an independent expert report does not speak to the qualifications of experts at the various insurance departments. We agree that, often, employees at the insurance department will have a better understanding of the insurer and its operations. And many departments have employees with the skillset to analyze the proposed transaction. The independent expert report does not, in any way, hamper or serve as a substitute for the authority and accountability of the insurance commissioner to make a final determination.
 - However, not all insurance departments are staffed at the same level or will necessarily remain at their current staffing in the future. The requirement to have an independent expert report puts all states on the same baseline standard regardless of how department expertise ebbs and flows over the years.
 - Additionally, an independent expert report that buttresses the insurance commissioner's findings provides additional public confidence in the outcome to consumers, creditors, and other regulators and interested parties, which will be critical if an acquiring or resulting insurer has solvency issues. Creating a process that results in heightened confidence is especially important because policyholders do not have the ability to opt out of an approved transaction.
- All impacted policyholders should receive notice of the proposed transaction, and the information the regulators and independent experts use to evaluate the transaction, along with the final reports, should be made publicly available. Although the insurer requesting the restructuring may want to hold information confidential, the public must

be able to understand the transaction and its potential impact. To inform decisions and allow for the opportunity to provide meaningful public comments, there must be public access to: (1) relevant financial analysis, including an independent expert report, (2) a business plan for the dividing/transferring and resulting/transferee insurers, and (3) information on the background and qualifications of controlling persons and management. This public transparency, which allows interested parties from varied backgrounds to review and comment, will be extremely valuable to reduce the risk of failure and to reduce the likelihood of process concerns if an acquiring or resulting company fails to perform as expected. If the requesting insurer does not want to make this information public, then it should not avail itself of the IBT or CD process.

- Given the extraordinary nature of these transactions, and the potentially significant impact on the established contractual rights of policyholders, court approval should be required. Approval should take place in two steps: (1) discretionary approval by the domiciliary insurance commissioner based on the information submitted regarding the proposed transaction, and (2) a court process leading to a formal judgment and a court order once statutory conditions are satisfied, giving all interested parties the benefit of an established legal process and the right to object. Court approval will further legitimize the approval of the transaction if an acquiring or resulting insurer becomes insolvent. Further, court approval may decrease the likelihood that these transactions face Constitutional scrutiny.

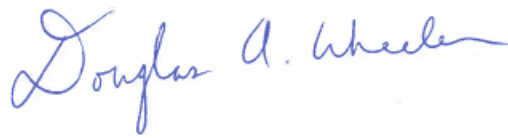
Long-Term Care Insurance Should Be Ineligible for Division or Transfer.

We appreciate that the White Paper devotes a section specifically to long-term care insurance. However, we would recommend that the White Paper specifically state that long-term care insurance should not be eligible for division or transfer. As we have highlighted in our prior comments, the history of reserve deficiencies, rate increases and, in some cases, insolvencies, associated with this product demonstrates the challenges of arriving at satisfactory valuations. Given this history and the long duration of the liabilities, it is clear to us that long-term care blocks should not be separated from other businesses that provide financial stability and diversification for the entity overall.

In addition, the riskiness of the investment strategy/assets backing these liabilities for transferred or divided businesses, particularly if used for long-term care insurance, is of significant concern. Many life/annuity/LTC insolvencies in the past were driven by liability issues, which tend to occur slowly over time. If business transfers or divisions lead to overly aggressive investment strategies, more future insolvencies could be driven by the assets – which could happen more quickly and as a result be much more impactful.

We appreciate the opportunity to comment. In the end, our comments attempt to drive towards one goal – ensuring that no policyholder should ever be left worse off after a restructuring transaction is completed. We would support a statement in the White Paper that, if there is any

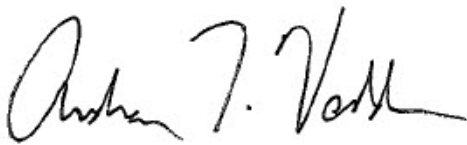
doubt about the ability of a transaction to live up to this standard over the long-term duration of the policies, the presumption should be to protect policyholders and not approve the transaction.



Douglas A. Wheeler
Senior Vice President, Office of Governmental Affairs
New York Life Insurance Company



Kevin L. Howard
Vice President, Deputy General Counsel & Head of Government Affairs
Western & Southern Financial Group



Andrew T. Vedder
Vice President – Enterprise Risk Management
The Northwestern Mutual Life Insurance Company



Dominick M. Ianno
Head of State Government Relations
Massachusetts Mutual Life Insurance Company

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BY E-MAIL

August 14, 2019

Elizabeth Kelleher Dwyer
Buddy Combs
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group

Attention: Dan Daveline (ddaveline@naic.org)
Casey McGraw (cmcgraw@naic.org)

Re: The Restructuring Mechanism Working Group's Charges

Dear Superintendent Dwyer and Deputy Commissioner Combs:

The undersigned companies support the important work being done by the Restructuring Mechanisms (E) Working Group and are grateful for the opportunity to deliver these comments.

Division and Transfer Laws Have Serious Implications that Demand Procedural Protections

As life insurers, the financial security that we provide to our policyholders is often delivered gradually, over decades. Consumers have this long-term promise in mind when they enter into life insurance, annuity, and long-term care insurance contracts, and expect that the company that sold them a policy will stand behind it over the years to come. Life insurers, knowing that their obligations will last decades, manage their assets and liabilities conservatively to ensure they will maintain the financial strength needed to fulfil their promises. And the guard rails of our state insurance regulatory framework and backstop provided by our guaranty association system have developed over the years to be efficient and effective counterparts to a system where life insurers remain obligated for their promises.

Insurance business transfer and insurer corporate division statutes have the potential to turn this paradigm on its head. If consumers no longer can expect that the company that sells them their policy will stand behind it, will they trust life insurers to meet their financial security needs? If life insurers anticipate that they have an out for unsuccessful business, will they have less incentive to exercise their traditional conservatism in writing and managing long-term business? And, what strains and gaps might appear in our insurance regulatory system and guaranty backstop if life insurer liabilities become "fungible"?

Put another way, life insurers have options to transfer their policyholder contracts without transfer and division statutes. Those options protect policyholders by requiring a life insurer that wants to be relieved of its promises to give the policyholder the opportunity to say "no". Removing this protection not only disadvantages affected policyholders, it raises the broader threats to our life insurance marketplace and regulatory system described above.

For these reasons, we urge extreme caution when considering laws that permit insurers to divide or transfer life, annuity, or long-term care contracts without policyholder consent. A prior letter

from New York Life and Northwestern Mutual to the Restructuring Mechanisms (E) Subgroup recommended principles for the regulatory review of proposed divisions or transfers. That letter (attached here for the Working Group's reference) focused on financial standards, consistent with the charges of the Subgroup. Given the Working Group's process-oriented charges, this letter elaborates on procedural safeguards we believe should be included in any such laws. We believe these procedural protections serve the principle that policyholders should never be left worse off by a division or transfer.

Our procedural recommendations follow four themes: (1) protecting policyholders in other states; (2) notice and transparency; (3) two-step approval process; and (4) ensuring uniform application of procedural protections. Robust financial standards can only succeed if they are accompanied by equally robust procedural safeguards. Procedural protections to reduce the potential for harm are particularly important because division and transfer laws do not include an effective proxy for policyholder consent, such as an "opt-out" right or a requirement for a supermajority vote by policyholders.

Protecting Policyholders in Other States

Although the dividing or transferring insurer may be licensed in multiple states, transfer and division laws have been silent regarding the process for bringing a division or transfer into force in states outside of the approving state. This omission creates significant uncertainty and magnifies the risk of adverse guaranty association impacts.

Any such law should require notice to the primary insurance regulator in each state with residents holding insurance contracts of a dividing or transferring insurer. Consultation with each foreign commissioner should be required, and each affected commissioner should have a right to object to the transaction, with a robust process to address objections. Policyholders should be able to participate and communicate regarding the transaction through their local insurance commissioner.

Lastly, the law should require that the resulting or transferee insurer be licensed in each state in which policyholders reside. This requirement is necessary to ensure that guaranty association coverage is provided directly in all states in which insureds reside rather than as orphan coverage provided by the domestic state guaranty association. The future of the state guaranty associations could be in jeopardy without this change.

Notice and Transparency

Policyholders and others affected by a proposed division or transfer must receive adequate information and the opportunity to make their voices heard. Some division and transfer laws provide even less public access to information than required in connection with a Form A filing. Public hearings should be required prior to commissioner or court action. Any division or transfer law should require delivery of a notice in sufficient detail to inform decision-making, well before any hearing or action, directly to all policyholders, agents, brokers, reinsurers, creditors, regulators and state guaranty associations of the dividing/transferring and resulting/assuming insurers.

Likewise, confidentiality provisions must balance the insurer's desire to safeguard competitively sensitive information with the public's interest in understanding the transaction and its potential impact. To inform decisions and allow for the opportunity to provide meaningful public comments, there must be public access to (1) relevant financial analysis, including an independent expert report, (2) a business plan for the dividing/transferring and resulting/transferee insurers, and (3) information on the background and qualifications of controlling persons and management.

Two-Step Approval Process

Unlike Part VII transfers in the United Kingdom and insurance business transfer legislation that has been enacted in the United States (e.g., in Oklahoma), insurer corporate division statutes enacted to date have not required court approval. Given the extraordinary nature of these transactions, and the potentially significant impact on the established contractual rights of policyholders, court approval should be required.

Approval should take place in two steps: (1) discretionary approval by the domiciliary insurance commissioner based on the insurer's application and the public hearing, and (2) a court process leading to judgment and a court order once statutory conditions are satisfied, giving all interested parties the benefit of an established legal process and the right to object.

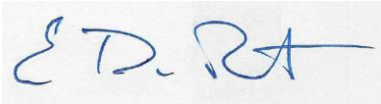
Ensuring Uniform Application of Procedural Protections

We have two recommendations to ensure that these important procedural protections are applied uniformly to protect policyholders. First, we suggest they should be set forth directly in statute, rather than being left to implementing regulations or to a set of best practices or guidance. Second, as with the standards for review addressed in the attached letter to the Subgroup, we believe it is essential for the NAIC to establish strong, minimum procedural requirements as accreditation standards. The strength of the procedural safeguards applied to division and transfer transactions will contribute importantly to the solvency implications of those transactions and would eliminate the threat of forum-shopping. And maintaining uniform state laws that protect solvency is the essential purpose of the NAIC's accreditation system.

* * *

We appreciate the opportunity to comment on this important topic. Please let us know if you need any additional information or would like to discuss our comments.

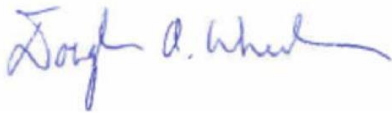
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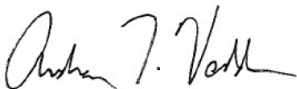
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BY E-MAIL

April 26, 2019

Doug Stolte
David Smith
Co-Chairs, NAIC Restructuring Mechanisms (E) Subgroup

Attention: Dan Daveline (ddaveline@naic.org)
Robin Marcotte (rmarcotte@naic.org)

Re: The Restructuring Mechanism Subgroup's Charges

Dear Messrs. Stolte and Smith,

The undersigned companies are grateful for the opportunity to comment on the charges of the Restructuring Mechanisms (E) Subgroup.

In general, we strongly support the subgroup's charges. While we endorse all the charges, we ask that the subgroup give special emphasis to the development of uniform minimum standards for restructuring mechanisms.

The Importance of Strong, Uniform Standards for Divisions and Business Transfers

Several states have recently enacted new "division" and "insurance business transfer" laws that allow insurers to transfer and novate business without policyholder consent. While these laws offer new flexibility to companies and regulators, they also introduce new dangers for policyholders and the state-based system of insurance regulation. Because we believe there are existing alternatives that provide sufficient flexibility in nearly all circumstances and because we want to maintain policyholder protections, our strong preference is against the enactment or use of division and insurance business transfer statutes for life, annuity or health insurance. However, recognizing that regulators may wish to find a way to permit, in limited circumstances, transactions that are beneficial to all policyholders, our comments in this letter address the minimum standards required if life, annuity or health divisions or transfers are to be considered.

Unlike traditional indemnity reinsurance, where the original insurer remains liable, these new structures allow the original insurer to extinguish liability to policyholders. We have grave concerns about several aspects of these new laws:

- There is no nationally uniform financial standard or actuarial level of confidence for regulators to apply when reviewing the financial strength of a business included in a division or transfer. A strong, nationally uniform standard is necessary to ensure that policyholders are protected against the risk of insolvency. This standard should become an NAIC accreditation requirement. The development of this standard should be a critical area of focus for the subgroup.

- In some states, division and insurance business transfer laws are open to any line of business, even when it is difficult or impossible to arrive at a credible long-term valuation of the business involved. For example, a division could allocate distressed, hard-to-value long-term care liabilities to a newly created splinter company. In this scenario, healthier business and associated assets might remain with the original company, endangering policyholders relegated to the splinter company.
- Some laws also allow the creation of monoline insurers, potentially depriving policyholders of the benefits of diversification without their consent.
- Some laws also allow the division of a multi-state insurer into a splinter company licensed in a single state, potentially overwhelming the state’s domestic guaranty association in the event of insolvency.
- Some laws sanction the use of non-admitted assets to support policy liabilities.
- Several laws lack other important procedural and substantive safeguards like public notice, requirements to consult with other interested states, independent expert review, a hearing or court process, and requirements to assess corporate governance and owner qualifications.

At their worst, these new laws could enable transactions that enrich shareholders at the expense of policyholders, guaranty associations and the reputations of both the industry and state-based system of insurance regulation. Effective, nationally uniform oversight of solvency has long been a hallmark of state-based insurance regulation. It is essential that the NAIC act to preserve this strength of the state-based system. These new transaction structures must not be allowed to undermine fundamental solvency regulation and policyholder protections. We expect that the subgroup’s work will be a critical part of this effort.

In the discussion below, we suggest several principles that should govern regulatory review of proposed division and business transfer transactions.

Policyholders Should Never Be Left Worse Off

Regulators should never approve a division or insurance business transfer if it would leave any class of policyholders worse off. Instead, policyholders should be left in the same or a better position after completion of the transaction. Before the regulator signs off, a valuation should be undertaken by an expert to establish at a high level of confidence that policyholders will experience no adverse effects. The expert should be independent of any influence from the companies involved.

This approach would align the U.S. regulatory framework with well-established international precedents like the United Kingdom’s “Part VII” business transfer regime. A focus on policyholder protection has been fundamental to the success of the U.K. regime. In a Part VII transaction, the regulator must provide a detailed report to the court and certify the solvency of the resulting entity. An independent expert must also provide a detailed report. When there are

questions about the strength of the business involved, the U.K. regulators and the court will normally insist on ensuring that the business is transferred to a stronger insurer, not isolated in a weaker insurer.

Some state laws provide that a regulator should approve a division or business transfer if there is no “material adverse effect” on policyholders. This standard falls far short of what should be required. The standard endorses policyholder harm so long as the harm does not rise to a vaguely defined materiality threshold. For example, a transaction might accomplish nothing more than benefit shareholders at the expense of policyholders. Although the damage to policyholders may not rise to the level of a “material adverse effect,” the law should not call on the regulator to approve unless the effect on policyholders is neutral or there is some expected policyholder benefit.

No Monolines

Regulators should never permit a transaction that transforms a diversified insurance company into one or more monoline insurers, especially when the transaction involves long-duration life, annuity or health insurance business. It makes little sense to deprive policyholders the benefits of diversification. The wisdom of this principle is borne out by the recent experience of carriers like Penn Treaty that concentrated their offerings in long-term care insurance.

Hard-to-Value Business Like LTC Should Be Ineligible for Division or Transfer

It is important that standards for approval acknowledge fundamental differences among lines of business. A standard that may be appropriate for short-duration commercial property and casualty risks is likely to need significant adjustments before it can be applied successfully to long-duration retail life, annuity and health businesses.

As a threshold matter, some lines of business are best excluded from division and business transfer transactions. Long-term care offers the best example. The history of reserve deficiencies, rate increases and, in some cases, insolvencies, associated with this product demonstrates the challenges of arriving at satisfactory valuations. Given this history and the long duration of the liabilities, it is clear to us that long-term care blocks should not be separated from other businesses that provide financial stability and diversification for the entity overall.

The experience of long-term care leads us to suggest the following possible approach to similar long-duration life and health businesses: for each such business, the regulator should be able to confirm the sufficiency of assets supporting the liabilities based on a reasonable valuation relative to an industry standard of experience. To make this determination, the Commissioner should first compare the valuation of liabilities to what the valuation would be using standardized valuation tables adopted by the NAIC for each line of business. If such standardized valuation tables are not available, the business should not be eligible for division or transfer.

Require Strong Financial Standards and Stress Testing for Long-Duration Business

Even if a long-duration life or health business is eligible for inclusion in a transaction, regulators will still need a robust framework to evaluate the long-term solvency of the business. Regulators should consider the following principles in the development of this framework:

- For long-duration life, annuity and health business, regulators should start with a focus on policy reserves, and should require stress testing of reserves at a “severely adverse” level. If reserves are not subjected to a high level of stress testing, a division or transfer may appear to leave a business adequately capitalized at the time of the transaction. However, the picture can change over time as long-term experience diverges from assumptions. Again, consider the recent experience of long-term care.
- Starting from a basis of reserves meeting a “severely adverse” standard, formulaic application of risk-based capital will, appropriately, result in a higher level of required capital for the business affected by the division or transfer. However, while risk-based capital may provide a useful starting point to establish capital requirements, it is not designed to measure relative financial strength and therefore would be insufficient on its own to determine the minimum required financial position of a transferred business.
- Instead, in addition to risk-based capital, regulators should explore capital standards for long-duration life and health business that are based on a defined ratio of asset adequacy standards. Capital standards based on this type of cash flow projection technique can help ensure that enough capital is held in a transferred business, supplementing the existing risk-based capital framework.
- Regulators should establish a confidence level based on the greatest present value of accumulated deficiencies over a long-term horizon across stochastic scenarios. The confidence level should be set at a standard that assures solvency over the life of the business so as to provide a robust backstop to the combination of reserves established to meet a “severely adverse” standard and risk-based capital.
- Prescribed assumptions should be included in capital calculations to avoid the manipulation of capital thresholds.
- Actuarial reserve and capital calculations should be performed by an expert that is independent of the insurance companies involved.

Use Uniform NAIC Valuation and Accounting Standards

When evaluating the solvency impact of a proposed transaction, regulators should not give credit for non-admitted assets. Decisions about these transactions should start from the NAIC’s uniform statutory valuation and accounting rules.

The possibility that non-admitted assets might be used to back reserves and capital in these transactions is deeply troubling for the following reasons:

- Most non-admitted assets are classified that way because they are not readily available to satisfy policyholder claims.
- Put another way, many non-admitted assets are not readily marketable or do not produce future cash flows.
- Non-admitted assets can include anything a company owns, from illiquid and contingent letters of credit to office furniture, equipment, hardware and software.
- It makes sense to exclude these items from the pool of assets an insurance company can count toward the payment of future claims, as they are illiquid, unlikely to retain their value, and generally do not produce additional income.
- The distinction between admitted and non-admitted assets should not change in the context of a division or business transaction. In fact, given the risk that companies will use restructuring mechanisms to wall off distressed businesses, it is especially important that regulators scrutinize the quality of the assets involved.

Minimum Requirements Should Become NAIC Accreditation Standards

Ultimately, it will be essential that the NAIC establish strong minimum requirements for these transactions as accreditation standards. The strength of state-based system depends upon the integrity of solvency regulation across the country. Regulators will need to rely on their counterparts in other states to ensure that transferred businesses are uniformly supported by sufficient reserves and capital, and are run off in a solvent manner. Companies should not be allowed to arbitrage their way to diminished solvency oversight by choosing one domicile over another.

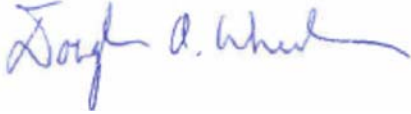
Other Procedural Safeguards Are Also Important

In this letter, we have focused primarily on the financial standards that should apply to divisions and insurance business transfers. We expect those standards will be a significant focus of the subgroup. However, there are other procedural safeguards that are equally important for these transactions. For example, since policyholders lose their normal right to consent, court oversight and approval should be required. Policyholders and other affected parties should always be given notice, access to all information needed to meaningfully review a proposed transaction, and an opportunity to be heard in court. Also, the process should require approval or non-objection of all affected states and the resulting entities should be licensed in all states needed so as not to impair policyholders' access to their state guaranty associations. We believe these protections should also be considered for accreditation requirements. We look forward to providing our views on this and other procedural safeguards to the Restructuring Mechanisms (E) Working Group.

* * *

We appreciate the opportunity to comment on this important topic. Please let us know if you need any additional information or would like to discuss.

Sincerely,

A handwritten signature in blue ink that reads "Douglas A. Wheeler". The signature is fluid and cursive, with the first name being the most prominent.

Douglas A. Wheeler
Senior Vice President, Office of Governmental Affairs
New York Life Insurance Company

A handwritten signature in black ink that reads "Andrew T. Vedder". The signature is cursive and somewhat stylized, with the first name being the most prominent.

Andrew T. Vedder
Vice President – Solvency Policy & Risk Management
The Northwestern Mutual Life Insurance Company

December 1, 2021

Elizabeth Dwyer
Superintendent of Insurance
Rhode Island Department of Insurance
1511 Pontiac Avenue
Cranston, RI 02920

Glen Mulready
Insurance Commissioner
Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105

Dear Superintendent Dwyer and Commissioner Mulready:

We are privileged to serve as counsel to ProTucket Insurance Company (“ProTucket”), a Rhode Island insurer formed to assist in the assumption and restructuring of legacy books of insurance, whether by traditional loss portfolio transactions or by future mechanisms that may result from the study undertaken by the NAIC Restructuring Mechanism Working Group (“RM Working Group”).

We appreciate the opportunity, on behalf of our client, to comment upon the draft White Paper dated October 22, 2021 exposed for comment by the RM Working Group on the subject of Insurance Business Transfers (“IBTs”) and insurer Corporate Divisions (“CDs”) (together, restructuring mechanisms [“RMs”]). We understand that in a related development the Property and Casualty Risk Based Capital Working Group (“RBC Working Group”) issued draft comments dated October 25, 2021 (attached) on Risk Based Capital (“RBC”) (the “RBC Memo”) as applied to run-off insurers.

We respectfully submit comments on the White Paper and the RBC Memo in the form of suggestions, set forth below, that the RM Working Group adopt charges for 2022 to elaborate upon and add to those found in the 2022 Proposed Charges with the objective of formulating a comprehensive evaluation of the issues, risks, benefits, timing and prospects involved in adopting RMs in the U.S. insurance market.

Specifically, we suggest that the RM Working Group:

1) Study and report upon the financial standards to apply to RMs:

a) Intra-Group vs. Third Party Transactions.

Recent RM transactions have occurred mainly between affiliated insurers. Regulators and the market are generally more comfortable with transactions where the ultimate controlling party after the transaction remains the same. (In two transactions noted in the White Paper, the post-transfer liabilities in the Enstar IBT and the AllState CD remained within the same group.) These transactions may be enhanced by intra-group guarantees or reinsurance.

Third party transactions that do not have the benefit of intra-group affiliations may nonetheless achieve similar results with strong third party guarantees or reinsurance.

We suggest that the RM Working Group consider the differences between intra-group and third party RM transactions and specifically address the standards that should apply to such transactions.

b) Comparison of Financial & Regulatory Review Procedures.

Domestic state regulators regularly review insurer transactions that affect policyholders in other states, including acquisitions (Form A), dividend distributions, reinsurance protection, affiliate transactions, investment restrictions, mergers and other issues of corporate finance and governance. Many of these domestic state regulatory procedures are governed or influenced by NAIC standards and some involve some coordination among the states. RM transactions could pose similar questions involving how domestic state actions might affect policyholders in other states.

We suggest that the RM Working Group specifically analyze these and similar financial and regulatory standards and procedures present in law and NAIC standards to compare how domestic regulators affect policyholders in sister states and to review proposals that might achieve similar results in RM transactions.

2) Possible Use of Supplemental Financial Tools.

In light of the novelty of RMs in the U.S. insurance market, it may be advisable to consider different or modified analytical tools to evaluate RM transactions, such as using longer term projections, imposing capital surcharges onto the assuming insurer or its parent, and conducting enhanced periodic oversight.

We suggest that the RM Working Group address this subject with specificity to formulate a variety of possible novel tools or methodologies to evaluate RMs.

3) Make a referral to the Capital Adequacy Task Force requesting specific guidance as to:

a) Definition and Licensing of Run-off Insurers.

The RBC Memo offered a suggestion to define “runoff” insurers so as to preclude insurers that may assume more than one book of discontinued business or that have any amount of continuing business. Such a definition would preclude those insurers that may assume more than one book and those that may have a de minimis amount of in-force business. Without prejudgment of the issue, it would appear that a more fulsome review of the options and consequences of such a definition would be important to the development and ultimate operation of a possible RM market. The market options available to those who wish to transfer books of business, the costs associated with such transactions and the profitability and financial viability of those who may wish to assume such business could all depend on such a definition. Of additional concern is that some states decline to license and may, in some cases, threaten the licensed status of runoff insurers. Creating difficulties for the licensing of runoff insurers can call into question protections for policyholders and oversight by regulators over such insurers.

We suggest that the RM Working Group re-refer this specific issue to the Capital Adequacy Task Force requesting reconsideration of the definition of a runoff insurer to allow for greater flexibility and practicality, including allowing such insurers to assume more than one book of business and to maintain a de minimis amount of in-force business. Insofar as some states may currently decline to license insurers in runoff, we suggest that the RM Working Group also refer the issue of the licensing of such insurers to appropriate NAIC committees with the purpose of liberalizing the standards for licensing.

b) Possible Reformulation of RBC.

We understand that the RM Subgroup has not yet completed its review of financial best practices for RMs, and consequently the White Paper does not yet address these issues. Nevertheless, we note that some consideration has already been given to some minor changes to the RBC formula (see the above-mentioned RBC Memo). However, we would posit that the RBC formula was not developed to consider the unique characteristics of insurers in run-off. A couple of examples illustrate this point: RBC factors when applied to RMs may result in distortions that fail to capture the true risk of the transaction to the assuming insurer, and also, insurers assuming business under a RM will not have all of the risks subject to the covariance formula. Consequently, the resulting capital requirements under the RBC formula may be overstated.

We suggest that the RM Working Group make a referral to the Capital Adequacy Task Force requesting that the RBC formula be reviewed to evaluate whether it fairly reflects the risk profile of runoff insurers, specifically in the context of possible RM transactions.

c) Possible Suspension of RBC for RMs.

We understand that considerable timing and policy issues may postpone revisions to the RBC factors.

Under the circumstances, the RM Working Group should request that the RM Subgroup consider whether it would be appropriate to suspend application of the RBC formula (or a portion thereof) in the determination of the capital adequacy of runoff insurers. The RBC laws in most, if not all states, allow the chief insurance regulator latitude in applying the RBC requirements. Consequently, guidance with regards to suspension or easing of those statutory RBC requirements would not necessarily violate financial best practices.¹

4) Make a referral as to financial aspects of U.K. Part VII:

More than 300 Part VII RM transfers have been effected with success in the U.K. over the last 20 years. Solvency II financial standards have been applied to these transactions without controversy. A deeper understanding of the differences between those standards and applicable U.S. financial standards could help U.S. regulators to evaluate the prudential issues in U.S. RMs.

We suggest that the RM Working Group make a referral to appropriate NAIC committees to report to the RM Working Group on the salient differences between Solvency II and U.S. insurer solvency standards as applicable to run-off insurers and RMs.

5) Make a referral as to regulatory standards for RMs:

Currently, approximately four states have adopted IBT statutes and a small number have adopted CD statutes. Although a few transactions have been effected under each of these types of RM statutes, most states have yet to adopt such legislation and still remain unfamiliar with the concept, process and implications of these transactions. Uniform standards for RMs would enhance regulatory and market understanding of RMs, and would assure sister states that requisite standards are being followed.

Guidance in the NAIC Financial Analysis Handbook, even short of a Model Law at the moment, may be sufficient to adopt these nationwide standards. Adopting such guidance in an existing NAIC Handbook, such as the Financial Analysis Handbook, may have the result of making such guidance an accreditation standard. Such guidance should include specifics, such as whether a court must participate in the proceeding (as is the case with IBTs, but not CDs), the use of independent experts, and the required degree of input or form of input from guaranty associations,

¹ Although the suspension of RBC requirements was mentioned in a slightly different context, it is interesting to note that a similar suggestion was made in the 1997 Liability Based Restructuring White Paper.

other regulators and affected parties.

We suggest that the RM Working Group make a referral to appropriate NAIC committees to adopt such standards and to do so, if possible, by way of a modification to the Financial Analysis Handbook, if not a Model Law.

6) Study and report upon distinctions by lines of insurance:

Regulators and market participants have commented extensively on the distinctions among lines of insurance that may become subject to RMs. Despite the fact that some RM statutes are not limited by line of insurance or nature of coverage, most regulators agree that RMs may not be appropriate for every line or type of insurance. Among the many relevant distinctions are property/casualty versus life or other long-term products, long-term care, personal lines versus commercial lines, admitted versus surplus lines or reinsurance, workers compensation and numerous others, in addition to the length of run-off or whether run-off liabilities need to be an essential element of the RM transaction. Different analysis may be necessary for these variations.

A study of these variations would be important to focus regulatory attention on those RMs that would be most useful, easiest to regulate and deserving most study. We note that the draft White Paper concludes that long-term care is not likely to be a line of business that is appropriate for RMs.

We suggest that the RM Working Group specifically address the distinctions among the lines and type of insurance to help establish priorities and focus the group's future work.

7) Make a referral as to guaranty association coverage for RM transactions:

There appears to be substantial consensus among regulators and market participants that whatever the form of RM and whoever the participants, there is no justification for policyholders to be deprived of guaranty fund protection or to gain a guaranty fund windfall as a result of a RM transaction. We have not performed a 50 state survey on the subject and cannot state whether all states have statutes that would assure a neutral result.

We suggest that the RM Working Group make a referral to appropriate NAIC committees to review and propose for adoption appropriate NAIC model laws to clarify that no guaranty fund coverage would be lost or changed and that new coverage would not be created as result of a proposed transaction.

8) Make a referral as to application of Assumption Reinsurance laws to RMs:

We are aware that a number of states have raised the question of whether the NAIC Model Assumption Reinsurance Law or derivative provisions under state law would have the effect of prohibiting IBTs (and perhaps CDs) from becoming effective

for certain policyholders in their states without complying with provisions of those laws.² While RM transactions by their terms would obviate the basis upon which such laws could prohibit these transactions³, the assertion of this prohibition can pose an obstacle for those who wish a “clean” transfer without objection. While the NAIC cannot enforce its interpretation of state laws upon the states, we would urge the appropriate committee at the NAIC or NAIC staff to clarify this issue as best it can, especially in respect of the NAIC Model Assumption Reinsurance Law. Clarifying its position on the Model law would help to eliminate confusion and discordant positions among the states on the laws that derive from the Model.

Although we believe that the Model does not effectively prohibit RMs as described above, if the appropriate NAIC committee or NAIC staff were to disagree, we would then urge the RM Working Group to refer the matter for amendment of the Model. We believe that a different result would be contrary to the very objectives of the RM Working Group.

We suggest that the RM Working Group make a referral to appropriate NAIC committees and/or the relevant NAIC staff to consider the application of the Model Assumption Reinsurance Law to IBTs and CDs to policyholders, specifically policyholders with insurance issued on an admitted basis. And, in the event that the determination resulting from such a referral were to indicate that the Model Law would be applicable, we suggest that the referral be amended to seek a revision to the Model to indicate that it would not be applicable.

9) Study and report upon legal recognition of RMs among the states:

ProTucket has previously supplied the RM Working Group with a White Paper (dated March 27, 2019, entitled “ProTucket Insurance Company Paper on Insurance Business Transfer Plans Under Rhode Island Law” [the “ProTucket White Paper”]) settling forth the legal basis for recognition of IBTs among the states. While no legal position can foreclose challenges, it would be helpful for the RM Working Group to report upon its working assumptions on the legal framework of RMs. In addition, nationwide standards for RMs, to be established as suggested above, could assist in the process of clarifying the legal validity of RMs.

We suggest that the RM Working Group specifically study and report upon its working assumptions on the legal framework of RMs and whether it will support a nationwide standard to advance its position on these issues.

² Provisions of the Model and derivative laws could effectively prohibit IBTs (and possibly CDs) by calling for an approved novation procedure that could require insurers to obtain approval to notify and obtain consent from policyholders, specifically those with admitted policies, in order to effectuate an assumption of their policies by the assuming insurer.

³ Both the IBT and CD laws are intended to effect a change in corporate structure that, by operation of law, replaces the obligor under the insurance (or reinsurance) contract. Consequently, although frequently spoken of as a statutory novation, the transfer is not a novation requiring consent of the insured (reinsured).

Elizabeth Dwyer
Glen Mulready
December 1, 2021
Page 7

10) Consider adopting interim guidance:

In light of the many issues before the RM Working Group and the limitations of time and resources and the interest and pace of developments in the market, it may be prudent to plan for interim measures pending development of final guidance.

We suggest that the RM Working Group adopt interim guidance on the suggestions raised above pending adoption of final guidance.

11) Review the issue of protected cells in the context of RMs:

Pursuant to the 2021 Adopted Charges and 2022 Proposed Charges, the RM Working Group is to identify and address the legal issues associated with restructuring insurers using protected cells. Those issues were addressed in the ProTucket White Paper in 2019, but were not addressed in the White Paper. The ProTucket White Paper also address the financial and accounting issues associated with restructuring insurers using protected cells.

We request that the RM Working Group include a discussion of the relevant issues related to protected cells in the context of RMs, including both legal and financial and accounting issues. Furthermore, if the RM Working Group decides that these protected cell issues should be referred to another committee of the NAIC, we would be pleased to further contribute to this subject.

We thank the RM Working Group for considering these suggestions and are available to answer questions or to supplement this submission at your convenience.

Sincerely,



Robert A. Romano

cc: Dan Daveline, Director, Financial Regulatory Services, NAIC
Casey McGraw, Legal Counsel, NAIC
Marvin Mohn, ProTucket Insurance Company
Al Miller, ProTucket Insurance Company
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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: David Smith (VA) and Doug Stolte (VA), Co-Chairs of the Restructuring Mechanisms (E) Subgroup
Judith L. French (OH), Chair of the Capital Adequacy (E) Task Force

FROM: Tom Botsko (OH), Chair of the Property and Casualty Risk-Based Capital (E) Working Group

DATE: Oct. 25, 2021

RE: Response to Request for Input Regarding Runoff Companies

The Property and Casualty Risk-Based Capital (E) Working Group formed a small ad hoc group to discuss this topic and try to determine the best course of action. The Restructuring Mechanisms (E) Subgroup requested that the Working Group take the lead in addressing the charge to “consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. “

After several discussions about what adjustments should be made to the risk-based capital (RBC) formula, the ad hoc group concluded that the best course of action is to monitor these companies through the state analysis and exam team functions. The characteristics and financial conditions of these runoff companies are very diverse, and it would be difficult to incorporate these varied characteristics into one adjusted formula. Many international countries monitor these companies through the analysis and exam processes and do not have a separate RBC formula.

Of the 2020 RBC filers, we identified 111 companies out of 2,477 that have the characteristics of a runoff company. Most of these companies have an RBC ratio greater than 300%. Five are below 200%.

During a series of discussions, the ad hoc group agreed that a runoff company, voluntary or involuntary, should include the following characteristics: 1) no renewing of policies for at least 12 months; 2) no new direct or new assumed business; and 3) no additional runoff blocks of business. In addition, the amount of renewal premium to reserves has also been identified as a characteristic of these types of companies when this ratio is de minimis.

The ad hoc group also recommends that a general and RBC interrogatory be added for the purpose of identifying a runoff company. The domiciliary state shall have the ability to verify the interrogatory response during the annual company financial analysis process.

As the ad hoc group considered various types and conditions of runoff companies, it became apparent that while many of these companies share the characteristic of very long tail liabilities, there are other characteristics of these companies that are so diverse that it made it difficult to summarize them into their own RBC formula.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The ad hoc group reviewed several international perspectives of runoff companies. The international treatment of runoff companies is handled through the Analysis and Exam Teams. The ad hoc group agrees that a similar treatment of runoff companies is warranted.

The ad hoc group has some recommendations for the Working Group regarding the RBC instructions, specifically to the runoff companies. These include the following:

- Remove the Trend Test from the RBC calculation. These are runoff companies, and the possible retrospective premium should not complicate the already diverse situation.
- Remove the charge for premium growth if the company is no longer writing business.
- Remove R_{cat} from the formula. Because one of the characteristics of a runoff company is to not have written any new business for at least 12 months, we believe this short-term liability risk is not warranted.

As the ad hoc group shares its findings with the other two RBC working groups, we expect to hear other perspectives regarding the unique conditions of runoff companies from the Life Risk-Based Capital (E) Working Group and the Health Risk-Based Capital (E) Working Group.

Please contact Eva Yeung, NAIC staff support for the Property and Casualty Risk-Based Capital (E) Working Group, at eyeung@naic.org with any questions.

Cc: Robin Marcotte; Dan Daveline; Jane Barr; Eva Yeung

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JOINT SUBMISSION OF NOLHGA AND NCIGF TO NAIC'S RESTRUCTURING MECHANISMS WORKING GROUP REGARDING THE RESTRUCTURING MECHANISMS WHITE PAPER DRAFT

December 1, 2021

The National Organization of Life & Health Insurance Guaranty Associations ("NOLHGA") and the National Conference of Insurance Guaranty Funds ("NCIGF") commend the Restructuring Mechanisms Working Group's (the "Working Group") efforts in preparing the draft Restructuring Mechanisms White Paper (the "White Paper"). NOLHGA and NCIGF appreciate the Working Group's recognition of the importance of ensuring that the guaranty association/fund protection a policyholder would have had prior to a restructuring transaction is preserved when the transaction is consummated.¹ We write to offer high-level observations on the White Paper for the Working Group's consideration, along with a few technical notes related to the differences between the life and health guaranty associations and the property and casualty guaranty funds, which are relevant to the effort to preserve guaranty protection.

Overarching Comments: Importance of Maintaining Policyholder Protections

NOLHGA and NCIGF remain neutral on whether restructuring statutes – either insurance business transfer ("IBT") or corporate division ("CD") statutes – should be adopted. We do, however, emphasize that the enactment of an IBT or CD statute should not affect important policyholder protections that existed prior to the transaction. As noted above and recognized by the White Paper, the policyholder protection of guaranty system coverage should not be lost, reduced, created, or otherwise changed as a result of a restructuring transaction. How this standard is satisfied likely differs depending on the type of business involved in the restructuring transaction (see below for additional detail).

The Restructuring Mechanisms Subgroup's work to develop standards for the review of restructuring transactions and identify *best practices for the ongoing monitoring of companies post-restructuring* also will be important to ensure that policyholders continue to receive the protection of robust solvency regulation. We applaud the recognition of this fact through the subgroup's existing charges and encourage continued focus on coordinated solvency regulation through FAWG, R-FAWG, and similar mechanisms.

¹ The White Paper currently provides, "In order to uphold the stated declaration that restructuring should not materially adversely affect consumers, guaranty association coverage should not be reduced or eliminated by the restructuring." White Paper, pg. 13.

Possible Approval Standards – Differences Between Systems

Section 4 of the White Paper appropriately identifies certain differences between the life and health guaranty associations and the property and casualty guaranty funds. As the Working Group considers potential solutions to ensure that restructuring transactions do not result in changes to guaranty association/fund coverage, it will be important to account for and address differences. Similarly, the analysis a regulator engages in to determine whether a restructuring transaction affects guaranty association/fund coverage will differ based on the type of business involved. We encourage the Working Group to consider making changes to Sections 4(A) and 6(B) of the White Paper (regarding guaranty association issues) to recognize that solutions and issues may differ based on the lines of business involved in a restructuring. We summarize the considerations by lines of business below. We have attached specific, proposed edits to the White Paper as **Attachment 1** to this letter for the Working Group's consideration.

Life & Health Guaranty Association Considerations

For life and health insolvencies, there is a concern that restructuring transactions could result in policyholders losing guaranty association coverage as it existed prior to the transaction. One potential remedy is to specifically require that an assuming or resulting insurer must be licensed in all states where the issuing insurer was licensed or had ever been licensed. That would preserve coverage from the guaranty association that would have provided coverage prior to the transaction. If the assuming or resulting insurer is not licensed in a state, it will not be a "member insurer" of the guaranty association in that state. If it is not a "member insurer," the guaranty association will not be statutorily triggered to provide coverage to resident policyholders in the event of the insurer's liquidation. (Such policyholders are sometimes referred to as "orphans.") Instead, policyholders residing in states where the insurer is not licensed may be eligible for guaranty association coverage only in the assuming or resulting insurer's domiciliary state. This could concentrate guaranty association coverage in a single state (the state of domicile). If there is a large enough concentration of coverage, it could strain assessment capacity in the domiciliary state.² It also could result in policyholders receiving different guaranty association coverage than they would have received from their state of residence, and create distortions and fairness issues with respect to member insurer assessments. To address these concerns, restructuring statutes (or the regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction.

Property & Casualty Guaranty Fund Considerations

The considerations for the property and casualty guaranty funds are equally urgent but substantially different and require different procedures/remedies. For property and casualty insolvencies, and as described more fully in Section 4 of the White Paper, possible technical

² The Baldwin-United insolvency in the 1980s was the tipping point in convincing regulators and stakeholders of the need to change from providing guaranty association coverage based on the state of domicile of the insolvent insurer to the state of residency of the covered person, an approach that has been adopted nationwide.

gaps in guaranty fund coverage may be created if a state has adopted the NAIC P&C Insurance Guaranty Association Model Law. The NCIGF has determined that an amendment to a state's guaranty fund act, or other related law, may be necessary in many states to address this issue. For those states that have adopted the NAIC P&C Insurance Guaranty Association Model Law, NCIGF has developed technical amendatory language to help ensure that guaranty fund protection is not changed as a result of a restructuring transaction. These revisions have been shared with the Working Group and are included as **Attachment 2** to this letter. NCIGF believes that state law amendments, along with careful review of guaranty fund issues by regulators reviewing a proposed restructuring transaction, will best protect the claimants that the guaranty fund system is intended to protect. This amendment can easily be tailored to the NAIC model or any state act. We encourage regulators and other sponsors of this legislation to work with the local guaranty fund to appropriately amend their act to achieve neutrality of guaranty fund coverage. As the White Paper recognizes, this needs to be a state-by-state process to fashion the appropriate remedy. The NCIGF stands ready to work in conjunction with the RITF to develop appropriate language for the NAIC model and assist and partner with regulators and other concerned parties in state-specific efforts to enact this remedy nationwide.

Both of the undersigned organizations are prepared to continue this dialogue and to work closely with the Working Group in providing any additional technical changes to the White Paper. Similarly, the organizations are prepared to offer any insight that might be helpful to the Working Group or subgroup as they work through their charges, and with other assigned committees that may take up issues related to restructuring mechanisms.

Thank you for the opportunity to share our perspective on the proposed White Paper, and we look forward to working with you as this important project moves forward.

Contact Information

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Attachment 1

NOLHGA and NCIGF Proposed Edits/Comments to Restructuring Mechanisms White Paper Draft



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Restructuring Mechanisms

Commented [A1]: NOLHGA/NCIGF Comments on draft White Paper – 12/1/21.

An NAIC White Paper

October 22, 2021

Created by the
Restructuring Mechanisms (E) Working Group
of the
Financial Condition (E) Committee

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Section 1: Overview of IBT and Corporate Division Laws and Mechanics

A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period requiring insurers to record a liability for these incurred but not reported claims. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer's business model and left to slowly runoff. For some insurance companies, runoff business¹ remains embedded with the core business without the ability to segregate the runoff business. There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers or individual policy novation. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remain with the original insurer. The only way to transfer a block of business with finality is an individual policy novation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled "Liability-Based Restructuring White Paper." (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off "material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities²" from current insurer operations. The white paper achieves this focus by inclusion of various section on related topics as well as multiple appendixes. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled "Alternative Mechanisms for Troubled Companies." (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States ("US") at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendixes.

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be

¹ For purposes of this paper "runoff business" is defined as a block of insurance business that is no longer being actively written by an insurance company and no premiums are being collected, except where required to in accordance with contractual or regulatory obligations, and where the existing or assumed group of insurance policies or contracts are managed through their termination. This definition was developed based on comments received by the Restructuring Mechanism Subgroup from both regulators and industry interested parties; however, this definition has not yet been adopted by the subgroup.

² Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper (1997).

Commented [A2]: The definition in the footnote states that runoff business has no premium being collected but has an exception where premium is being collected because of contractual or regulatory obligations. It seems like the exception undermines the "no premium" requirement. What is the purpose of the no premium requirement? We also would note that there are premium paying runoff blocks (e.g., LTC insurance).

broken down into two categories generally referred to as insurance business transfer (“IBT”) and corporate division (“CD”). Several states, including Arkansas, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes while other states such as Arizona, Connecticut, Illinois, Iowa, Arkansas, Pennsylvania, and Michigan have enacted CD statutes. The stated intent of all these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the United Kingdom (“UK”) are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, better allocate specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsureds and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as redirect regulatory focus away from the insurer’s on-going business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.

Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such

as mass tort, asbestos, environmental and general liability risks. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business.³ With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities.⁴ One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; 2) finality of economic transfer and 3) operational efficiencies.⁵

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulator Concerns with Restructuring Plans

While restructuring may provide value to the insurer, regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that provides less capital than is needed to satisfy the insurer's obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to approve the restructuring plan. Regulators have utilized procedures to ensure the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

Section 2: History of Restructuring in the United Kingdom

³ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁴ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁵ David Scasbrook (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.

A. Part VII Transfers in the United Kingdom

IBT and CD laws and regulations are relatively new in the US, but the legal mechanism for the transfer of insurance business has been implemented and operational in the UK for over twenty years. Part VII of the Financial Services and Markets Act of 2000⁶ (“Part VII” and “FSMA”) enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 300⁷ successful Part VII transfers have taken place in the UK providing guidance to American insurers on how this process could continue to unfold in the US.

A Part VII transfer is a regulatory mechanism, governed by sections 104–116 within Part VII of the FSMA. This act allows an insurer or reinsurer to transfer long-term as well as general insurance business from one legal entity to another, subject to approval of a court. Many insurers use the procedure to give effect to group reorganizations and consolidations. Part VII transfers have also been used extensively in response to Brexit.

In accordance with the FSMA, the Prudential Regulatory Authority (“PRA”) and the Financial Conduct Authority (“FCA”) maintain a Memorandum of Understanding which describes each regulator’s role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. Under the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

Section 110 of the FSMA allows both the PRA and the FCA to be heard in the proceedings. The Memorandum of Understanding confirms that both the PRA and the FCA may provide the court with written representations setting out their views on the proposed scheme, and the PRA may prepare a report regarding the IBT.

As set out in the Memorandum of Understanding, before nominating or approving an independent expert under section 109(2)(b) of FSMA . . . the PRA will first consult the FCA. Further, the PRA will consult appropriately with the FCA before approving the notices required under the Business Transfers Regulations.

Part VII transfers require a “scheme report.” This report is similar to the independent expert report under US IBTs, however, because the word “scheme” has a different context in the US, the word “scheme” is not used. Under section 109(2) of FSMA an independent expert report may only be made by a person:

- (a) appearing to the PRA to have the skills necessary to enable him to make a proper report; and
- (b) nominated or approved by the PRA.

⁶ Financial Services and Markets Act of 2000, 48 Eliz. 2, part 7 (Eng.). FOR CITATION TO ONLINE SOURCE USE: Financial Services and Markets Act of 2000, part 7 (Eng.), <https://www.legislation.gov.uk/ukpga/2000/8/contents>.

⁷ Comment letter from the IBT Coalition Interested Parties to the Restructuring Mechanisms (E) Subgroup dated July 22, 2019.

The regulators expect the independent expert making the report to be a neutral person, who:

- (a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and
- (b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group's discussion of the Part VII transfers, consumer representatives raised the UK court's decision in *Prudential v Rothesay*⁸ which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals⁹ found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to

⁸ As noted by Biny Bimbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. Note this was overturned by *The Prudential Assurance Company Limited v. Rothesay Life PLC* [2020] EWCA Civ 1626.

⁹ *Prudential Assurance Company Ltd and Rothesay Life Plc, Re*, England and Wales Court of Appeal (Civil Division) (Dec. 2, 2020).

give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

- (1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.
- (2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries' capital.
- (3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.¹⁰

Despite this set of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of transferred. While such an arrangement may provide some of the same features as a Part VII transfer the solvent scheme does not continue the coverage with a new insurer the way a Part VII transfer does. Other differences may exist in law but are not deemed to be relevant to this specific white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. Those generally following the UK structure began with Rhode Island in 2002 adopting a statute titled Voluntary Restructuring of Solvent Insurers¹¹ patterned after Solvent Schemes of Arrangements. This type of process was renamed Commutation Plans and differs from the UK law in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.¹² Commutation Plans continue to be available under RI law.

¹⁰ *Id.* at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15

¹¹ [R.I. Gen. Laws Chapter 27-14.5.](#)

¹² [In re GTE Reinsurance Co., No. PB 10-3777, 2011 WL 7144917, at *5-6 \(R.I. Super. Ct. Apr. 25, 2011\)](#)

In 2015 Rhode Island adopted an Insurance Business Transfer Plan regulation¹³ structured similar to the Part VII transfers. Again, in contrast to the UK, the regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments ~~receives~~received, continues to believe that it meets the statutory requirement ~~have been met~~, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act (“LIMA”).¹⁴ LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act¹⁵ modeled after UK’s Part IV regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed two IBTs in October 2020 and September 2021, involving a Rhode Island and Wisconsin insurer respectively, which are described below. Neither of the plans were challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act¹⁶ which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is ~~be~~ made for an extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report

The National Council of Insurance Legislators has promulgated a model IBT law¹⁷ modeled after the Oklahoma IBT statutes, as well as a model CD law¹⁸. A number of states have adopted CD statutes, whether specific to insurance or based on the state’s general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania¹⁹. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

¹³ 230 RICR 20-45-6.

¹⁴ See Legacy Insurance Management Act, 2014 Vt. Acts & Resolves 93 (codified as amended at VT. STAT. ANN. tit. 8, §§ 7111–7121 (West 2017)).

¹⁵ Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 *et seq.*

¹⁶ As announced by the Arkansas Department of Insurance July 8, 2021, ACA §§ 23-69-501, *et seq.* (See Arkansas statute at <https://www.arkleg.state.ar.us/Bills/Detail?id=SB203&ddBienniumSession=2021%2F2021R>)

¹⁷ Insurance Business Transfer Model Act (Nat’l Council of Ins. Legislators 2020).

¹⁸ Insurer Division Model Act (Nat’l Council of Ins. Legislators 2021).

¹⁹ See A.R.S. §§ 29-2601, *et seq.*; C.G.S.A §§ 38a-146, *et seq.*; 215 ILCS 5/35B-1 *et seq.*; M.C.L.A. §§ 500.5500 *et seq.*; A.C.A. §§ 23-69-501, *et seq.*; 15 Pa.C.S. §§ 361 *et seq.*

A. Similarities and Differences between Statutes

Rhode Island's IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer's domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer plan on policyholders considering whether the security position of policyholders is materially adversely affected by the transfer. All states also require notification to all affected policyholders as well as the opportunity to be heard at a public hearing.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate ~~runoff~~ certain books of business from an insurer.

The Illinois' Domestic Stock Company Division Law²⁰ requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless the following characteristics exist:

- (1) policyholder/shareholder interest are not protected;
- (2) each insurer would not be eligible to receive a license in the state;
- (3) division violates the uniform fraudulent act;
- (4) division is made for the purpose of hindering, delaying, or defrauding other creditors;
- (5) any of the companies are insolvent after the division is complete.

The Connecticut CD statute²¹ creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the domestic insurer; (2) the resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will

Commented [A3]: These laws are not necessarily limited to runoff blocks.

²⁰ 215 ILL. COMP. STAT. 5 as found at <https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1249&ChapterID=22>.

²¹ C.G.S.A. §§ 38a-146, *et seq.*, Public Act No. 17-2 as found at <https://www.cga.ct.gov/2017/act/pa/pdf/2017PA-00002-R00SB-01502SSI-PA.pdf>

require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing.

The Pennsylvania CD statute²² was enacted in 1990 and is the subject of the NAIC 1997 white paper on Liability Based Restructuring. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the states equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal experts.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in announced that it had approved a transaction that transferred a book of business from one entity to another. This transaction is discussed within Attachment 1, which is the 1997 Liability-Based Restructuring White Paper, and is commonly referred to as “the Brandywine” transaction, but within the 1997 White Paper is discussed within Appendix 1 and relates to Cigna, where more information is available. During the Working Group’s discussions in 2019, the Pennsylvania Insurance Department, which is captured in the following paragraph.

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to

²² 15 PA. CONS. STAT. §§ 361 *et seq.*

any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and immaterial to the policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re²³ completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision²⁴ on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company's ("PWIC") IBT plan.²⁵ The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company ("Sentry"), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for approval.²⁶ This IBT transfers a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2020. The transaction was a transfer of risks with distinct characteristics into a single insurer within a holding company structure. All the transfers originated and ended within the same holding company. The Illinois Department of Insurance has indicated that it will issue a detailed regulation as experience develops with CD plans proposed and completed under the statute.

Section 4: Impact of IBTs and CDs to Personal Lines

A. ~~Guarantee~~Guaranty Association Issues

An important issue for corporate restructuring is the availability of guaranty association coverage in the event of the insolvency of the restructured insurer. In order to uphold the stated declaration that restructuring should not materially adversely affect consumers, guaranty association coverage should not be reduced ~~or~~, eliminated or otherwise changed by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine association coverage. ~~Although most states pattern their laws after the NAIC model law, there could potentially be different results concerning guaranty association coverage depending on where the insured resides~~ guaranty association coverage. It is possible that a corporate restructuring could result in the reduction, elimination or change in guaranty association coverage provided to a policyholder in the event of the restructured insurer's insolvency if steps are not taken to prevent that result. The potential coverage issues are different

²³ C.A. No. PB 10-3777 (R.I. Super. Apr. 25, 2011)

²⁴ State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777
<https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/decisions/10-3777.pdf>

²⁵ Judgment & Order of Approval & Implementation of the IBT Plan, In re Transfer and Novation of Insurance Policies from Province Wash. Ins. Co., et al., CJ-2019-6689 (D.Ct. Okla. Cnty Oct. 15, 2020) at
<https://www.oscn.net/dockets/GetCaseInformation.aspx?db=oklahoma&number=CJ-2019-6689&cmid=3831864>.

²⁶ Approval Order in Case No. 20-0582-IBT from Oklahoma Insurance Commissioner, filed on November 23, 2020, at
<https://www.oid.ok.gov/wp-content/uploads/2020/11/20-0582-IBT-SAW-Order-11-23-20.pdf>.

for life and health guaranty association coverage and property and casualty guaranty fund coverage. We address them separately below.

Transactions Involving Life or Health Insurance

The Working Group received input from ~~both~~ the National Organization of Life and Health Insurance Guaranty Associations (“NOLHGA”) ~~and the National Conference of Insurance Guaranty Funds (“NCIGF”). NOLHGA described how about~~ the concerns for insurance consumers of personal lines life and health insurance business is particularly pronounced.

NOLHGA indicated that for there to be guaranty association coverage in the event of ~~an~~ life or health insurer insolvency, there are three conditions that must be present. Those conditions are:

- (1) The consumer seeking protection must be an eligible person under the guaranty association statute; typically, this is achieved by being a resident of ~~at~~ the guaranty association’s state ~~who has a guaranty association at the time of the insurer’s liquidation;~~
- (2) The product must be a covered policy; and
- (3) The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state, or have been licensed in the state to write the lines of business covered by the guaranty association.

In most states, coverage can be provided for an “orphan” policyholder of the insurer ~~when~~ by the coverage is issued but the policyholder has since moved to a state that is not a guaranty association member. Those policies are covered under the state in which the insolvent insurer’s domestic state. Orphan policyholders are policyholders who are residents of states where the guaranty association cannot provide coverage because the insolvent insurer is domiciled. This provision not a member insurer due to not being licensed at the time required by the guaranty association act. The orphan policyholder situation can arise when a policyholder purchases a policy in a state where the issuing company is licensed (i.e., is a member of the guaranty association) but subsequently moves to a state where the issuing insurance company was never licensed (i.e., is not a member of the guaranty association). The provision in the NAIC Life and Health Insurance Guaranty Association Model Act, and the laws of most states, that provides that orphan policies are covered by the guaranty association in the insolvent insurer’s domestic state is designed to plug the gap in these rare situations. Orphan coverage was not designed to provide coverage to all policyholders regardless of domicile as might occur if

A key factor when considering a life or health IBT or CD transaction is whether the resulting insurer in an IBT does not meet the requirements for guaranty association coverage. These issues can is or will be addressed in legislative and regulatory manners including maintaining a certificate of authority in each state, so the insurer is a guaranty association a member insurer in each state. However, if an of the same guaranty associations where the transferring insurer is unwilling or unable was a member insurer. If the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer, guaranty association coverage will be preserved and not changed for all policyholders. (Of course, specific guaranty association coverage will be determined if/when the resulting insurer is placed under an order of liquidation with a finding of insolvency.) If the resulting insurer is not a member insurer of the same guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or

be covered as orphans by the guaranty association in the insurer's domestic state. Orphan coverage was not designed to plug the gap in this situation. Shifting the coverage obligation to meet such requirements in the domestic state guaranty association could impede the ability result in guaranty association coverage being concentrated in that state.

To address these concerns with respect to complete a restructure, IBT and CD transactions involving life or health insurance, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

Transactions Involving Property and Casualty Insurance

The Working Group received input from the National Conference of Insurance Guaranty Funds ("NCIGF") about the concerns for insurance consumers of personal lines property and casualty insurance business.

One interpretation of the NAIC Property and Casualty Insurance ~~Guarantee~~ Guaranty Association Model Act (Model # 540)²⁷ is that based on the definitions of "Covered Claim," "Member Insurer," "Insolvent Insurer," and "Assumed Claim Transaction" an orphan policyholder could not be covered by the state ~~guarantee~~ guaranty association.²⁸ Consequently, there is a concern that no ~~guarantee-guaranty association fund~~ coverage would be provided if policies are transferred to a nonmember insurer. ~~Many~~ Many property and casualty guaranty fund statutes require that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred. These limitations, however, are designed to avoid coverage being provided when the policy at issue did not "contribute" to the association, which would not exist in the case of an accessible policy later transferred to a nonmember insurer. ~~Moreover, the restrictions exist to prevent claims resulting from a company regulated as a surplus lines or a similar structure to benefit from the protections afforded licensed business when a licensed company is liquidated.~~

NCIGF's position is that where there was guaranty ~~association fund~~ coverage before the IBT or CD, state regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate or in any way impact guaranty ~~association fund~~ coverage. An CD or IBT should not create, expand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states that have adopted the NAIC Property & Casualty ~~Insurance~~ Guaranty Association Model Act.²⁹ These gaps could include the definitions of Covered Claim, Member Insurer, Insolvent Insurer, and the Assumed Claims Transaction found in Section 5 of the model law.

Fulfilling this intent ~~may will likely~~ require property and casualty guaranty ~~association fund~~ statutes be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and

²⁷ Available at <https://content.naic.org/sites/default/files/inline-files/MDL-540.pdf>.

²⁸ See ~~NOHLGA~~ ~~NOLHGA~~ and NCIGF joint submission to NCOIL dated February 24, 2020 for more information. Available at <http://ncoil.org/wp-content/uploads/2020/02/2020-02-24-Comment-on-NCOIL-IBT-Model.pdf>.

²⁹ Property and Casualty Guaranty Association Model Act (Nat'l Ass'n of Ins. Comm'r's 2009).

oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee's work is discussed in the Recommendations section below.

B. Assumption Reinsurance

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholder with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, ~~in situations where the solvency of the insurer might be at risk.~~ There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.³⁰

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be affected. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act by implication prohibit an IBT or a CD. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholders express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper. The issue has not yet been addressed by any court nor raised in the proceedings on restructurings. Therefore, while it is raised here for informational purposes, resolution of the issue is left unanswered for now and for the courts to determine in the future.

³⁰ Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)

C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the ~~regulators~~regulator's willingness to consider the restructuring of certain lines of business. During the Working Group's discussion, it was noted by a number of regulators that restructuring of certain lines of business, such as long-term care insurance, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care insurance, is likely to be subject to a great deal of opposition and higher capital requirements for the insurers involved.

The nature of long-term care insurance policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care insurance policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others,³¹ a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. The US Constitution includes the Full Faith and Credit Clause as well as the Privileges and Immunities Clause (also referred to as the doctrine of Comity) in Article IV. These clauses create methods of extending the effect of a restructuring mechanism beyond the state that issued the judgment and giving that state's judgment effect in all other states in which the insurer does business.³²

Thus, the Privileges and Immunities Clause or the Full Faith and Credit Clause are two methods stemming from the US Constitution that provide for recognition of court orders from other states. We will briefly touch on both concepts but leave these non-core insurance topics to others to discuss in more depth.

The policyholder challenging the decision must first identify the property of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to the resulting insurer, but alleges no additional harm, may have difficulty identifying the property interest of which they have been deprived. The determination on full faith and credit will likely rely upon the issues raised and considered in the Court of the domestic state.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full

³¹ Gendron, Matthew Esq. (2018) "Rhode Island's Voluntary Restructuring of Solvent Insurers Law and Similar Efforts in Other States," *Roger Williams University Law Review*: Vol.23: Iss. 3, Article 3, available at: https://docs.rvu.edu/rvu_LR/vol23/iss3/3. That article briefly raises questions about whether full faith and credit or comity would apply to help insulate an IBT transaction from collateral challenge in a court outside the approving state.

³² The same analysis does not apply to jurisdictions outside the United States and is not addressed in this white paper.

Commented [A4]: Is the Working Group suggesting that, if LTCI deals are going to be considered, there should be more detailed and rigorous standards for the regulatory review? If yes, this should be stated more explicitly.

faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK.³³ This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis,³⁴ while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. *Narragansett Electric Co. v. American Home Assurance Co.* is one such case.³⁵ In *Narragansett Electric Co.*, the court reviewed claims by London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier.³⁶ Equitas argued that it had not assumed the obligations at issue. As the court summarized, “Equitas’s motion to dismiss raises the question whether this [Part VII] transfer of insurance obligations from Lloyd’s to Equitas is effective and enforceable under U.S. law.” First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent to US policyholders raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High

³³ See SIDLEY AUSTIN LLP, PART VII TRANSFERS EFFECTUATED PURSUANT TO THE UK FINANCIAL SERVICES AND MARKETS ACT 2000 (2017), <https://www.sidley.com/-/media/publications/part-vii-transfers.pdf>.

³⁴ See Jennifer D. Morton, Note, *Recognition of Cross-Border Insolvency Proceedings: An Evaluation of Solvent Schemes of Arrangement and Part VII Transfers under U.S. Chapter 15*, 29 FORDHAM INT’L L.J. 1312, 1314–15 (2006).

³⁵ See *Narragansett Elec. Co. v. Am. Home Assur. Co.*, No. 11 Civ. 8299(PKC), 2012 WL 4075171 (S.D.N.Y. Sept. 12, 2012). There, a claim originating in Pawtucket, Rhode Island, but with waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co.*, 57 N.E.3d 18, 24 (Mass. App. Ct. 2016).

³⁶ See Steven E. Sigalow & Richard E. Stewart, *How Lloyd’s Saved Itself*, 37 THE INS. FORUM (2010), reprinted in JONES DAY, <http://www.jonesday.com/files/Publication/dac28676-d6c8-4dc6-9cbb-c05aee419d4b/Presentation/PublicationAttachment/533860ba-d4f1-4056-85d9-78b84dc71af5/How%20Lloyd's%20Saved%20Itself.pdf> (last visited June 9, 2021).

Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a UK’s independent expert’s report.³⁷ Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. *Allianz Insurance Co.* is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. *Allianz Insurance Co.* also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

~~Allianz~~*Allianz Insurance Co.* concerned General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared an ultimate parent company—Berkshire Hathaway.³⁸ At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in *Allianz Insurance Co.* seemed to be that the post-Part VII insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden’s potential asbestos claims.

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law.³⁹ The court determined that, given the location of the petitioner’s assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action.⁴⁰ The court in *Hopewell* also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.⁴¹

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

³⁷ *Air & Liquid Sys. Corp. v. Allianz Ins. Co.*, No. 2:11-CV-00247-JFC, 2012 U.S. Dist. LEXIS 121553 (W.D.P.A. 2012).

³⁸ *Id.* at *12. This interrelated nature is not unusual and is referred to as an intra-company transaction.

³⁹ *In re Bd. of Dirs. of Hopewell Int’l Ins. Ltd.*, 238 B.R. 25, 31–32 (Bankr. S.D.N.Y. 1999).

⁴⁰ Written by then the Chief United States bankruptcy judge in the Southern District of New York Tina Brozman, this decision detailed relevant history behind the Bermuda schemes of arrangement, including the different methods available to companies. One arrangement involved a cut-off scheme, developed in 1995, in which companies have no more than five years to submit additional claims prior to a bar date. This scheme greatly reduced the time for a run-off to wind down its business.

⁴¹ Citing to 11 U.S.C. § 101(23) (2012), The court applied a standard that “a foreign proceeding is a foreign judicial or administrative process whose end is to liquidate the foreign estate, adjust its debts or effectuate its reorganization.” *Id.* at 49 (internal quotations omitted).

As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The Working Group believes that trust in these mechanisms and protection of the policyholders who will be impacted by them, demands a standard set of financial principles under which to judge the transaction. As such, the Working Group created a subgroup to specifically address these financial issues.

The Restructuring Mechanism Subgroup (“Subgroup”) has been charged with the following initial work related to this White Paper:

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.⁴²

Members of the Subgroup have studied and acknowledge that UK Part VII procedures set forth robust processes and that setting similar requirements should be applied to IBT and CDs.

As of the date of this paper, the charge related to best practices has not been completed. The Subgroup will continue its work with the goal of developing financial best practices. Those practices will be exposed for comment and discussion prior to referral to other groups.

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. ~~A number of states—Connecticut, California, and Oklahoma—have enacted statutory solutions to these issues. In addition, NCIGF has provided proposed statutory language. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.~~

On the life and health side, as noted above, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for life and health guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

On the property and casualty side, amendments to the guaranty fund statutes likely will be necessary. A number of states—California, Illinois, and Oklahoma—have enacted statutory solutions to the property and casualty guaranty association issues similar to what NCIGF has suggested to the working group. In addition, NCIGF has provided proposed statutory language for other states to consider. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership

⁴² Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).

and Insolvency Task Force for consideration. Specifically, the Working Group recommends that the language proposed by NCIGF be included in the NAIC Property and Casualty Insurance Guaranty Association Model Act. Regulators, guaranty funds and other appropriate industry stakeholders should work cooperatively to implement this statutory remedy with all deliberate speed.

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the property and casualty guaranty association issues to assure that consumers are not harmed by the transaction.

C. Statutory Minimums

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

- (1) Requirement of court approval must be required for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.
- (2) Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.
- (3) Requirement of a notice to stakeholders, a public hearing, robust regulatory process, and an opportunity to submit written comments are necessary for all policyholders, reinsurers, and guaranty associations.

None of the restructuring mechanism are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes are different and drafted by the legislatures of the states which enacted the statutes. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transaction. Other transactions, however, may not need all of these provisions. For example, an intra holding company transaction may not need full faith and credit.

While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies have difficulty getting licensed in the various states either because of

“seasoning” issues or because they are not writing ongoing business so the state may be hesitant to grant a license. Lack of licensure can provide a lack of regulatory control which can lead to actions which harm consumers. The Working Group, therefore, recommends that the appropriate committee look at licensing standards consider whether any changes should be made to the licensure process for runoff companies resulting from restructuring transactions of runoff blocks. A streamlined process that states still ensures appropriate regulatory oversight (and any licensure necessary to preserve guaranty association coverage) may wish to adopt be appropriate in limited circumstances.

Commented [A5]: If possible, we suggest that the appropriate committee be identified here.

Attachment 2

NCIGF Proposed Edits to Property and Casualty Insurance Guaranty Association Model

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. 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 a ffiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk una ccompanied 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 preinsolvency 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; 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.
- 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.
- 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.

- 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.
- 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 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.
 - (c) Notwithstanding any other provision in this Act, an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a nother insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity (commonly known as “Division” or “Insurance Business Transfer” statutes), shall be considered to have been issued by a member insurer which is an Insolvent Insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation.
 - (d) An insurance policy that was issued by a non-member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under a state statute described in subsection (a) shall not be considered to have been issued by a member insurer for the purposes of this Act.

- (2) Except as provided elsewhere in this section, “covered claim” shall not include:
- (a) Any amount awarded as punitive or exemplary damages;
 - (b) Any amount sought as a return of premium under any retrospective rating plan;
 - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
 - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;
 - (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
 - (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
 - (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
 - (h) Any claims for interest; or
 - (i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

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 of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

- 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.

- J. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.
- 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.

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

- 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 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 board 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.
- (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 1a]** 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.

[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) **[Alternate 1b]** 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

a 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.]

- (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.]

- (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.
- (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 a 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 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 a 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 have serious 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 a 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 State priority 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./

[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, defense or otherwise./

[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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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. CODE §§ 27-42-1 to 27-42-20 (1981/2009) (Uses separate account option).	
Alaska		ALASKA STAT. §§ 21.80.010 to 21.80.190 (1970/2004) (uses separate account option) (previous version of model).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-661 to 20-680 (1977/2014) (previous version of model).
Arkansas		ARK. CODE ANN. §§ 23-90-101 to 23-90-123 (1977/1999).
California		CAL. INS. CODE §§ 1063 to 1063.15 (1969/2013).
Colorado		COLO. REV. STAT. §§ 10-4-501 to 10-4-519 (1963/2002) (uses separate account option) (previous version of model).
Connecticut		CONN. GEN. STAT. §§ 38a-836 to 38a-853 (1971/2011) (uses separate account option) (previous version of model).
Delaware		DEL. CODE ANN. tit. 18, §§ 4201 to 4221 (1982/1991) (previous version of model).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
District of Columbia		D. C. CODE §§ 31-5501 to 31-5515 (1993) (previous version of model).
Florida		FLA. STAT. §§ 631.50 to 631.70 (1982/2010) (previous version of model).
Georgia		GA. CODE ANN. §§ 33-36-1 to 33-36-19 (1970/2005).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. REV. STAT. §§ 431:16-101 to 431:16-117 (1988/2003) (previous version of model).
Idaho		IDAHO CODE ANN. §§ 41-3601 to 41-3621 (1970/2014) (previous version of model).
Illinois	215 ILL. COMP. STAT. 5/532 to 5/553 (1977/2013) (Uses separate account option).	
Indiana		IND. CODE §§ 27-6-8-1 to 27-6-8-19 (1973/2013) (uses separate account option) (previous version of model).
Iowa	IOWA CODE §§ 515B.1 to 515B.26 (1970/2010).	IOWA CODE §§ 518C.1 to 518C.19 (2000) (separate fund for state and county mutuals).
Kansas		KAN. STAT. ANN. §§ 40-2901 to 40-2919 (1970/2005) (previous version of model).
Kentucky		KY. REV. STAT. ANN. §§ 304.36-010 to 304.36-170 (1972/1990) (previous version of model).
Louisiana	LA. REV. STAT. ANN. §§ 22:2051 to 22:2070 (1970/2010).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 4431 to 4452 (1969/2009) (uses separate account option) (previous version of model).
Maryland		MD. CODE ANN., INS. §§ 9-301 to 9-316 (1971/1997) (previous version of model); BULLETIN 2012-13 (2012).

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Massachusetts		MASS. GEN. LAWS ch. 175D, §§ 1 to 16 (1970/2004) (previous version of model).
NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Michigan		MICH. COMP. LAWS §§ 500.7901 to 500.7949 (1969/1982); BULLETIN 2010-10-INS; BULLETIN 2010-04-INS (2010); BULLETIN 2014-12-INS (2014).
Minnesota		MINN. STAT. §§ 60C.01 to 60C.20 (1971/2003) (uses separate account option) (previous version of model).
Mississippi		MISS. CODE ANN. §§ 83-23-101 to 83-23-137 (1970/1992) (previous version of model).
Missouri		MO. REV. STAT. §§ 375.771 to 375.780 (1971/2013) (uses separate account option) (previous version of model).
Montana		MONT. CODE ANN. §§ 33-10-101 to 33-10-117 (1971/2013) (previous version of model).
Nebraska		NEB. REV. STAT. §§ 44-2401 to 44-2418 (1971/1990) (uses separate account option) (previous version of model).
Nevada		NEV. REV. STAT. §§ 687A.010 to 687A.160 (1971/2005) (previous version of model).
New Hampshire		N.H. REV. STAT. ANN. §§ 404-B:1 to 404-B:18 (1970/2004) (uses separate account option); §§ 404-H:1 to 404-H:20 (2004) (previous version of model).
New Jersey		N.J. STAT. ANN. §§ 17:30A-1 to 17:30A-20 (1974/2003) (previous version of model); N.J. INS. ORDER A12-108 (2012); N.J. INS. ORDER A13-110 (2013); N.J. BANKING & INS. ORDER A16-111 (2016).
New Mexico		N.M. STAT. ANN. §§ 59A-43-1 to 59A-43-18 (1985/1989) (uses separate account option) (previous version of model); §§ 59A-30A-1 to 59A-30A-18 (1999) (Title insurance fund).

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New York		N.Y. INS. LAW §§ 7601 to 7614 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-48-1 to 58-48-130 (1971/2009) (uses separate account option) (previous version of model).

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
North Dakota		N.D. CENT. CODE §§ 26.1-42.1-01 to 26.1-42.1-15 (1999) (previous version of model).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3955.01 to 3955.21 (1970/2005) (uses separate account option) (previous version of model).
Oklahoma		OKLA. STAT. tit. 36, §§ 2001 to 2019 (1980/2014) (uses separate account option) (previous version of model).
Oregon		OR. REV. STAT. §§ 734.510 to 734.710 (1971/2003) (previous version of model).
Pennsylvania		40 PA. CONS. STAT. §§ 41-201 to 41-220 (1995) (previous version of model).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 3801 to 3819 (1974/1980) (previous version of model).
Rhode Island	R. I. GEN. LAWS §§ 27-34-1 to 27-34-19 (1988/2010) (Uses separate account option).	
South Carolina		S. C. CODE ANN. §§ 38-31-10 to 38-31-180 (1988/2001) (uses separate account option) (previous version of model).
South Dakota		S.D. CODIFIED LAWS §§ 58-29A-54 to 58-29A-109 (2001/2013) (Uses separate account option) (previous version of model).
Tennessee		TENN. CODE ANN. §§ 56-12-101 to 56-12-119 (1971/1999) (previous version of model).
Texas		TEX. INS. CODE ANN. §§ 462.001 to 462.351 (2007) (previous version of model).

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Utah		UTAH CODE ANN. §§ 31A-28-200 to 31A-28-220 (1986/2002) (uses separate account option) (previous version of model); UTAH ADMIN. CODE r. 71-3 (1971).
NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Vermont		VT. STAT. ANN. tit. 8, §§ 3611 to 3633 (1969/1979) (uses separate account option) (previous version of model).
Virgin Islands		V.I. CODE ANN. tit. 22, §§ 231 to 247 (1984/1986) (previous version of model).
Virginia		VA. CODE ANN. §§ 38.2-1600 to 38.2-1623 (1986/2014) (previous version of model).
Washington		WASH. REV. CODE §§ 48.32.010 to 48.32.930 (1971/2005) (uses separate account option) (previous version of model).
West Virginia		W. VA. CODE §§ 33-26-1 to 33-26-19 (1970) (uses separate account option) (previous version of model).
Wisconsin		WIS. STAT. §§ 646.01 to 646.73 (1979/2013) (“Insurance Security Fund”).
Wyoming		WYO. STAT. ANN. §§ 26-31-101 to 26-31-117 (1971/2013) (previous version of model).

**PROPERTY AND CASUALTY
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A regulator discussed the history of revising this model in relation to the new NAIC model law process. He stated that the draft was re-exposed for new comments. **2008 Proc. 1st Quarter Vol. II 10-440.**

The Financial Condition (E) Committee adopted amendments to this model. The Committee summarized the more significant changes including the Task Force’s recommendation on the assumed business options. **2008 Proc. 4th Quarter Vol. II 10-5.**

The joint Executive Committee/Plenary adopted amendments to this model. A commissioner noted that an interested party provided a comment requesting reconsideration of the optional net worth exclusion provision. The commissioner reiterated that the provision was optional and intended to provide uniform language for states interested in implementing a net worth exclusion. **2009 Proc. 1st Quarter Vol. I 3-5.**

Section 1. Title Section 2. Purpose

In 1969 the NAIC prepared a statement of position on automobile insurance. One part of that study concerned automobile insurer insolvencies. It was stated that the “... position of the NAIC [is] that no innocent person should suffer as a result of the insolvency of an insurer...” and the association vowed to take action to assure that end. They recommended serious consideration be given to the establishment of an industry facility regulated by the states to guarantee solvency and to indemnify the public against the insolvency of any casualty insurer. A federal guaranty corporation was suggested in a congressional bill, but a resolution was adopted by the NAIC in opposition to this proposal. The resolution emphasized the fact that the NAIC was recommending a program in each state to establish a means to guarantee the payment of claims against insolvent insurers. **1969 Proc. II 549-552.**

Every insurance company failure undermines public confidence in, and the value of, the insurance institution whose continued existence is the result of the public’s desire and need to be secure from risk. Like taxes, the over-all cost of the solvency of an individual company and of such industry-wide schemes as guaranty funds ultimately falls upon the consumer. **1970 Proc. I 262.**

An insurer association recommended that Section 2 be deleted because it added no substance to the model. **1994 Proc. 2nd Quarter 510.**

The working group decided instead to retain the section, but decided to replace the word “avoid” with “the extent provided in this act, minimize.” The group also deleted a phrase that said one of the purposes was “the detection and prevention of insurer insolvencies.”

The working group felt that the two changes made the section better reflect the purpose of the guaranty association. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 3. Scope

In a report comparing losses of insurance companies and banks, it was pointed out that the property/casualty insurance industry is quite different from the life insurance industry. **1969 Proc. II 564.** The first priority was drafting legislation implementing the NAIC position on automobile insurance problems. **1970 Proc. I 252.**

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Basic to drafting a model bill is the determination of its scope. What types of insurance and insurers should be included and excluded? The existing bills range from including only automobile insurance to one embracing both life and property coverages. What contacts must there be with the state before recourse may be had against the fund? **1970 Proc. I 263.**

Section 3

The task force was charged with the task of considering whether the term “direct” needed to be defined. There has been litigation and many questions arising as to the types of coverage considered “direct” by the model act language. Courts have found large self-insured groups who purchase excess and aggregate stop loss coverage to be covered by the guaranty associations since there was no underlying contract of insurance, even though the coverage was more in the nature of reinsurance coverage. **1989 Proc. II 331.**

A. The drafters intended that a state choose the term “health insurance,” “disability insurance,” or “accident and sickness insurance” to conform to the terminology found elsewhere in the insurance code of the state in question. **1973 Proc. I 157.**

Amendments proposed in 1985 were considered a “radical departure” from the original model by the task force chair. The proposed amendments excluded products unless they were specifically listed as included. That meant new products would be excluded unless they fit under a generic term. Some of the items not included under the industry-suggested approach were based on a desire to exclude them, such as financial guarantee insurance. Other exclusions resulted from the belief that, recognizing the extraordinary nature of a guaranty fund, many insured exposures did not represent an extreme hardship to the person involved. Still others may have resulted from drafting difficulties. **1985 Proc. II 473-475.**

By the time the amendments were adopted at the end of 1985, the mechanics of the scope section had changed from the earlier draft. Rather than limiting coverage only to stated types of insurance, the list excluded certain types of coverage. One listed item was removed just before adoption of the model. It had provided an exclusion from the act for errors and omissions insurance for directors and officers of for-profit organizations. **1986 Proc. I 294.**

B. The task force was unanimously in favor of excluding financial guaranty insurance from the coverage of the guaranty fund. **1986 Proc. I 431.**

C. After the insolvencies of two large writers of surety business the federal government urged the NAIC to consider coverage of surety bonds under the guaranty association. It had not been the policy to do so because such bonds were generally associated with commercial ventures. **1986 Proc. I 429.**

D. Clarification of the subsection was made in 1986. Originally the model only said “credit insurance” but the additional language was inserted to make clear other types of collateral protection insurance similar to credit insurance were also originally intended to be excluded. **1987 Proc. I 450.**

E. In 1995 the NAIC considered an amendment to Subsection E to amplify the exclusion of coverage for insurance of warranties or service contracts. This provision was included in the package of amendments adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter 571.**

I. When model amendments were adopted in 1985, consideration was given to adding a subsection to exclude coverage for claims covered under a governmental insurance program. The exclusion was not adopted at that time, but instead Section 12 was amended to add a requirement to exhaust governmental benefits before the guaranty fund would be responsible for the claim. **1986 Proc. I 296, 304.** In 1986 the Section 12 limitation was deleted and the exclusion contained in Subsection I added. **1987 Proc. I 421.**

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An industry association suggested that the comment at the end of the section be amended to note that the Life and Health Insurance Guaranty Association Model Act addresses some of the lines of coverage excluded by this provision. **1994 Proc. 2nd Quarter 510.**

When considering amendments to the model in the latter part of 1995, the working group agreed to add a comment at the end of Section 3. It contained a definition of ocean marine insurance for states whose codes did not contain a definition, so that there would be no question as to the coverages encompassed by the exclusion of ocean marine insurance. The working group agreed to limit the exclusion to craft used for commercial purposes. The working group also decided not to include within the **Section 3**

definition coverage written pursuant to the Jones Act or the Longshore and Harbor Worker's Compensation Act. It was the opinion of the group that these coverages were properly classified as workers' compensation insurance. **1995 Proc. 3rd Quarter 586.**

Section 4. Construction

An industry association recommended that Section 4 be deleted because it added no substance to the model act. **1994 Proc. 2d Quarter 510.**

The working group recommended that the section be retained to encourage appropriate construction of the Act by the courts and to lessen the likelihood that courts would strain to interpret the Act in a manner inconsistent with the intentions of the drafters. The group did remove one word so that the model no longer said *liberally* construed. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 5. Definitions

F. "Covered claim" was considered for modification in 1985. An industry draft suggested a net worth exclusion under which no protection was extended to wealthy persons. The draft recommended exclusion of coverage for any claim in favor of a person having a net worth of \$50 million or more. It was their belief that an insured with that much net worth ought to buy insurance intelligently enough so that it would not be insured by an unsound insurer. They suggested it was not good public policy to send bills for such wealthy persons' losses or claims to all of the homeowners and small business insureds to pay. **1985 Proc. II 474.**

The net worth exclusion was adopted because of potential capacity problems for guaranty funds. The advisory committee felt the suggested change would provide a more even balance between those who really need the protection of guaranty funds and giant corporations. **1985 Proc. II 510.**

Just before adoption of the model revisions in December 1985, the Guaranty Fund Task Force voted to remove a net worth limit of \$10 million that had been included in the draft. A net worth provision was added instead to Section 11. **1986 Proc. I 294.**

The National Committee on Insurance Guaranty Funds approved a document called "Guiding Principles for Settling Disputes Between Property and Casualty Insurance Guaranty Associations as to Responsibility for Claims" and asked the NAIC's acceptance of the program. The purpose was to answer questions about which state's fund should handle the covered claim. **1986 Proc. I 457-459.**

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A suggestion made to the working group considering amendments to the model in 1994 was to revise the definition of “covered claim” to make it clear that unearned premium claims are covered by the guaranty fund in the state where the policyholder resided at the time the policy was issued. **1994 Proc. 2nd Quarter 510.**

The working group did not follow the suggestion because of a concern that the proposed revised language would be construed to limit the claims that would be covered. **1994 Proc. 3rd Quarter 419.**

Just before adoption of the amendments by the working group, further discussion was held on the suggestion to assign coverage of an unearned premium claim to the guaranty association in the state where the insured resided at the time of issuance of the policy. One regulator said the proposed amendment would place an additional burden on receivers of insolvent insurers, who often must deal with policy records that are unorganized, inadequate or non-existent. Another

Section 5

regulator agreed the proposal could cause delays in paying claims and increase the workload of both receivers and guaranty associations. The working group agreed to defer action on the suggestion. **1994 Proc. 4th Quarter 575.**

Amendments were considered again later in 1995 and Paragraph (2) was revised. It clarifies which guaranty association is primarily liable for the claim for property damage and does not narrow coverage. **1995 Proc. 3rd Quarter 586.**

At a hearing on the proposed amendments held in early 1996 one regulator objected to this proposed amendment. An interested party responded that the amendment does not restrict guaranty association coverage, but only determines the guaranty association that has primary responsibility for a property damage claim. The purpose of the amendment is to clarify that the guaranty association in the jurisdiction where the property giving rise to the claim is located has primary responsibility for the claim. **1996 Proc. 1st Quarter 569.**

An association of guaranty funds recommended that the exclusion from “covered claim” be expanded to exclude claims for reinsurance recoveries, contribution and indemnification brought by other insurers and to prohibit insurers from pursuing such claims against an insured of an insolvent company up to the guaranty fund limits. **1994 Proc. 2nd Quarter 510.**

Paragraph (3)(d) was added in the 1994 revisions. It contains a net worth exclusion for first party claims by an insured whose net worth exceeds \$25 million. The association of guaranty funds had suggested \$10 million as the appropriate level. **1994 3rd Quarter 419.**

G. “Insolvent insurer” was modified in 1972 to change the definition from an insurer “authorized” to transact to one “licensed” to transact insurance. It was the intent of the NAIC committee which drafted the bill to provide coverage only for carriers licensed in the state. In other words, coverage was not to be included for unauthorized insurers since they were not subject to the state’s regulation for solvency. “Authorized” might have been construed to include eligible surplus lines insurers. **1973 Proc. I 155.**

At the June 1976 meeting the industry advisory committee submitted a recommendation for an amendment to the definition of “insolvent insurer.” They contended the law was designed to apply to companies being liquidated, but the language of the model was not sufficiently precise to accomplish that limited objective. The suggestion to add specific language to clarify this point was not acted upon at that time. **1978 Proc. I 277.** It was, however, adopted in December 1978. **1979 Proc. I 217.**

The definition was revised in 1994 to require a final order of liquidation with a finding of insolvency. A drafting note explaining that “final order” means an order that has not been stayed was also included in the amendments. **1994 Proc. 3rd Quarter 419.**

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H. Paragraph (2) was added in 1994 to incorporate language concerning termination of membership and liability for assessment in the event of a termination. **1994 Proc. 3rd Quarter 419.**

Section 6. Creation of the Association Section 7. Board of Directors

A. This provision was modified to allow vacancies to be filled by a majority vote of the remaining board members. By the terms of the original model, it would have been necessary to call a meeting of all member insurers, which would have been extremely cumbersome. **1972 Proc. I 480.**

An advisory group was asked to consider the issue of public representation on guaranty association boards in 1992. The committee report recommended against it, but one member proposed that a drafting note be added to include a provision for public representation on the board where the state had a premium tax offset. **1993 Proc. IB 703.**

Section 7

One member of the advisory group submitted a minority report explaining her reasons for recommending public representation on guaranty association boards. The main reasons given by the consumer representative were because the public ultimately bears the cost of guaranty fund assessments, because a different perspective is needed, and because accountability is needed. **1993 Proc. I 707.**

As a follow-up from that minority report, the working group decided to draft amendments to both the Life and Health Insurance Guaranty Association Model Act and the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, which were designed to add two public representatives as members of the board of directors of the guaranty associations without increasing the overall number of members on the boards. The amendments also addressed potential conflicts of interest by requiring that the public representatives not be employed or contracted by any entity regulated by the state insurance department or required to register as a lobbyist in the state, or related to either. **1993 Proc. 2nd Quarter 619.**

A representative from an association of guaranty funds said an earlier suggestion for public representatives failed to gain support because of a perception that the commissioner was the representative of the public. Another association representative said his organization's position was that it was a public policy question for the legislatures to determine. The underlying question related to the individual members themselves: their expertise, a accountability and responsibility. **1993 Proc. 2nd Quarter 619.**

The consumer representative who authored the minority report restated her position. She believed that because the public ultimately bears the burden of insolvencies either through increased taxes or policy surcharges, the public was entitled to representation on the boards. Any problem experienced with incentive to attend meetings or structure of the board should be addressed separately from the overall issue of representation and should not result in a denial of representation of the public. **1993 Proc. 2nd Quarter 619.**

In a letter of comment on the exposure draft providing for public representation, one association said it had developed a position opposed to public representation when the model was originally drafted. The association's position was that there were substantial conflicts of interest in having consumers and other public representatives on the board. The state guaranty funds stand in the shoes of the insolvent insurer and must pay claims and decide coverage issues as the insolvent insurer would have done. Had the insolvent insurer remained solvent, it would not have had consumers involved in its internal claims process. **1993 Proc. 2nd Quarter 605.**

The consumer representative said insurers also faced a conflict of interest because their interests were not aligned with those of policyholders either, but rather with the solvent insurers who paid the assessment. **1993 Proc. 2nd Quarter 619.**

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Another insurer association gave conditional support for the amendment. Its experience had been that qualified public representatives can make a positive contribution to board deliberations. The association expressed some concern about selecting qualified individuals who should be knowledgeable about the insurance industry. It recommended the draft be revised to require only one public member, who should not be eligible to serve as the chair of guaranty fund boards. **1993 Proc. 2nd Quarter 604.**

Before the Executive Committee voted on a adoption of the amendment regarding public representatives, further discussion took place. The chair of the Financial Condition Subcommittee said the purpose of the amendment was to improve communication among regulators, the insurance industry and consumers on guaranty fund and insurer insolvency issues. The addition of public representatives to the governing boards would provide consumers with access to the guaranty fund process and a direct means to express concerns. The addition of public representatives also recognizes the impact of insurer insolvencies on the general revenues of states and taxpayers. Another commissioner stated that he occupied a position on the guaranty association boards and acted as a public representative since it was his function to protect the public interest. A third commissioner said that public input into the guaranty fund process would be valuable, and that even though the commissioner's function was protection of the consumers, the issue was one of direct public access. He did not favor inclusion of this provision in the financial regulation standards for accreditation. The chair of the subcommittee responded that this was not being recommended. **1993 2nd Quarter 32.**

Section 7

Before final adoption the NAIC plenary body considered the matter again. Concern was expressed that this amendment would be required for a state to be accredited. After assurance that the amendments were not being considered, indeed were not even related to financial solvency, the model amendment was adopted. **1993 Proc. 2nd Quarter 12.**

In 1994 language was added to Section 7A to allow the commissioner to appoint the initial members of the board of directors if not selected by the member insurers within 60 days. A provision was also added to allow the commissioner to fill any vacancies in position held by public representatives. **1994 Proc. 3rd Quarter 419.**

Late in 1995 the working group reviewing suggestions for change to the model recommended that Subsection A be amended to simplify the qualifications for serving as a public member of the board of directors of a guaranty association. **1995 Proc. 3rd Quarter 586.**

The amendment to Subsection A was adopted in 1996, as well as the drafting note following the subsection. **1996 Proc. 1st Quarter 573.**

Section 8. Powers and Duties of the Association

One of the major areas of concern when initially drafting the model was the manner in which the guaranty function was to be performed. Should the program be administered by the commissioner or through an industry association? What functions should the group perform? Shall they be authorized to delegate functions to a servicing insurer? **1970 Proc. I263.**

A. The drafters started with the promise that the first draft should be a post-assessment rather than a prefunded plan. Then a number of decisions needed to be made in determining those assessments. Should insurers be assessed by lines of business? What, if any, should the maximum rate of assessment be? Should assessments be recognized in the making of premium rates? **1970 Proc. I263.**

Paragraph (3) of this subsection was amended in December 1971. As the model existed before, if the amount raised by a maximum assessment was insufficient to pay all covered claims, the association would have to marshal all the claims before it

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could make any payment on any one particular claim. Language was added giving the association the right to pay claims in the order it deemed reasonable, thus avoiding administrative problems and delay. **1972 Proc. I 480.**

A second amendment in December 1971 provided that if a company had deferred payment of an assessment due to its financial condition, that company could not pay any dividends to shareholders or policyholders during the period of deferral, and would have to pay the deferred amount as soon as payment would not reduce capital or surplus below required minimums. **1971 Proc. I 480.**

A December 1978 amendment added a sentence to the last paragraph of Subsection A(1) to eliminate claims filed after the final date set by the court for filing claims against the liquidator. **1979 Proc. I 217.**

The model originally contained a \$100 deductible provision that was deleted in December 1980. At the same time a sentence was added at the end of Subsection A(1) to pay only the amount of unearned premium over \$100. The reasoning for this was that certain consumers bore a disproportionate share of the losses; if there were no deductibles, the losses would be borne more equitably by all insureds. The administrative costs of handling the deductibles were high in relation to the amounts involved, sometimes exceeding what would have been paid out in claims. **1981 Proc. I 225, 228.**

The most notable of the amendments to the model act considered in 1994 included deletion of the \$100 deductible for unearned premium claims. **1994 Proc. 4th Quarter 574.**

The working group was asked to consider deletion of the provision that allows the guaranty fund to pay only that portion of an unearned premium claim in excess of \$100. In support of his proposal, the regulator said his state's receiver spent \$91.18 in costs to adjudicate each policyholder claim for the deductible. He said the substantial number of these claims filed also

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creates an administrative burden, as well as depleting assets of the insolvent insurer. An industry spokesperson said the industry favored the deductible because it had the effect of spreading the loss due to insolvency and also reduced the cost of each insolvency to the guaranty association. The working group decided to recommend the deletion of the provision for the deductible. **1994 Proc. 3rd Quarter 419.**

Several industry associations commented on the proposal to delete the \$100 deductible and indicated a desire to retain the provision. A regulator responded that the costs to the estate associated with the deductible were out of proportion to any benefit to policyholders. Another regulator said she received numerous complaints from policyholders about the application of the deductible to their claims. Another regulator said that, although guaranty associations might initially derive some cost savings from the deductible, those savings were offset by the cost to the estate, which ultimately results in less money available for distribution to policyholders, guaranty associations and other creditors. Another added that the necessity of processing claims for the deductible unnecessarily prolongs the administration of estates, which is detrimental to the guaranty association. A guaranty association representative argued that the cost savings related to the deductible was important to guaranty associations. He said in one state it was estimated that the deductible had resulted in savings of more than \$13 million. He suggested other options for addressing the issue, including an exclusion of nominal claims from payment by the receiver and lowering the priority of claims for reimbursement of the deductible. He said costs of the guaranty associations are passed on to the public through rate surcharges and premium tax offsets, and that it was appropriate for policyholders to share some of the costs associated with an insolvency. After much discussion the working group decided to dispense with the deductible for unearned premium claims. **1994 Proc. 4th Quarter 574-575.**

The amendments adopted in December 1985 included a revision of this section, including a limit of \$10,000 per policy for claims on return of unearned premiums. The advisory committee also suggested a limit of \$50,000 on non-economic loss, but this suggestion was not adopted. **1986 Proc. I 300, 344.**

In 1986 an alternative provision was drafted to give the liquidator authority to sell a limited optional reporting period to insureds of an insolvent company that would provide coverage for the time period for filing claims with the liquidator. To prevent inconsistencies the time period was set for 18 months. **1986 Proc. II 409-411.** This provision was adopted six months later. **1987 Proc. I 421.**

Revisions were made to this section in 1994 to eliminate the alternative section that had been included for states with a provision in the liquidation law giving the liquidator authority to sell a limited extended reporting period for claims made policies. **1994 Proc. 3rd Quarter 424-425.**

The last sentence of the subsection originally read “Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.” That sentence was deleted as being unnecessary and a potential cause of conflict. **1987 Proc. I 450.**

Section 8A(1) was amended to be consistent with the revised definition in Section 5G by replacing “determination of insolvency” with “order of liquidation.” Language was added at the end of Paragraph (1) that provided that the association’s duty to defend ceased upon payment or tender of an amount equal to the lesser of the association covered claim limit or the applicable policy limit. **1994 Proc. 3rd Quarter 419.**

Late in 1995 a working group considering amendments to the model discussed a proposal from a group suggesting a change to the provision regarding the date at which liability to the guaranty association is cut off and discussed the exclusion from coverage of policyholder protection claims. After lengthy discussion the regulators decided not to recommend the proposed amendments. The group also considered amending Paragraph (1)(b) to provide for an aggregate limit of \$10 million per insured. **1995 Proc. 3rd Quarter 586.**

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Members of the working group expressed their support for the idea of an aggregate limit per insured in general, but raised some specific concerns with the proposal. These concerns included the difficulty of application of the aggregate limit if not adopted uniformly by all states and whether the amendment would create an incentive for a guaranty association to delay **Section 8A** (cont.)

claim payments so that payments by other guaranty associations would satisfy the limit, thereby avoiding its statutory responsibility. Another concern was that guaranty association coverage would be exhausted by those who filed claims early, leaving other claimants without any coverage. **1996 Proc. 1st Quarter 569.**

The working group decided to adopt the proposed package of amendments without including the aggregate limit, but to consider a revised proposal in the future. **1996 Proc. 1st Quarter 570.**

A provision was added to Paragraph (2) authorizing the association to pursue and retain salvage and subrogation as to claims paid by the association. **1994 Proc. 3rd Quarter 419.**

An association of guaranty funds recommended that the guaranty funds have the exclusive right to appoint and direct legal counsel retained to defend liability claims. The working group decided to add a provision to Paragraph (4) giving the association the right to choose legal counsel for the defense of covered claims. **1994 Proc. 3rd Quarter 419. Section 8** (cont.)

B. A suggestion was made by an association of guaranty funds to amend Subsection B(3) to afford guaranty associations the right to intervene in a proceeding involving an insolvent insurer. Some members of the working group expressed concern that this provision would result in the estate incurring unnecessary litigation expenses. Another concern expressed was that other creditors would, by extension, also be granted a right to intervene. One regulator felt that guaranty associations should not have rights superior to those of other creditors. No amendments to this subsection were included in the recommendations adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter.**

C. The working group agreed to create an optional Subsection C providing a method of raising funds in excess of the association's normal assessment capacity to pay claims resulting from a natural disaster. This provision was patterned after legislation already enacted in one state. **1995 Proc. 3rd Quarter 586.**

The amendments adopted in 1996 included an optional Subsection C and a comment on that subsection. **1996 Proc. 1st Quarter 576.**

Section 9. Assessments Section 10. Plan of Operation

To supplement the model bill a separate model plan of operation was also adopted. **1970 Proc. IIB 1092-1096.**

When considering revisions to the model in 1994, a suggestion was made to the working group that provision be made for disposition of dividends and other advances received by a guaranty fund from an estate. **1994 Proc. 2nd Quarter 510.**

Section 11. Duties and Powers of the Commissioner

A. The second sentence was added to Paragraph (1) in December 1972. Receipt of a copy of the commissioner's petition for insolvency upon the filing of such a petition with a court would assist the guaranty funds in beginning to prepare to handle a insolvency once declared by a court of competent jurisdiction. **1973 Proc. I 156.**

B. Subsection B contained a provision requiring the association to notify insureds and other interested parties of the insolvency. This provision was deleted in 1994. **1994 Proc. 3rd Quarter 420.**

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Section 11. Effect of Paid Claims (Previous version of model)

In 1975 the drafters considered an amendment which would have given guaranty funds immediate access to insolvent company assets, declare the guaranty funds priority creditors, and offer a “rescue” funding mechanism. **1976 Proc. I 296.**

The recommendation was not adopted by the executive committee, but was sent back to the drafting task force. **1975 Proc. I 9.**

B. On a close vote the Guaranty Fund Task Force decided to include an amendment to this section limiting covered claims to claimants whose net worth was under \$50 million. All of Subsection B was new material added in December 1985. **1986 Proc. I 340, 347.**

The task force generally favored the net worth exclusion as long as third-party liability claimants who may not have a sufficient net worth were protected. This approach would serve as an incentive to risk managers for commercial insureds to shop wisely in placing their insurance. **1986 Proc. I 431.**

The footnote in Subsection B was added to clarify the original drafter’s intent that the net worth provision apply to workers’ compensation claims. **1987 Proc. I 451.**

A working group considering amendments in 1995 was asked to lower the net worth exclusion to \$25 million but declined to make that recommendation. **1995 Proc. 3rd Quarter 586.**

C. In 1994 Subsection C was substantially amended to clarify the rights of the association as claimant in the estate of an insolvent insurer and to require receivers to accept settlements of covered claims and determination of covered claim eligibility by guaranty associations. **1994 Proc. 3rd Quarter 420.**

In late 1995 an amendment was proposed to Subsection C to address the concern of some members that guaranty association determination of covered claims not affect the receiver’s adjudication of excess claims. **1995 Proc. 4th Quarter 728.**

A second issue identified by the working group was whether the receiver should be bound to accept the guaranty fund’s determination of a covered claim and the amount paid by the guaranty fund in satisfaction of the claim. The suggested amendments addressed the concerns of regulators. **1995 Proc. 4th Quarter 728.**

Section 12. Exhaustion of Other Coverage (Previous version of model)

Section 12 was titled “Nonduplication of Recovery” from the time the original model was adopted in 1962. The title was changed in 1996 to better reflect the intent of the section. **1996 Proc. 1st Quarter 570.**

A new Subsection B was added in December 1985 requiring a person with any right of recovery under a governmental insurance program to exhaust his right there first before submitting a claim to the guaranty association. **1986 Proc. I 296, 304.** A year later this paragraph was deleted and the model returned to its original language. Instead Section 3 was amended to add an additional subsection excluding any insurance provided by or guaranteed by the government. This would have the effect of excluding flood and crop hail insurance guaranteed by the federal government from covered claims. **1987 Proc. I 421.**

A. In 1994 Subsection A was amended to clarify that “other insurance” was not limited to coverage provided by a member insurer. **1994 Proc. 3rd Quarter 420.**

Section 12. Prevention of Insolvencies

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Protection against insolvency is one of the paramount objectives of insurance regulation. Two approaches are used to achieve this objective. First, insolvency funds have been created to afford protection when insolvencies actually occur. Second, statutes have armed insurance departments with various regulatory standards, procedures and tools to prevent or reduce the likelihood of insolvencies. The drafters also questioned whether additional insolvency preventive measures should be incorporated in the model bill. **1970 Proc. I 263.**

The section was rewritten in 1983 at the urging of the guaranty funds because they felt the section imposed duties on the guaranty funds boards which were more appropriately carried out by insurance departments. **1983 Proc. I 350.** The recommended changes allowed interaction between the guaranty funds and the insurance commissioners. **1984 Proc. I 326.**

A. The old Subsection A was deleted in 1994 to address antitrust concerns. It had required the board of directors to make recommendations to the commissioner for ways to detect and prevent insolvency and to discuss and make recommendations about the status of any member insurer whose financial condition might be hazardous to its policyholders. This was replaced with a provision authorizing the board of directors to make general recommendations concerning solvency regulation. **1994 Proc. 3rd Quarter 420.**

Section 13. Credits for Assessments Paid (Tax Offsets) – OPTIONAL

A regulator stated that the E Committee requested the Task Force reconsider a solution regarding assumed claims transactions. Another regulator stated that the Working Group considered the topic twice and agreed that something should be covered by the guaranty associations. A regulator suggested optional language to avoid controversy and ensure a timely response. After extensive discussion, the Task Force agreed to further study the issue. **2008 Proc. 2nd Quarter Vol. II 10-490 to 10-492.**

A regulator recommended including two options – one option where assumed business was covered, and a second option where assumed business was not covered. Another regulator explained a third option as having two parts. This alternative would be a way to take care of all assumed claims, not necessarily with guaranty fund coverage but by means of a segregated account. The Task Force discussed comments received on these options and whether drafting notes would resolve the issue. A commissioner summarized the four existing options and the potential fifth option. The Task Force decided to draft a background summary and finalize a decision at the 2008 Fall National Meeting. **2008 Proc. 3rd Quarter Vol. II 10-368 to 10-370.**

A commissioner stated that the Committee requested that the Task Force reconsider the assumed business language by considering optional language. A regulator stated that Option Three appeared to be an interim step for when insolvency takes place before a company issues their own policies. This option would be a way to handle the previous incurred losses before the assumption. The Task Force discussed issues related to this option. **2008 Proc. 4th Quarter Vol. II 10-622.**

A commissioner stated that Option Four followed Virginia Law. An interested party stated that Option Four is the mechanism by which Virginia implemented Option One. A regulator asked for clarification on the options. Another regulator said that Option Five was an attempt to be in the middle ground. The Task Force discussed the various aspects of Option Five. An interested party stated that he had an alternative that achieved Option Five's goal through a different mechanism. Another interested party stated that the option they were most supportive of was Option Three. This option leaves parties as close as possible to the position into which they put themselves while still providing relief on a going forward basis for those people finding themselves with a new insurer, but after the transaction date, their claims would be covered just as if they had been issued by the assuming carrier. The Task Force discussed the pros and cons of Option Three. A regulator polled the members on the different options. Options One and Five, received positive support from the majority. Options Two and Three did not receive support. **2008 Proc. 4th Quarter Vol. II 10-624 to 10-625.**

The Task Force voted to send Option One and Option Five to the Financial Condition (E) Committee as optional language within the model. **2008 Proc. 4th Quarter 10-626.**

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

Section 14. Miscellaneous Provisions Section 15. Examination of the Association; Annual Report Section 16. Tax Exemptions Section 16. Recognition of Assessments in Rates

At the December 1972 meeting of the NAIC Property and Liability Guaranty Fund Subcommittee, it was suggested that a task force consisting of both regulators and industry actuaries and rate-making personnel create a recoupment formula under the model law. **1973 Proc. I 395.**

The task force made the following recommendations: (1) In making rates consideration should be given to past assessments paid. It is the intent of the guaranty fund law that the assessments are to be borne by the policyholders eventually through their premium payments. (2) The language is quite clear on the point that, if assessments have been paid, rates are not to be considered excessive because they contain an amount to recoup the assessments paid. Because rate-making is prospective in nature, the rating law required that due consideration be given to prospective expenses as well as past expenses. (3) The task force recommended numeric formulas considering available information from prior insolvencies covered by guaranty funds. **1973 Proc. II 396-397.**

In 1995 the working group recommended the deletion of the assessment recoupment formula because it appeared that the formula had not been utilized by any state. **1995 Proc. 3rd Quarter 586.**

Section 17. Immunity

An amendment to this section was made in December 1986. The words “... for any action taken *or any failure to act* by them ...” were added to strengthen the immunity and reflect more clearly the intent of the drafters. **1987 Proc. I 451.**

A provision was added in 1994 amendments to extend immunity to those persons substituting for a member of the board of directors. **1994 Proc. 3rd Quarter 420.**

Section 18. Stay of Proceedings

Three years after the model was originally adopted, a change was made allowing a proceeding to be stayed for six months instead of the 60 days in the original model. It was found that the records of an insolvent company were in many cases nonexistent, and it took time to determine what actions were pending. The amendment allowed the association up to six months within which to prepare a proper defense, and such time thereafter as the court may grant in its discretion. **1973 Proc. I 156.**

The liquidator of an insolvent insurance company was reluctant, in some cases, to turn over the insolvent company’s claims files to the servicing carrier. Because the association couldn’t function without access to the insolvent company’s files, the second paragraph of Section 18 was added. **1973 Proc. I 156-157.**

The language in the first sentence of this section was modified to remove the words “up to” which had preceded “six months.” It was the view of the committee that the words “up to six months” imposed an unnecessary restriction upon the staying power of the court. **1987 Proc. I 451.**

An association of guaranty funds recommended that the stay be extended to the claim filing deadline to allow the guaranty funds more time to obtain and review claim files and determine what actions need to be taken. **1994 Proc. 2nd Quarter 511.**

The drafting group declined to follow the suggestion and recommended retention of the six-month period. The group did, however, add a provision allowing the association to waive the stay in instances where circumstances justify or require quicker action. **1994 Proc. 4th Quarter 588.**

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

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Section 18 (cont.)

A set of general comments had been included after Section 18 with further suggestions for drafters. When amendments were considered in 1994, one suggestion was to omit these comments. An insurer association suggested that many comments in the model were outdated and no longer applicable and should be deleted. **1994 Proc. 2nd Quarter 521.**

Chronological Summary of Actions

June 1969: Model adopted.

December 1971: Amended Section 7 to provide method for filling board vacancies and Section 8 to allow payment of claims in any order deemed reasonable.

December 1972: Amended definition of insolvent insurer and added procedures to assist the guaranty association in its duties.

June 1973: Recoupment formula adopted.

December 1978: Revised definition of insolvent insurer and added sentence to limit covered claims to those timely filed.

December 1980: Eliminated \$100 claims deductible but added sentence to retain \$100 unearned premium deductible.

December 1983: Modified Section 13 to aid in detection and prevention of insolvencies.

December 1985: Extensive amendments adopted to clarify and limit scope of act, to add definitions of “claimant” and “control” and to expand section on limits of payments. The net worth limit in Section 11 was added.

December 1986: Amendments adopted to provide for extended reporting period endorsement of a claims-made policy, to exclude flood and crop hail damage insurance provided or guaranteed by the federal government, and to make technical amendments.

September 1993: Adopted amendment to Section 7 to provide for public representatives on the guaranty fund board.

March 1995: Adopted amendments to clarify and update the model.

June 1996: Adopted amendments to clarify and update the model.

January 2009: Adopted amendments to clarify and update the model.



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Restructuring Mechanisms

Commented [A1]: NOLHGA/NCIGF Comments on draft White Paper – 12/1/21.

An NAIC White Paper

October 22, 2021

Created by the
Restructuring Mechanisms (E) Working Group
of the
Financial Condition (E) Committee

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Section 1: Overview of IBT and Corporate Division Laws and Mechanics

A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period requiring insurers to record a liability for these incurred but not reported claims. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders -because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer's business model and left to slowly runoff. For some insurance companies, runoff business¹ remains embedded with the core business without the ability to segregate the runoff business. There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers or individual policy novation. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remain with the original insurer. The only way to transfer a block of business with finality is an individual policy novation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled "Liability-Based Restructuring White Paper." (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off "material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities²" from current insurer operations. The white paper achieves this focus by inclusion of various section on related topics as well as multiple appendixes. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled "Alternative Mechanisms for Troubled Companies." (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States ("US") at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendixes.

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be

Commented [A2]: The definition in the footnote states that runoff business has no premium being collected but has an exception where premium is being collected because of contractual or regulatory obligations. It seems like the exception undermines the "no premium" requirement. What is the purpose of the no premium requirement? We also would note that there are premium paying runoff blocks (e.g., LTC insurance).

¹ For purposes of this paper "runoff business" is defined as a block of insurance business that is no longer being actively written by an insurance company and no premiums are being collected, except where required to in accordance with contractual or regulatory obligations, and where the existing or assumed group of insurance policies or contracts are managed through their termination. This definition was developed based on comments received by the Restructuring Mechanism Subgroup from both regulators and industry interested parties; however, this definition has not yet been adopted by the subgroup.

² Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper (1997).

broken down into two categories generally referred to as insurance business transfer (“IBT”) and corporate division (“CD”). Several states, including Arkansas, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes while other states such as Arizona, Connecticut, Illinois, Iowa, Arkansas, Pennsylvania, and Michigan have enacted CD statutes. The stated intent of all these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the United Kingdom (“UK”) are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, better allocate specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsureds and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as redirect regulatory focus away from the insurer’s on-going business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.

Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such

as mass tort, asbestos, environmental and general liability risks. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business.³ With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities.⁴ One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; 2) finality of economic transfer and 3) operational efficiencies.⁵

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulator Concerns with Restructuring Plans

While restructuring may provide value to the insurer, regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that provides less capital than is needed to satisfy the insurer's obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to approve the restructuring plan. Regulators have utilized procedures to ensure the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

Section 2: History of Restructuring in the United Kingdom

³ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁴ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

⁵ David Scasbrook (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.

A. Part VII Transfers in the United Kingdom

IBT and CD laws and regulations are relatively new in the US, but the legal mechanism for the transfer of insurance business has been implemented and operational in the UK for over twenty years. Part VII of the Financial Services and Markets Act of 2000⁶ (“Part VII” and “FSMA”) enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 300⁷ successful Part VII transfers have taken place in the UK providing guidance to American insurers on how this process could continue to unfold in the US.

A Part VII transfer is a regulatory mechanism, governed by sections 104–116 within Part VII of the FSMA. This act allows an insurer or reinsurer to transfer long-term as well as general insurance business from one legal entity to another, subject to approval of a court. Many insurers use the procedure to give effect to group reorganizations and consolidations. Part VII transfers have also been used extensively in response to Brexit.

In accordance with the FSMA, the Prudential Regulatory Authority (“PRA”) and the Financial Conduct Authority (“FCA”) maintain a Memorandum of Understanding which describes each regulator’s role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. Under the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

Section 110 of the FSMA allows both the PRA and the FCA to be heard in the proceedings. The Memorandum of Understanding confirms that both the PRA and the FCA may provide the court with written representations setting out their views on the proposed scheme, and the PRA may prepare a report regarding the IBT.

As set out in the Memorandum of Understanding, before nominating or approving an independent expert under section 109(2)(b) of FSMA . . . the PRA will first consult the FCA. Further, the PRA will consult appropriately with the FCA before approving the notices required under the Business Transfers Regulations.

Part VII transfers require a “scheme report.” This report is similar to the independent expert report under US IBTs, however, because the word “scheme” has a different context in the US, the word “scheme” is not used. Under section 109(2) of FSMA an independent expert report may only be made by a person:

- (a) appearing to the PRA to have the skills necessary to enable him to make a proper report; and
- (b) nominated or approved by the PRA.

⁶ Financial Services and Markets Act of 2000, 48 Eliz. 2, part 7 (Eng.). FOR CITATION TO ONLINE SOURCE USE: Financial Services and Markets Act of 2000, part 7 (Eng.), <https://www.legislation.gov.uk/ukpga/2000/8/contents>.

⁷ Comment letter from the IBT Coalition Interested Parties to the Restructuring Mechanisms (E) Subgroup dated July 22, 2019.

The regulators expect the independent expert making the report to be a neutral person, who:

- (a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and
- (b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group's discussion of the Part VII transfers, consumer representatives raised the UK court's decision in *Prudential v Rothesay*⁸ which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals⁹ found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to

⁸ As noted by Birny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. Note this was overturned by *The Prudential Assurance Company Limited v. Rothesay Life PLC* [2020] EWCA Civ 1626.

⁹ *Prudential Assurance Company Ltd and Rothesay Life Plc, Re*, England and Wales Court of Appeal (Civil Division)(Dec. 2, 2020).

give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

- (1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.
- (2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries' capital.
- (3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.¹⁰

Despite this set of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of transferred. While such an arrangement may provide some of the same features as a Part VII transfer the solvent scheme does not continue the coverage with a new insurer the way a Part VII transfer does. Other differences may exist in law but are not deemed to be relevant to this specific white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. Those generally following the UK structure began with Rhode Island in 2002 adopting a statute titled Voluntary Restructuring of Solvent Insurers¹¹ patterned after Solvent Schemes of Arrangements. This type of process was renamed Commutation Plans and differs from the UK law in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.¹² Commutation Plans continue to be available under RI law.

¹⁰ *Id.* at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15

¹¹ [R.I. Gen. Laws Chapter 27-14.5.](#)

¹² [In re GTE Reinsurance Co., No. PB 10-3777, 2011 WL 7144917, at *5-6 \(R.I. Super. Ct. Apr. 25, 2011\)](#)

In 2015 Rhode Island adopted an Insurance Business Transfer Plan regulation¹³ structured similar to the Part VII transfers. Again, in contrast to the UK, the regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments ~~receives~~received, continues to believe that it meets the statutory requirement ~~have been met~~, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act (“LIMA”).¹⁴ LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act¹⁵ modeled after UK’s Part IV regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed two IBTs in October 2020 and September 2021, involving a Rhode Island and Wisconsin insurer respectively, which are described below. Neither of the plans were challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act¹⁶ which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is ~~be~~ made for an extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report

The National Council of Insurance Legislators has promulgated a model IBT law¹⁷ modeled after the Oklahoma IBT statutes, as well as a model CD law¹⁸. A number of states have adopted CD statutes, whether specific to insurance or based on the state’s general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania¹⁹. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

¹³ 230 RICR 20-45-6.

¹⁴ See Legacy Insurance Management Act, 2014 Vt. Acts & Resolves 93 (codified as amended at VT. STAT. ANN. tit. 8, §§ 7111–7121 (West 2017)).

¹⁵ Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 *et seq.*

¹⁶ As announced by the Arkansas Department of Insurance July 8, 2021, ACA §§ 23-69-501, *et seq.* (See Arkansas statute at <https://www.arkleg.state.ar.us/Bills/Detail?id=SB203&ddBienniumSession=2021%2F2021R>

¹⁷ Insurance Business Transfer Model Act (Nat’l Council of Ins. Legislators 2020).

¹⁸ Insurer Division Model Act (Nat’l Council of Ins. Legislators 2021).

¹⁹ See A.R.S. §§ 29-2601, *et seq.*; C.G.S.A §§ 38a-146, *et seq.*; 215 ILCS 5/35B-1 *et seq.*; M.C.L.A. §§ 500.5500 *et seq.*; A.C.A. §§ 23-69-501, *et seq.*; 15 Pa.C.S. §§ 361 *et seq.*

A. Similarities and Differences between Statutes

Rhode Island's IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer's domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer plan on policyholders considering whether the security position of policyholders is materially adversely affected by the transfer. All states also require notification to all affected policyholders as well as the opportunity to be heard at a public hearing.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate ~~runoff~~certain books of business from an insurer.

The Illinois' Domestic Stock Company Division Law²⁰ requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless the following characteristics exist:

- (1) policyholder/shareholder interest are not protected;
- (2) each insurer would not be eligible to receive a license in the state;
- (3) division violates the uniform fraudulent act;
- (4) division is made for the purpose of hindering, delaying, or defrauding other creditors;
- (5) any of the companies are insolvent after the division is complete.

The Connecticut CD statute²¹ creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the domestic insurer; (2) the resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will

Commented [A3]: These laws are not necessarily limited to runoff blocks.

²⁰ 215 ILL. COMP. STAT. 5 as found at <https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1249&ChapterID=22>.

²¹ C.G.S.A. §§ 38a-146, *et seq.*, Public Act No. 17-2 as found at <https://www.cga.ct.gov/2017/act/pa/pdf/2017PA-00002-R00SB-01502SS1-PA.pdf>

require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing.

The Pennsylvania CD statute²² was enacted in 1990 and is the subject of the NAIC 1997 white paper on Liability Based Restructuring. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the states equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal experts.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in announced that it had approved a transaction that transferred a book of business from one entity to another. This transaction is discussed within Attachment 1, which is the 1997 Liability-Based Restructuring White Paper, and is commonly referred to as “the Brandywine” transaction, but within the 1997 White Paper is discussed within Appendix 1 and relates to Cigna, where more information is available. During the Working Group’s discussions in 2019, the Pennsylvania Insurance Department, which is captured in the following paragraph.

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to

²² 15 PA. CONS. STAT. §§ 361 *et seq.*

any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and immaterial to the policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re²³ completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision²⁴ on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company's ("PWIC") IBT plan.²⁵ The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company ("Sentry"), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for approval.²⁶ This IBT transfers a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2020. The transaction was a transfer of risks with distinct characteristics into a single insurer within a holding company structure. All the transfers originated and ended within the same holding company. The Illinois Department of Insurance has indicated that it will issue a detailed regulation as experience develops with CD plans proposed and completed under the statute.

Section 4: Impact of IBTs and CDs to Personal Lines

A. ~~Guarantee~~Guaranty Association Issues

An important issue for corporate restructuring is the availability of guaranty association coverage in the event of the insolvency of the restructured insurer. In order to uphold the stated declaration that restructuring should not materially adversely affect consumers, guaranty association coverage should not be reduced ~~or~~, eliminated or otherwise changed by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine ~~association coverage~~. Although most states pattern their laws after the NAIC model law, there could potentially be different results concerning guaranty association coverage depending on where the insured resides guaranty association coverage. It is possible that a corporate restructuring could result in the reduction, elimination or change in guaranty association coverage provided to a policyholder in the event of the restructured insurer's insolvency if steps are not taken to prevent that result. The potential coverage issues are different

²³ C.A. No. PB 10-3777 (R.I. Super. Apr. 25, 2011)

²⁴ State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777
<https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/decisions/10-3777.pdf>

²⁵ Judgment & Order of Approval & Implementation of the IBT Plan, In re Transfer and Novation of Insurance Policies from Province Wash. Ins. Co., et al., CJ-2019-6689 (D.Ct. Okla. Cnty Oct. 15, 2020) at
<https://www.oscn.net/dockets/GetCaseInformation.aspx?db=oklahoma&number=CJ-2019-6689&cmid=3831864>.

²⁶ Approval Order in Case No. 20-0582-IBT from Oklahoma Insurance Commissioner, filed on November 23, 2020, at
<https://www.oid.ok.gov/wp-content/uploads/2020/11/20-0582-IBT-SAW-Order-11-23-20.pdf>.

for life and health guaranty association coverage and property and casualty guaranty fund coverage. We address them separately below.

Transactions Involving Life or Health Insurance

The Working Group received input from ~~both~~ the National Organization of Life and Health Insurance Guaranty Associations (“NOLHGA”) ~~and the National Conference of Insurance Guaranty Funds (“NCIGF”). NOLHGA described how about~~ the concerns for insurance consumers of personal lines life and health insurance ~~business is particularly pronounced.~~

NOLHGA indicated that for there to be guaranty association coverage in the event of ~~an~~ a life or health insurer insolvency, there are three conditions that must be present. Those conditions are:

- (1) The consumer seeking protection must be an eligible person under the guaranty association statute; typically, this is achieved by being a resident of ~~the guaranty association’s~~ the guaranty association’s state ~~who has a guaranty association at the time of the insurer’s liquidation;~~
- (2) The product must be a covered policy; and
- (3) The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state, or have been licensed in the state to write the lines of business covered by the guaranty association.

In most states, coverage can be provided for an “orphan” policyholder of the insurer ~~when~~ by the ~~coverage is issued but the policyholder has since moved to a state that is not a guaranty~~ guaranty association ~~member. Those policies are covered under the state in which the insolvent insurer’s domestic state. Orphan policyholders are policyholders who are residents of states where the guaranty association cannot provide coverage because the insolvent insurer is domiciled. This provision not a member insurer due to not being licensed at the time required by the guaranty association act. The orphan policyholder situation can arise when a policyholder purchases a policy in a state where the issuing company is licensed (i.e., is a member of the guaranty association) but subsequently moves to a state where the issuing insurance company was never licensed (i.e., is not a member of the guaranty association). The provision in the NAIC Life and Health Insurance Guaranty Association Model Act, and the laws of most states, that provides that orphan policies are covered by the guaranty association in the insolvent insurer’s domestic state is designed to plug the gap in these rare situations. Orphan coverage was not designed to provide coverage to all policyholders regardless of domicile as might occur if~~

A key factor when considering a life or health IBT or CD transaction is whether the resulting insurer in an IBT does not meet the requirements for guaranty association coverage. These issues can be addressed in legislative and regulatory manners including maintaining a certificate of authority in each state, so the insurer is a guaranty association a member insurer in each state. However, if an of the same guaranty associations where the transferring insurer is unwilling or unable as a member insurer. If the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer, guaranty association coverage will be preserved and not changed for all policyholders. (Of course, specific guaranty association coverage will be determined if/when the resulting insurer is placed under an order of liquidation with a finding of insolvency.) If the resulting insurer is not a member insurer of the same guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or

be covered as orphans by the guaranty association in the insurer's domestic state. Orphan coverage was not designed to plug the gap in this situation. Shifting the coverage obligation to meet such requirements in the domestic state guaranty association could impede the ability result in guaranty association coverage being concentrated in that state.

To address these concerns with respect to ~~complete a restructure.~~ IBT and CD transactions involving life or health insurance, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

Transactions Involving Property and Casualty Insurance

The Working Group received input from the National Conference of Insurance Guaranty Funds ("NCIGF") about the concerns for insurance consumers of personal lines property and casualty insurance business.

One interpretation of the NAIC Property and Casualty Insurance ~~Guarantee~~ Guaranty Association Model Act (Model # 540)²⁷ is that based on the definitions of "Covered Claim," "Member Insurer," "Insolvent Insurer," and "Assumed Claim Transaction" an orphan policyholder could not be covered by the state ~~guarantee~~ guaranty association.²⁸ Consequently, there is a concern that no ~~guarantee~~ guaranty association fund coverage would be provided if policies are transferred to a nonmember insurer. ~~Many~~ Many property and casualty guaranty fund statutes require that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred. These limitations, however, are designed to avoid coverage being provided when the policy at issue did not "contribute" to the association, which would not exist in the case of an accessible policy later transferred to a nonmember insurer. Moreover, the restrictions exist to prevent claims resulting from a company regulated as a surplus lines or a similar structure to benefit from the protections afforded licensed business when a licensed company is liquidated.

NCIGF's position is that where there was guaranty ~~association fund~~ coverage before the IBT or CD, state regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate or in any way impact guaranty ~~association fund~~ coverage. An CD or IBT should not create, expand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states that have adopted the NAIC Property & Casualty Insurance Guaranty Association Model Act.²⁹ These gaps could include the definitions of Covered Claim, Member Insurer, Insolvent Insurer, and the Assumed Claims Transaction found in Section 5 of the model law.

Fulfilling this intent ~~may will likely~~ require property and casualty guaranty ~~association fund~~ statutes be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and

²⁷ Available at <https://content.naic.org/sites/default/files/inline-files/MDL-540.pdf>.

²⁸ See ~~NOHLGANOLHGA~~ and NCIGF joint submission to NCOIL dated February 24, 2020 for more information. Available at <http://ncoil.org/wp-content/uploads/2020/02/2020-02-24-Comment-on-NCOIL-IBT-Model.pdf>.

²⁹ Property and Casualty Guaranty Association Model Act (Nat'l Ass'n of Ins. Comm'r's 2009).

oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee's work is discussed in the Recommendations section below.

B. Assumption Reinsurance

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholder with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, ~~in situations where the solvency of the insurer might be at risk.~~ There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.³⁰

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be affected. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act by implication prohibit an IBT or a CD. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholders express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper. The issue has not yet been addressed by any court nor raised in the proceedings on restructurings. Therefore, while it is raised here for informational purposes, resolution of the issue is left unanswered for now and for the courts to determine in the future.

³⁰ Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)

C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the ~~regulators~~regulator's willingness to consider the restructuring of certain lines of business. During the Working Group's discussion, it was noted by a number of regulators that restructuring of certain lines of business, such as long-term care insurance, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care insurance, is likely to be subject to a great deal of opposition and higher capital requirements for the insurers involved.

The nature of long-term care insurance policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care insurance policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders.

Commented [A4]: Is the Working Group suggesting that, if LTCL deals are going to be considered, there should be more detailed and rigorous standards for the regulatory review? If yes, this should be stated more explicitly.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others,³¹ a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. The US Constitution includes the Full Faith and Credit Clause as well as the Privileges and Immunities Clause (also referred to as the doctrine of Comity) in Article IV. These clauses create methods of extending the effect of a restructuring mechanism beyond the state that issued the judgment and giving that state's judgment effect in all other states in which the insurer does business.³²

Thus, the Privileges and Immunities Clause or the Full Faith and Credit Clause are two methods stemming from the US Constitution that provide for recognition of court orders from other states. We will briefly touch on both concepts but leave these non-core insurance topics to others to discuss in more depth.

The policyholder challenging the decision must first identify the property of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to the resulting insurer, but alleges no additional harm, may have difficulty identifying the property interest of which they have been deprived. The determination on full faith and credit will likely rely upon the issues raised and considered in the Court of the domestic state.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full

³¹ Gendron, Matthew Esq. (2018) "Rhode Island's Voluntary Restructuring of Solvent Insurers Law and Similar Efforts in Other States," *Roger Williams University Law Review*: Vol. 23: Iss. 3, Article 3, available at: https://docs.rwu.edu/rwu_LR/vol23/iss3/3. That article briefly raises questions about whether full faith and credit or comity would apply to help insulate an IBT transaction from collateral challenge in a court outside the approving state.

³² The same analysis does not apply to jurisdictions outside the United States and is not addressed in this white paper.

faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK.³³ This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis,³⁴ while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. *Narragansett Electric Co. v. American Home Assurance Co.* is one such case.³⁵ In *Narragansett Electric Co.*, the court reviewed claims by London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier.³⁶ Equitas argued that it had not assumed the obligations at issue. As the court summarized, “Equitas’s motion to dismiss raises the question whether this [Part VII] transfer of insurance obligations from Lloyd’s to Equitas is effective and enforceable under U.S. law.” First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent to US policyholders raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High

³³ See SIDLEY AUSTIN LLP, PART VII TRANSFERS EFFECTUATED PURSUANT TO THE UK FINANCIAL SERVICES AND MARKETS ACT 2000 (2017), <https://www.sidley.com/-/media/publications/part-vii-transfers.pdf>.

³⁴ See Jennifer D. Morton, Note, *Recognition of Cross-Border Insolvency Proceedings: An Evaluation of Solvent Schemes of Arrangement and Part VII Transfers under U.S. Chapter 15*, 29 FORDHAM INT’L L.J. 1312, 1314–15 (2006).

³⁵ See *Narragansett Elec. Co. v. Am. Home Assur. Co.*, No. 11 Civ. 8299(PKC), 2012 WL 4075171 (S.D.N.Y. Sept. 12, 2012). There, a claim originating in Pawtucket, Rhode Island, but with waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co.*, 57 N.E.3d 18, 24 (Mass. App. Ct. 2016).

³⁶ See Steven E. Sigalow & Richard E. Stewart, *How Lloyd’s Saved Itself*, 37 THE INS. FORUM (2010), reprinted in JONES DAY, <http://www.jonesday.com/files/Publication/dae28676-d6c8-4de6-9cbb-c05aee419d4b/Presentation/PublicationAttachment/533860ba-d4f1-4056-85d9-78b84dc71af5/How%20Lloyd's%20Saved%20Itself.pdf> (last visited June 9, 2021).

Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a UK’s independent expert’s report.³⁷ Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. *Allianz Insurance Co.* is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. *Allianz Insurance Co.* also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

~~*Allianz*~~ *Allianz Insurance Co.* concerned General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared an ultimate parent company—Berkshire Hathaway.³⁸ At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in *Allianz Insurance Co.* seemed to be that the post-Part VII insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden’s potential asbestos claims.

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law.³⁹ The court determined that, given the location of the petitioner’s assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action.⁴⁰ The court in *Hopewell* also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.⁴¹

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

³⁷ *Air & Liquid Sys. Corp. v. Allianz Ins. Co.*, No. 2:11-CV-00247-JFC, 2012 U.S. Dist. LEXIS 121553 (W.D.P.A. 2012).

³⁸ *Id.* at *12. This interrelated nature is not unusual and is referred to as an intra-company transaction.

³⁹ *In re Bd. of Dirs. of Hopewell Int’l Ins. Ltd.*, 238 B.R. 25, 31–32 (Bankr. S.D.N.Y. 1999).

⁴⁰ Written by then the Chief United States bankruptcy judge in the Southern District of New York Tina Brozman, this decision detailed relevant history behind the Bermuda schemes of arrangement, including the different methods available to companies. One arrangement involved a cut-off scheme, developed in 1995, in which companies have no more than five years to submit additional claims prior to a bar date. This scheme greatly reduced the time for a run-off to wind down its business.

⁴¹ Citing to 11 U.S.C. § 101(23) (2012), The court applied a standard that “a foreign proceeding is a foreign judicial or administrative process whose end is to liquidate the foreign estate, adjust its debts or effectuate its reorganization.” *Id.* at 49 (internal quotations omitted).

As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The Working Group believes that trust in these mechanisms and protection of the policyholders who will be impacted by them, demands a standard set of financial principles under which to judge the transaction. As such, the Working Group created a subgroup to specifically address these financial issues.

The Restructuring Mechanism Subgroup (“Subgroup”) has been charged with the following initial work related to this White Paper:

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long- term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.⁴²

Members of the Subgroup have studied and acknowledge that UK Part VII procedures set forth robust processes and that setting similar requirements should be applied to IBT and CDs.

As of the date of this paper, the charge related to best practices has not been completed. The Subgroup will continue its work with the goal of developing financial best practices. Those practices will be exposed for comment and discussion prior to referral to other groups.

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. ~~A number of states—Connecticut, California, and Oklahoma—have enacted statutory solutions to these issues. In addition, NCIGF has provided proposed statutory language. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.~~

On the life and health side, as noted above, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for life and health guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

On the property and casualty side, amendments to the guaranty fund statutes likely will be necessary. A number of states—California, Illinois, and Oklahoma—have enacted statutory solutions to the property and casualty guaranty association issues similar to what NCIGF has suggested to the working group. In addition, NCIGF has provided proposed statutory language for other states to consider. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership

⁴² Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).

and Insolvency Task Force for consideration. Specifically, the Working Group recommends that the language proposed by NCIGF be included in the NAIC Property and Casualty Insurance Guaranty Association Model Act. Regulators, guaranty funds and other appropriate industry stakeholders should work cooperatively to implement this statutory remedy with all deliberate speed.

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the property and casualty guaranty association issues to assure that consumers are not harmed by the transaction.

C. Statutory Minimums

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

- (1) Requirement of court approval must be required for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.
- (2) Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.
- (3) Requirement of a notice to stakeholders, a public hearing, robust regulatory process, and an opportunity to submit written comments are necessary for all policyholders, reinsurers, and guaranty associations.

None of the restructuring mechanism are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes are different and drafted by the legislatures of the states which enacted the statutes. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transaction. Other transactions, however, may not need all of these provisions. For example, an intra holding company transaction may not need full faith and credit.

While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies have difficulty getting licensed in the various states either because of

“seasoning” issues or because they are not writing ongoing business so the state may be hesitant to grant a license. Lack of licensure can provide a lack of regulatory control which can lead to actions which harm consumers. The Working Group, therefore, recommends that the appropriate committee ~~look at licensing standards consider whether any changes should be made to the licensure process~~ for runoff companies resulting from restructuring transactions of runoff blocks. A streamlined process that ~~states~~ still ensures appropriate regulatory oversight (and any licensure necessary to preserve guaranty association coverage) may ~~wish to adopt~~ be appropriate in limited circumstances.

Commented [A5]: If possible, we suggest that the appropriate committee be identified here.

NATIONAL WORKERS COMPENSATION REINSURANCE ASSOCIATION NFP

December 1, 2021

The Honorable Elizabeth Kelleher Dwyer
State of Rhode Island Department of Business
Regulation -- Division of Insurance
1511 Pontiac Avenue, Bldg. #69-2
Cranston, Rhode Island 02920
elizabeth.dwyer@dbr.ri.gov

The Honorable Glen Mulready
Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105-1816
glen.mulready@oid.ok.gov

Re: NAIC Restructuring Mechanisms (E) Working Group
Workers Compensation Residual Market Considerations in Restructuring Transactions

Dear Superintendent Dwyer and Commissioner Mulready:

On behalf of the NWCRA Board of Directors, we reiterate the concerns and comments included in my prior letter dated July 14, 2021 (copy attached), which do not yet appear to be addressed in the exposure draft of the Working Group's white paper. However, we also recognize that several NWCRA representatives have been invited to participate in the December 6 meeting of the Working Group and hope our concerns and comments on the draft white paper will be discussed for consideration at that meeting. The NWCRA Board's concerns focus on avoiding restructuring transactions creating uncertainty with regard to NWCRA member company obligations. We appreciate the invitation and opportunity to discuss those concerns and address any questions the working Group might have on these issues.

For your information, the individuals planning to participate as NWCRA representatives are Gerald Chiddick (NWCRA Board Chair), Rowe Snider (Board counsel), and Cliff Merritt and Michael Kahlowsky (NCCI as NWCRA Administrator). We look forward to the discussion.

Very truly yours,



Gerald Chiddick
NWCRA Board Chair

CC: Cliff Merritt (NCCI -- Senior Division Executive, Residual Markets)
Brian Mourer (NCCI -- Director of Plan Administration)
Michael Kahlowsky (NCCI-Director of Reinsurance)
Rowe W. Snider (Locke Lord LLP -- NWCRA Counsel)

NATIONAL WORKERS COMPENSATION REINSURANCE ASSOCIATION NFP

July 14, 2021

The Honorable Elizabeth Kelleher Dwyer
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Re: NAIC Restructuring Mechanisms (E) Working Group
Workers Compensation Residual Market Considerations in Restructuring Transactions

Dear Superintendent Dwyer and Commissioner Mulready:

I am writing to you in my capacity as Chair of the Board of Directors (the "Board") of the National Workers Compensation Reinsurance Association NFP ("NWCRA"), which is an industry organization that manages the reinsurance mechanism presently supporting the workers compensation residual market in 23 states. That residual market reinsurance mechanism was affected by the initial Insurance Business Transfer ("IBT") transaction completed last October in Oklahoma. The transferor in the Oklahoma IBT, Providence Washington Insurance Company ("PWIC"), was a participant in the residual market reinsurance mechanism and its workers compensation policies were transferred to Yosemite Insurance Company ("Yosemite"). As explained below, the Board understands that the transaction included the transfer of PWIC's residual market reinsurance obligations to Yosemite. Further, based upon its review of this initial IBT transaction, the NWCRA Board has developed some suggestions related to residual market obligations which we respectfully submit for the Working Group's consideration. The Board believes that these suggestions, if included in the Working Group's forthcoming White Paper, could improve how workers compensation residual market obligations are analyzed and treated in the review and approval process for IBTs and Company Divisions (together, "Restructuring Transactions").¹ The same concepts applicable to the NWCRA states may also be applicable to the workers compensation residual market mechanisms in other states, particularly those using a similar reinsurance mechanism to facilitate the residual market.

¹ While this letter primarily addresses IBT transactions in reaction to the Oklahoma IBT, the Board believes that the concepts and suggestions discussed in this letter are also applicable to company divisions under statutes like those enacted in Illinois and Connecticut, for example.

Background Discussion

Before turning to the Oklahoma IBT and our suggestions, some background regarding the NWCRA's workers compensation residual market may be useful context for the Working Group.

The Workers Compensation Residual Market in NWCRA states.

Given the mandatory nature of workers compensation insurance for most employers in almost all states, most states provide for a "residual market" for difficult-to-place employers so they may comply with the law by obtaining workers compensation insurance. In the NWCRA states, the workers compensation residual market is implemented through a statutorily-authorized Workers Compensation Insurance Plan ("WCIP" or "Plan"). The Plan is a filed program established and maintained by the National Council on Compensation Insurance ("NCCI") and approved by each state's insurance regulator. The Plan provides a process through which eligible employers who are unable to secure such coverage through ordinary means, *i.e.*, in the voluntary market, may obtain workers compensation insurance. The Plan is also known as the "involuntary market" or the "assigned risk market." (The latter term applies because involuntary market employers are assigned to a specific insurer, which issues them a workers compensation policy.) In general, all admitted workers compensation insurers in a state must participate in that state's Plan, either through membership in the NWCRA and its reinsurance mechanism or, in states where permitted, as Direct Assignment Carriers.²

National Workers Compensation Reinsurance Pooling Mechanism

The National Workers Compensation Reinsurance Pooling Mechanism ("NWCRP" or "residual market reinsurance mechanism") is a contractual quota share reinsurance mechanism that affords participating workers compensation insurers a means for complying with state Plan requirements by the participating insurer's sharing in the operating results of certain involuntary market policies written pursuant to state insurance Plans. Through the NWCRP, participating insurers reinsure certain servicing carriers, who issue the involuntary market policies to eligible employers who apply through the Plan. By electing to participate in this residual market reinsurance mechanism, participating voluntary market insurers in a state each share an equitable proportion of the residual market results in the state with all other participants based upon each insurer's share of the state's calendar year direct written premium, avoiding random and variable burden of each insurer assuming and absorbing the results of individual assigned risk policies.

The NWCRP, as a quota share reinsurance mechanism, has been in existence since 1970. As noted above, the participants' quota shares are calculated on a policy year basis in each NWCRA state.³ Consequently, the NWCRP is comprised of approximately 1500 individual state residual market policy year quota share reinsurance calculations, each of which is adjusted quarterly. Overall operating results, including remittance of involuntary market premium minus servicing carrier allowances and indemnity owed reinsured servicing carriers for paid losses, are netted quarterly. NCCI, as administrator of the NWCRP, calculates statements of net account balances

² Not all NWCRA states allow Plan participants to opt to be a Direct Assignment Carrier, rather than participating in the residual market reinsurance mechanism. This letter does not address the potential impact Restructuring Transactions may have, if any, on Direct Assignment Carriers.

³ While the NWCRA presently reinsures the residual market in 23 states, that number has varied over time. There are presently open reinsured policy years in a total of 41 states.

of the participating companies and servicing carriers and settles the cash flow of such accounts quarterly, with participating insurers retaining liability for unearned premium and unpaid loss reserves. At year-end 2020, the total amount of reinsured residual market liabilities within the NWCRP exceeds \$ 4 Billion.

It is important for present purposes to emphasize that the NWCRP is a pass-through reinsurance mechanism, so in addition to members' proportional assumption of the reinsurance liabilities, the related assets, intended to cover the reinsurance obligations, are also almost entirely distributed to the participating members. Aside from a relatively small "working fund" advanced by participating companies to provide liquidity and cover expenses between quarterly settlements, the NWCRP reinsurance mechanism distributes proportionately all assets to participating companies. Accordingly, any restructuring transaction involving an NWCRP participating company and transferring or allocating policies written in a NWCRA state will need to evaluate not only any affected residual market reinsurance obligations, but should not separate those obligations from the associated assets held by the participating company.

The National Workers Compensation Reinsurance Association NFP

Insurance companies participate in the NWCRP residual market reinsurance mechanism as members of the National Workers Compensation Reinsurance Association NFP ("NWCRA"), which is organized as a not-for-profit corporation. The NWCRA is responsible for all policymaking and oversight functions for the NWCRP residual market reinsurance mechanism. The NWCRA operates that mechanism pursuant to the NWCRA Bylaws under the direction of the NWCRA's Board of Directors and consistent with quota share reinsurance agreements between the servicing carrier and the participating members. The NWCRA contracts with NCCI for operational and managerial support, as well as for administration of the residual market reinsurance mechanism (the "NWCRA Administrator").

The NWCRA and the Initial Oklahoma IBT

At the time the initial Oklahoma IBT transaction was approved, PWIC was a member of the NWCRA having residual market obligations in more than twenty states and totaling approximately \$2.3 Million. These obligations include unpaid loss reserves and thus present exposure capable of adverse development.

Based upon non-sealed, available court records and a limited investigation by Board's counsel, the Board believes that PWIC's residual market obligations were not specifically analyzed in the review of the transaction. There was a suggestion in at least one public discussion of the transaction that these residual market obligations were considered not to be material to the analysis. The Board, of course, recognizes that it has limited insight into the review process and there are sealed court filings, so there may be relevant information and aspects of the analysis of which we are not aware.

The Board was unable to confirm that NCCI, in its capacity as NWCRP Administrator, received notice of the proposed IBT. Nor was the NWCRP Administrator contacted to verify PWIC's residual market obligations or their amount. The NWCRP Administrator did receive a copy of the October 15, 2020, Judgment and Order of Approval (the "Order") implementing the IBT. The Order, however, contains no express reference to or direction regarding PWIC's residual market

obligations, which PWIC had assumed as a result of the “subject business” that was being transferred to Yosemite in the IBT.

Given our understanding that PWIC’s entire book of workers compensation policies were included in the “subject business” being transferred to Yosemite, the NWCRP Administrator concluded that the intention of the IBT was that all of PWIC’s residual market reinsurance obligations were also transferred to Yosemite. This conclusion seems further supported by the language in paragraph 46 of the Order, which states as a conclusion of law that Yosemite will be treated as the “original insurer” from inception of the transferred PWIC policies for not only with regard to “contractual rights, obligations, and liabilities, but also to seamless application of regulatory laws applicable to the Subject Business...” as if Yosemite has issued the transferred policies initially. Nowhere in the Order was transfer of these residual market obligations expressly addressed. Because Yosemite was already a member of the NWCRA and had executed the appropriate membership documents, NCCI could readily transfer PWIC’s outstanding residual market obligations to Yosemite in the NWCRP records. At this point, no NWCRP operational issues have arisen from the Oklahoma IBT, but we note that it was an intra-group transfer, which may have decreased the chances of any operational issue arising. If the IBT had transferred residual market obligations to a non-affiliated insurer without being explicitly addressed, operational issues with billing and payment of quarterly settlement balances would have been more likely to arise.

Suggestions for consideration of Workers Compensation Residual Market Obligations in the Review and Approval of proposed Restructuring Transactions.

The NWCRA Board, as part of its managerial responsibilities, followed and has discussed the initial Oklahoma IBT transaction, given it involved PWIC as a member company with residual market obligations. Further, aware of the increasing number of states that have enacted or may enact statutes authorizing Restructuring Transactions, the Board has consulted with its counsel and developed some suggestions related to the NWCRA and the residual market for the Working Group’s consideration in conjunction with the White Paper it is drafting. We respectfully suggest that these suggestions may be appropriate for the Working Group to incorporate in some way in the White Paper.

1. Identify and verify any Residual Market Reinsurance Obligations affected by a proposed Restructuring Transaction.

We suggest that when a regulator is reviewing a proposed Restructuring Transaction involving workers compensation policies, the regulator should be certain that the review process has specifically identified what residual market obligations may be affected by the Restructuring Transaction. The existence of such obligations may need to be verified, which, in the case of NWCRA states, an appropriate representative of the regulator could contact the NWCRP Administrator for such verification. Almost all insurers that have written workers compensation insurance in one of the NWCRA states at any time since 1970 will have incurred residual market reinsurance obligations for various policy years. In the first instance, the applicant insurer should be able to provide information about the existence of any such residual market obligations and whether those obligations are potentially affected by the proposed Restructuring Transaction. If there is any doubt or uncertainty about these obligations or what states and policy years may be affected, it may be prudent for the reviewing regulator (or his/her appropriate representative) to

contact the NWCRA Administrator to verify the nature and extent of the residual market obligations that may be affected.

2. Where an applicant's Residual Market Obligations are affected, verify that those Residual Market Obligations are accurately stated in the applicant's financial statements and in the application documents.

Given the nature of the NWCRA's quota share reinsurance mechanism, each NWCRA member participating insurer has individually assumed its proportionate share of the residual market reinsurance obligations as its own liability. NCCI's policies and procedures, as NWCRA Administrator, provide all NWCRA member insurers with sufficient information for each member insurer to appropriately record the member's share of the residual market reinsurance obligations on its financial statements. That being said, the NWCRA Board has no knowledge of each member insurer's actual practices in accounting for its participation in the NWCRA residual market reinsurance mechanism. Accordingly, it may be prudent to have the reviewing regulator (or his/her appropriately credentialed representative) contact the NWCRA Administrator to verify that the residual market reinsurance obligations affected by the transaction are accurately stated as they are considered in the review process.

3. Ensure that both Residual Market Obligations and associated assets are considered as part of the evaluation process and are appropriately transferred or allocated in Restructuring Transactions.

As noted above, in the NWCRA residual market reinsurance mechanism, both reinsurance obligations and associated assets are distributed to participating member insurers. If a proposed Restructuring Transaction affects residual market reinsurance obligations, the reviewing regulator should make certain that both residual market reinsurance obligations and appropriate related assets are taken into consideration in the evaluation process. Each NWCRA member insurer has not only residual market reinsurance obligations, but also holds related assets (basically, a share of residual market insurance premiums) distributed to the member insurer at approximately the same time the reinsurance obligations were originally assumed. Accordingly, appropriate consideration should be given to the allocation/transfer of both the obligations and related assets in the effectuation of any Restructuring Transaction.

4. In approving any Restructuring Transaction affecting the Residual Market Reinsurance Obligations, the approval orders or judgements should provide clear and specific guidance regarding the disposition of the affected residual market obligations.

Clarity and certainty in the administration of residual market mechanisms benefits all stakeholders. Given the nature of Restructuring Transactions, the NWCRA Board understands that, generally, outstanding residual market reinsurance obligations would be transferred or allocated in a fashion that follows responsibility for the voluntary market policies that generated the direct written premium on the basis of which those residual market reinsurance obligations originally arose as quota share obligations. As noted above, based upon the IBT transferring *all PWIC's workers compensation policies* and, further, the Order "deeming" Yosemite to have been the original insurer of the transferred policies for regulatory purposes, PWIC's residual market obligations have been transferred to Yosemite by the IBT. An explicit direction to make this transfer would have removed any uncertainty for all stakeholders. Additional direction and more

specific communications may be required if some other result were intended in other Restructuring Transactions, or if only a portion of an applicant's workers compensation book is being transferred or allocated to the transferee insurer while other blocks of workers compensation business remain with the applicant transferor insurer. To make the point in stark practical terms, NCCI, as NWCRA Administrator of the NWCRA reinsurance mechanism, needs to know with certainty the insurer to whom it sends quarterly reports and from whom it will collect reinsurance obligations when a net amount is due and owing to the residual market reinsurance mechanism.

Conclusion

The Board appreciates the Working Group's consideration of our suggestions and hopes these prove helpful. Should you have any questions or wish to discuss any of the suggestions, please feel free to contact me (gerald.chiddick@zurichna.com) or Cliff Merritt (cliff_merritt@ncci.com) and/or counsel (rsnider@lockelord.com).

Very truly yours,



Gerald Chiddick
NWCRA Board Chair

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