

Draft date: 8/3/23

2023 Summer National Meeting
Seattle, Washington

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Monday, August 14, 2023

11:00 a.m. – 12:00 p.m.

Hyatt Regency Seattle—Regency Ballroom A—Level 7

ROLL CALL

James J. Donelon, Chair	Louisiana	Troy Downing	Montana
Glen Mulready, Vice Chair	Oklahoma	Eric Dunning	Nebraska
Mark Fowler	Alabama	Justin Zimmerman	New Jersey
Lori K. Wing-Heier	Alaska	Mike Causey	North Carolina
Peni Itula Sapini Teo	American Samoa	Jon Godfread	North Dakota
Michael Conway	Colorado	Judith L. French	Ohio
Andrew N. Mais	Connecticut	Andrew R. Stolfi	Oregon
Dana Popish Severinghaus	Illinois	Michael Humphreys	Pennsylvania
Doug Ommen	Iowa	Elizabeth Kelleher Dwyer	Rhode Island
Vicki Schmidt	Kansas	Michael Wise	South Carolina
Sharon P. Clark	Kentucky	Carter Lawrence	Tennessee
Timothy N. Schott	Maine	Cassie Brown	Texas
Gary D. Anderson	Massachusetts	Mike Kreidler	Washington
Chlora Lindley-Myers	Missouri	Nathan Houdek	Wisconsin

NAIC Support Staff: Jane Koenigsman

AGENDA

1. Consider Adoption of its Spring National Meeting Minutes Attachment One
—*Commissioner James J. Donelon (LA)*
2. Consider Adoption of its Working Group and Subgroup Reports
 - A. Receivership Financial Analysis (E) Working Group
—*Donna Wilson (OK) and Jacob Stuckey (IL)*
 - B. Receivership Law (E) Working Group—*Laura Lyon Slaymaker (PA)* Attachment Two
3. Consider Exposure of Amendments to *Property and Casualty Insurance Guaranty Association Model Act (#540)* Attachment Three
—*Laura Lyon Slaymaker (PA)*
4. Consider Exposure of Sample Text Describing the U.S. Receivership Regime—*Commissioner James J. Donelon (LA)* Attachment Four



5. Hear an Update on International Activities—*Robert Wake (ME)*
6. Discuss Accreditation Standards for Receivership and Guaranty Association Model Acts—*Commissioner James J. Donelon (LA)*
7. Hear an Update on the Receivership Tabletop Exercise
—*Commissioner James J. Donelon (LA)*
8. Discuss Any Other Matters Brought Before the Task Force
—*Commissioner James J. Donelon (LA)*
9. Adjournment

Draft Pending Adoption

Draft: 8/13/23

Receivership and Insolvency (E) Task Force
Louisville, Kentucky
March 23, 2023

The Receivership and Insolvency (E) Task Force met in Louisville, KY, March 23, 2023. The following Task Force members participated: James J. Donelon, Chair, and Stewart Guerin (LA); Glen Mulready, Vice Chair, represented by Donna Wilson and Jamin Dawes (OK); Mark Fowler represented by Ryan Donaldson (AL); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais (CT); Doug Ommen represented by Daniel Mathis (IA); Dana Popish Severinghaus represented by Kevin Baldwin and Bruce Sartain (IL); Vicki Schmidt represented by Levi Nwasoria (KS); Sharon P. Clark represented by Rodney Hugle (KY); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Troy Downing represented by Steve Matthews (MT); Mike Causey represented by Monique Smith (NC); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented by Lindsay Crawford (NE); Marlene Caride represented by David Wolf (NJ); Andrew R. Stolfi represented by Doug Hartz (OR); Michael Humphreys represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Michael Wise represented by Ryan Basnett (SC); Cassie Brown represented by Brian Riewe (TX); and Nathan Houdek represented by Mark McNabb (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Smith made a motion, seconded by Donaldson, to adopt the Task Force's Dec. 14, 2022, minutes (*see NAIC Proceedings – Fall 2022, Receivership and Insolvency (E) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Receiver's Handbook (E) Subgroup

Baldwin said the Receiver's Handbook (E) Subgroup met Dec. 21, 2022, and took the following action: 1) adopted revisions to Chapters Three, Four, and Five of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook); and 2) exposed Chapters Six and Seven of the Receiver's Handbook for a 45-day public comment period ending Feb. 6, 2023. The Subgroup received helpful clarifications.

The Subgroup plans to schedule a meeting to adopt Chapters Six and Seven. The drafting groups are continuing their work to complete the remaining chapters. The Subgroup is expected to complete the Receiver's Handbook project by the fall of 2023.

Hartz made a motion, seconded by Slaymaker, to adopt the report of the Receiver's Handbook (E) Subgroup, including its Dec. 21, 2022, minutes (Attachment One). The motion passed unanimously.

3. Adopted the Report of the Receivership Financial Analysis (E) Working Group

Wilson said the Receivership Financial Analysis (E) Working Group plans to meet March 23 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.

Matthews made a motion, seconded by Crawford, to adopt the report of the Receivership Financial Analysis (E) Working Group. The motion passed unanimously.

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4. Adopted the Report of the Receivership Law (E) Working Group

Slymaker said the Receivership Law (E) Working Group exposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)* related to the coverage of policies that are subject to restructuring mechanisms, specifically insurance business transfers (IBTs) and corporate divisions (CDs). The Working Group received comments and alternative amendments. The comments raised some additional considerations and scenarios specifically around novation and assumptions, as well as which sections of the model may also be affected. A drafting group comprised of Working Group members, the National Conference of Insurance Guaranty Funds (NCIGF), and interested parties was formed. The drafting group met March 6 to discuss a revised draft of amendments. There is a remaining item to resolve, therefore, the drafting group plans to meet again before sending the draft to the Working Group.

Slymaker said if the Executive (EX) Committee approves the Request for NAIC Model Law Development related to cybersecurity insurance at its meeting on March 23, the Working Group will also schedule a call to discuss and expose draft amendments to Model #540 for cybersecurity insurance.

Hartz made a motion, seconded by Kaumann, to adopt the report of the Receivership Law (E) Working Group. The motion passed unanimously.

5. Heard an Update on International Activities

Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group released for public consultation the application paper on policyholder protection schemes. Comments on the public consultation are due to the IAIS on April 14. The International Insurance Relations (G) Committee will hold a meeting on April 13 to consider comments from the NAIC. Anyone wishing to submit comments for the Committee to consider should send them to NAIC staff by March 27.

Wake said in follow-up to the IAIS's Targeted Jurisdictional Assessment (TJA) for which the U.S. participated and was assessed, the IAIS will conduct a follow-up to assess each jurisdiction's progress in addressing the findings where a jurisdiction did not receive a "fully observed" assessment.

Wake said the IAIS is expected to begin a project to update the IAIS Insurance Core Principles (ICPs) and Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) provisions related to resolution and recovery issues. The ICPs and the related issue papers will be discussed at the IAIS meeting in May 2023.

6. Heard a Presentation on a Proposed Receivership Tabletop Exercise

Peter G. Gallanis (National Organization of Life and Health Insurance Guaranty Associations—NOLHGA) presented a tabletop receivership proposal. He said the NOLHGA and the NCIGF conducted a tabletop exercise on how to respond to the insolvencies of hypothetical insurance carriers. He said there has been a lot of turnover in the receivership community, and many have not had hands-on experience with how troubled insurers are identified by the financial regulators, how the domiciliary commissioner determines remediation steps, developing a rehabilitation plan, liquidation, developing a response to a nationally significant company that triggers the guaranty associations, and management of an insolvency case. The tabletop is a hands-on interactive participatory exercise to talk through various issues. Gallanis said the NOLHGA membership found it to be a very helpful training exercise. He said he spoke with Commissioner Donelon and Tom Travis (LA) about this exercise. State insurance regulators have also seen some turnover. He said he discussed with Commissioner Donelon about the tabletop

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being an exercise that could provide training to financial regulators, commissioners, and states' receivership staff who may wish to participate and who attend other educational programs or the NAIC national meetings.

Gallanis said he was asked by Louisiana to develop a timeline, provide more details on how to move forward with the proposal, provide more details on who from the financial regulators, receivership staff, and possibly industry would participate, and work with the NAIC to identify a date and time for a presentation such as this (Attachment Two).

Roger Schmelzer (NCIGF) said this is a time of relative strong agreement between state insurance regulators, guaranty funds, and receivers. He said it would be important to go through issues and figure out where the disagreement is before having a real insolvency scenario where stakes become extremely high. The recent banking industry issues with Silicon Valley Bank and others and the actions of the federal banking regulators indicate an inclination for the federal government to be more involved in financial services that are regulated at the state level. This program is a way to take that seriously and be more prepared for what might come.

Bill O'Sullivan (NOLHGA) said as more practical knowledge is gained from the program, as well as a better understanding of the tools, relationships and collegiality are built to be able to better share information and strategies and agree on a common approach to protect policyholders. This program builds the foundation for those kinds of critical relationships.

Schmelzer said the NCIGF is doing more work to plan what a program would look like and get input. Connecting this program with an NAIC meeting or event would facilitate attendance by the state insurance regulators. Regarding timing, Schmelzer said some time in the fall would work if everything can be pulled together. He said the NCIGF welcomes the Task Force's support in this effort.

Guerin said he agrees that this training would be beneficial for the reason of staff turnover. He said Louisiana had not had a receivership for over 15 years and suddenly had multiple receiverships due to a hurricane. He said this training would have been beneficial and allowed Louisiana to work more expeditiously through some of the issues.

Commissioner Donelon said the receiverships in Louisiana over the past year have the Louisiana legislature and industry looking at modifications to its guaranty fund law and, in particular, the assessments and recoupment of those assessments. He said he agrees with Guerin, and he said Louisiana has been able to contract with receivership experts that have decades of experience doing receiverships. He said the banking challenge Schmelzer referenced is one that state insurance regulators need to gear-up for to be prepared.

Guerin said as the program is still in development, he requested an update at a future time. He said to let the Task Force know if the NOLGHA or the NCIGF have any requests of the Task Force.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

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Virtual Meeting

RECEIVERSHIP LAW (E) WORKING GROUP

July 24, 2023

Summary Report

The Receivership Law (E) Working Group met July 24, 2023. During this meeting, the Working Group:

1. Adopted its May 23 minutes, which included the following action:
 - A. Exposed draft amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) for a 30-day public comment period ending June 23. The amendments address guaranty fund coverage for policies that are included in insurance business transfers (IBTs) and corporate divisions (CDs) and clarify guaranty fund coverage of cybersecurity insurance.
2. Discussed comments received from interested parties on the exposure of the amendments to Model #540 related to IBT and CD transactions including optional provisions. No comments were received on amendments related to cybersecurity insurance.
3. Adopted amendments to Model #540 for cybersecurity insurance, and IBT and CD transactions including optional provisions.
4. Heard a presentation from Arcina Risk Group requesting preservation of closed receivership estate records.

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PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. [Other than coverages that may be set forth in a cybersecurity insurance policy, insurance](#) ~~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

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benefits;

- F. Title insurance;
- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

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

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

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;
2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;
3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;
4. Changes in the value of specific assets or commodities, or price levels in general.

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

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

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

Section 4. Construction

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

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Section 5. Definitions

As used in this Act:

[Optional:

- A. “Account” means any one of the three accounts created by Section 6.]

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

- A. “Affiliate” means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. “Association” means the [State] Insurance Guaranty Association created under Section 6.
- C. “Association similar to the association” means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

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

- D. ——— ~~[Alternative 1] “Assumed claims transaction” means the following:~~

- (1) ——— ~~Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or~~
- (2) ——— ~~An assumption reinsurance transaction in which all of the following has occurred:~~
- (a) ——— ~~The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and~~
- (b) ——— ~~The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and~~
- (c) ——— ~~As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies~~

- ~~[Alternative 2] “Assumed claims transaction” means the following:~~

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

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- 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 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.~~
 - (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.~~

DE. “Claimant” means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

EF. “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.

FG. “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.

GH. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the ~~policy was issued by an~~ insurer ~~that~~ becomes an insolvent insurer after the effective date of this Act and: ~~the policy was either issued by the insurer or assumed by the insurer in an assumed claims transaction; and~~
- (a) The claimant or insured is a resident of this State at the time of the insured event, provided

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that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or

- (b) The claim is a first party claim for damage to property with a permanent location in this State.

(2) ~~“Covered claim” includes claim obligations that arose through the issuance of an insurance policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:~~

- ~~(a) The original member insurer has no remaining obligations on the policy after the transfer;~~
- ~~(b) A final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member’s coverage obligations by a court of competent jurisdiction in the insurer’s State of domicile;~~
- ~~(c) The claim would have been a covered claim, as defined in Section 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and~~
- ~~(d) In cases where the member’s coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.~~

[Optional:

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

- ~~(a) A merger in which the surviving company was a member insurer immediately after the merger;~~
- ~~(b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or~~
- ~~(c) A transaction entered into pursuant to a plan approved by the member insurer’s domiciliary regulator.]~~

~~**Drafting Note:** Optional Section 5G(3) provides coverage for certain claims that are not within the scope of Sections 5G(1) or (2) because the original coverage was not provided by a member insurer. Sections 5G(3)(a) and (3)(b) are based on Alternative 1 of the former definition of “assumed claims transaction” (below), and Section 5G(3)(c) is based on the additional scenario included in Alternative 2 of the former definition of assumed claims transaction (below). The reference to “assumption consideration” in that clause of the former definition is now addressed by Optional Section 8A(4).~~

~~**Definition of “Assumed Claims Transaction”:** Former Drafting Note to the Former Definition of Assumed Claims Transaction: There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self-insurer. Alternative 1 below provides that these claims shall be covered by the guaranty association if the licensed insurer becomes~~

Commented [Staff1]: This sentence added in place of the next deleted paragraph, as this paragraph explains how to use 5G(3).

Note that the former alternative definitions of assumed claims transactions are part of the drafting note. The font size of drafting notes will be reduced upon NAIC publication of adopted amendments.

~~insolvent subsequent to the assumption. Alternative 2 below provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1 below, it must select Alternative 1 below and Alternative 1 or 1a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 below, the former definitions of Assumption Consideration and Novation (below) and Alternative 2 or 2a in Section 8A(3).~~

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

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
- (2) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

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

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
- (3) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

~~Former Definition for Assumption Consideration: “Assumption Consideration” shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any~~

Commented [Staff2]: Former definition deleted from the drafting note, as assessments are addressed in optional 8A(4); and novation is a common term, the intent of which is addressed in optional 5G(3).

~~assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.~~

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

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

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

- (3) Except as provided elsewhere in this section, “covered claim” shall not include:
- (a) Any amount awarded as punitive or exemplary damages;
 - (b) Any amount sought as a return of premium under any retrospective rating plan;
 - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
 - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;
 - (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
 - (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
 - (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
 - (h) Any claims for interest; or
 - (i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

Drafting Note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to

expressly include the existing intent of this provision and make it clear that “policyholder protection” proofs of claim, while valid to preserve rights against the ~~State-estate~~ of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

[Optional:

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

HH. “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.

IJ. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

JK. (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.

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

[Optional:

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

Commented [Staff3]: Removed "Optional" from the body of the paragraph as states would not adopt the Subsection with the term "optional". 5G(3) is defined as optional above.

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

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

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

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

Drafting Note: Each State should conform the definition of “receiver” to the definition used in the State’s insurer receivership act.

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

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

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

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

Section 6. Creation of the Association

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

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K 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.

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Section 8. Powers and Duties of the Association

A. The association shall:

- (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
- (i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;
 - (ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (iii) An amount not exceeding \$500,000 per claimant for all other covered claims.
 - (iv) In no event shall the Association be obligated to pay an amount in excess of \$500,000 for all first- and third-party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of claimants.
- (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

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

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

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

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

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising

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

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

Commented [Staff4]: Deleted this drafting note to eliminate the conflict with optional 8A(4), which is intended to replace this alternative.

~~(3) [Alternative 1a for Subsection 8A(3)] Assess insurers 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 bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full~~

payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

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

- (3) **[Alternative 1b2]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The

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association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

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

Commented [Staff5]: Deleted this drafting note to eliminate the conflict with optional 8A(4), which is intended to replace this alternative.

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

(3) — [Alternate 2b] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims

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

[Optional:

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

Commented [Staff6]: Removed "Optional" from the body of the paragraph as states would not adopt the Subsection with the term "optional". 5G(3) is defined as optional above. Use reference to "Section" for consistency in added text.

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

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

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

the domiciliary receiver.

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.
 - (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
 - (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
- (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
- (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

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B. The association may:

- (1) Employ or retain persons as are necessary to handle claims, provide covered policy benefits and services, and perform other duties of the association;
- (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
- (3) Sue or be sued;
- (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
- (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
- (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

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

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

C. Suits involving the association:

- (1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.
- (2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional:
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;*

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- (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

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this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

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

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

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

Section 9. Plan of Operation

- A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
- (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
 - (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;

- (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
- (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
- (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
- (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;
- (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

B. The commissioner may:

- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;
- (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
- (3) Examine, audit, or otherwise regulate the association.

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

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

competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

- A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
- B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.
- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to 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.~~f~~
- i. The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(1). In that case, the Association shall recover from the high net worth insured under this section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association’s attorney’s fees, and all court costs in any action necessary to collect the full amount to the Association’s reimbursement under this section.]

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

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;

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- (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.^f
- (5) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this section.]

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

[Alternative 3 for Section 13B

- B. The association shall not be obligated to pay any first party claims by a high net worth insured.]
- C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.
- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the

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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

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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).*

SAMPLE TEXT FOR DESCRIBING THE U.S. RECEIVERSHIP REGIME IN RESOLUTION PLANS

The following is sample text that may be used by a U.S. lead state to describe the U.S. receivership regime within resolution plans or to facilitate dialogue with international supervisors during Supervisory Colleges and Crisis Management Group (CMG) discussions.

This sample text does NOT constitute a complete resolution plan, but rather focuses on one element of a resolution plan—a description of the receivership process in the U.S.

The sample text must be modified for the individual state’s laws, regulations, and receivership practices, and supplemented with specific insurer scenarios and information depending on the nature and complexity of the insurer for which the resolution plan or Supervisory College/CMG discussion applies.

TRIGGERS FOR RESOLUTION

[Insert this state’s Commissioner/Director/Superintendent title] has broad discretion to take regulatory action if any of the hazardous conditions listed in [Insurance Code] are triggered, which provides the hazardous conditions that can be considered. *[Insert details from the insurance code for hazardous financial condition law.]*

The Commissioner would also be required to take regulatory action if the risk-based capital (RBC) level falls to or below the Mandatory Control Level as defined by the NAIC RBC model or *[Insert the Insurance Code for RBC]*. Below are the Authorized Control Level (ACL) RBC trigger points.

ACL RBC Percentage	RBC Action Levels
Above 200%	No negative trend, no action
150% to 200%	Company Action Level – company submits a plan to improve capital
100% to 150%	Regulatory Action Level – the regulator specifies correction actions
70% to 100%	Authorized Control Level – the regulator may take control of company
Below 70%	Mandatory Control Level – the regulator is required to take control

[Insert any differences between the ACL RBC triggers and the triggers outlined in the Recovery Plan (if applicable) or elsewhere in the Resolution plan].

[Insert additional summary information describing RBC. For example, include a description of the applicable trend test calculation for life, health or P&C.]

In addition to triggers for hazardous conditions and RBC action levels, the receivership statute within *[Insurance Code]* provides that following grounds for receivership. *[If the state’s receivership law contains additional triggers for receivership, add or combine with the above.]*

IMPACT OF FAILURE ON POLICYHOLDER PROTECTION

While the laws governing state insurance guaranty associations vary, most states’ laws are patterned after the *[Insert applicable Model: Life and Health Insurance Guaranty Association Model Act (#520), or the*

Property and Casualty Insurance Guaranty Association Model Act (#540)] adopted by the National Association of Insurance Commissioners (NAIC). Under the Model Act, a state’s guaranty association generally must cover resident claims of an insolvent insurer (placed into liquidation). For life and health insurers, the guaranty association may cover resident claims of an impaired insurer (placed into rehabilitation and not an insolvent insurer). Benefit limits vary by state.

The *Life and Health Insurance Guaranty Association Model Act* proposes the following benefit limits, with respect to one life, regardless of the number of policies or contracts:

- (1) \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance,
- (2) in health insurance benefits:
 - i. \$100,000 for coverages not defined as disability insurance or health benefit plans or long-term care insurance including any net cash surrender and net cash withdrawal values,
 - ii. \$300,000 for disability insurance,
 - iii. \$300,000 for long-term care insurance,
 - iv. \$500,000 for health benefit plans, and,
- (3) \$250,000 in the present value of annuity benefits, including any net cash surrender and net cash withdrawal values.

Aggregate limits and other rules may apply.

The *Property and Casualty Insurance Guaranty Association Model Act* proposes the following benefit limits,

- (1) Full amount of workers’ compensation insurance coverage,
- (2) \$10,000 per policy, for return of unearned premium for a covered claim, and,
- (3) \$500,000 per claimant for all other covered claims.

High net worth exclusions and other rules may apply.

OVERVIEW OF A RESOLUTION REGIME

A resolution of [Insurer Name] would be handled under the insurance laws of the state of [this state]. The Commissioner of [this state] would be appointed as the receiver by a judge from the [Name and location of the court]. Receivership proceedings are conducted in state courts because insurance companies are specifically exempted from the provisions of the U.S. Federal Bankruptcy Code (See 11 U.S.C. § 109(b)). The court would oversee and be required to approve any significant actions taken by the receiver. [Insurance Code] provides the statutory authority and creditor priority for any receivership proceeding of an insurer domiciled in [this state]. *[Insert a comment on who handles receivership within the state – internal department or outside firm, and who appoints that firm.]*

[If multiple legal entity insurers are within scope of the resolution plan, insert a comment that “receivership actions would be independent for each individual insurance legal entity. Factors would be considered independently such as, minimum capital requirements or RBC levels in determining whether it should be placed into any receivership proceeding.”]

Timelines to complete a receivership depend on factors such as size and complexity of the insurer, ability to sell assets including selling books of business and affiliated assets, legal issues including handling

affiliated or third-party agreements, stays and injunctions, and coordination with other states and jurisdictions where the insurer has business. Therefore, any receivership action is difficult to predict and may take years to complete.

The [other state insurance department] would handle any resolution of [affiliated insurance entity domiciled in another state]. [Other state]’s receivership scheme would be similar to [this state]’s scheme in that any receivership would be overseen by the local court.

To provide an indication of relative size, the following sets out some comparative details for the insurer and its insurance subsidiaries as of December 31, 20xx. *[Customize the following table or other information to the U.S. insurers within the scope of the resolution plan.]*

	Insurer #1	Insurer #2	Insurer #3
General Account Assets			
(Separate Account Assets for L/H or Protected Cell Assets for P&C)			
Total Assets			
General Account Liabilities			
Separate Account Liabilities for L/H or Protected Cell Liabilities for P&C)			
Total Liabilities			
Total Policyholder Surplus			
Total (Direct/Net) Premiums			
Largest Line of Business			
Net Income or Loss			
ACL Risk-Based Capital %			

Should there be an insolvency of the insurer, [this state] must coordinate its activities on the receivership with [this state’s] guaranty association. Attached is [Insurance Code] that provides the statutory authority of [this state’s] guaranty association, and coverage limits provided by the association. The guaranty funds in all the states where the insurer sold business would be triggered to cover the policyholder liabilities as defined by insurance laws of those states. [This state’s guaranty association] would work with [the National Organization of Life & Health Life Guaranty Associations (NOLHGA) or the National Conference of Insurance Guaranty Funds (NCIGF)] to coordinate the efforts of all the states’ guaranty funds.

[Insurance Code] provides the Commissioner several regulatory actions when insurance companies experience financial difficulties. Regulatory action is taken when insurance companies trigger any of the hazardous financial condition standards delineated in [Insurance Code], including if the company triggers action under RBC standards as developed by the NAIC and adopted by [this state]. RBC requirements have absolute actions that must be taken given the reported level of the reporting entity. The hazardous condition requirements are much broader in nature and give the Commissioner authority to take action before a company is insolvent. *[Specify the regulatory actions]* within [Insurance Code] require a court order and oversight.

- Supervision is an order from the Commissioner that orders the insurance company to take certain actions to abate the hazardous conditions. Supervision is frequently used as the first step in a process to resolve financial issues within the insurer.

- If the issue is significant and needs immediate action to protect policyholders the Commissioner may decide Conservation, Seizure, Rehabilitation or Liquidation are appropriate, and petition the court.

The most appropriate action(s) to take in a resolution of the insurer will depend on the cause of the financial issues that are prompting the need for regulatory action.

RESOLUTION DIFFERENCES

[Include an explanation of any material differences in how resolution may be handled based on the unique nature of an insurer's book of business, for example insurance products that require special legal and regulatory consideration, unique receivership processes and procedures; or that may not be covered by guaranty funds. Examples may include the following:]

General Account vs. Separate Account

[This state] differentiates between the resolution of [the insurer's] general account business and its separate account business. A separate account refers to an investment account used to manage policyholder funds placed in variable insurance products. This account is maintained separately from the general account, and distinctions are important in this context.

The insurer's separate account supports its *[List the products included in the separate account]*. In addition to being established under state insurance law, [the insurer's] separate accounts are *[Specify how they are considered under federal laws, such as "unit investment trusts under federal securities law and registered as investment companies with the U.S. Securities and Exchange Commission"]*. In any receivership proceeding, the receiver will need to communicate and consult with the U.S. Securities and Exchange Commission regarding the separate accounts business. We also note that separate account policyholders may not be subject to any of the rehabilitation or liquidation moratoriums on policy withdrawals or surrenders.

Pursuant to [Insurance Code], separate accounts are insulated from general account creditors and liquidation claims. *[Consider inserting sections of the insurance code that define insulated vs. non-insulated; that further define separate account and differentiate general account vs. separate account assets; and that explain how separate accounts and guarantees within the general account are viewed under the state's guaranty association law.]*

Reinsurance Assumed Business

[Where a US insurance entity is a professional reinsurer, the exclusion of assumed reinsurance from guaranty association coverage and the potential complexity and multitude of the reinsurance agreements may result in different considerations of how to handle a rehabilitation vs. liquidation that should be described here.]

Pursuant to [Insurance Code], policies or contracts of reinsurance are not covered by the guaranty association unless the assumption certificates have been issued to the direct insureds.

Unique Lines of Business or Insurance Entities in the Group

[If material to the insurer, consider adding a description or distinct considerations for how the exclusion of significant lines of business from guaranty association coverage would be handled in receivership.]

While domestic captives and risk retention groups (RRGs) are subject to most states' receivership laws, insureds within captives or RRGs do not have guaranty association coverage. Additionally, captives and RRGs may be subject to different parts of a states' insurance code with respect to financial regulation. If material and applicable to the resolution of a unique domestic insurance entity in the group, consider including a description of any material insurance code provisions related to supervision, seizure, conservation, rehabilitation, and liquidation that may either apply or does not apply.]

RESOLUTION ACTIONS

The following defines each of the resolution actions available in [this state].

The order from the court on any Rehabilitation or Liquidation would give the receiver (this state's Commissioner) the authority to marshal and take title to all assets of the insurer's estate.

Administrative Supervision

[Insurance Code] allows the Commissioner to issue an order of Supervision, which allows the Commissioner to order the insurer to take actions to abate the hazardous conditions as identified by the Commissioner. In this level of action, management and the board of directors remain in place, and continue to run the day-to-day operations.

Seizure or Conservation

[State laws vary as to the reference to Seizure or Conservation as a resolution action, as these actions are generally similar. Include the description of the actions available under this state's law.]

Another possible regulatory action is an order of Seizure [or Conservation]. This order is used to ensure assets remain in place and under control of the receiver and the general supervision of the court. This order would be issued by a judge at the [Name of Court]. [This state] would pursue the order privately in chambers with the judge, and not in a public forum or even with the company present. The company would have the right to contest the order after it is issued. Generally, this action gives the receiver the ability to control the assets but does not remove management or the board from running the day-to-day operations.

Rehabilitation

An order of Rehabilitation is sought when the receiver wants a period of time to evaluate whether actions can be taken to restore or transform the insurer and restore financial stability. The receiver receives authority to marshal and take title to all assets of the insurer's estate and runs the day-to-day operations.

Liquidation

An order of Liquidation is sought when the receiver determines there is no possibility to rehabilitate the insurer, and the best option to protect policyholders and creditors is to liquidate the insurer. In a Liquidation, all new and renewal business ceases. Again, the receiver receives authority to marshal and

take title to all assets of the insurer's estate. The liquidation order would also place a temporary stay on any litigation. The Board of Director's powers would be suspended, and the receiver placed in charge of running the day-to-day operations. Some or all of the insurer's upper management could be terminated as determined by the receiver.

In all the above actions, dividends would cease, and it is likely [this state] would have stopped any dividends prior to the deterioration in financial condition to the point where regulatory action was necessary. The Commissioner has broad authority to object to ordinary dividends and must prior approve any extraordinary dividends.

ANALYSIS OF RESOLUTION ACTIONS

The following summarizes key elements of each of the resolution actions available in [this state]. Notwithstanding the following, each receivership situation and cause is often unique to the insolvent entity. An analysis must be quickly made, and a plan developed for dealing with any event. The plan must also be continually reviewed and adjusted as events unfold.

1. ORDER OF SUPERVISION

Supervision is the least severe delinquency action. It is dependent on the success of identifying the causes of the hazardous financial condition and taking efficient and timely actions to correct them. The correct identification of problem areas and developing an effective correction action plan is dependent on the skill and cooperation of the company employees, management and board of directors, as well as having an adequate company infrastructure (i.e., IT systems) in place. Another factor to consider is the unexpected severity of the hazardous conditions. Administrative supervision orders are sometimes useful in temporarily stabilizing a deteriorating situation prior to the entry of an order of conservation, rehabilitation or liquidation.

The Order

- [Insurance Code] allows the Commissioner to issue an order of Supervision which allows the Commissioner to order the insurer to take actions to abate the hazardous conditions identified by the Commissioner. Under Supervision there is no judicial oversight. *[If judicial action is required in this state, replace applicable language.]*
- The Supervision order provides an *[Insert timeframe]* for the company to abate the hazardous conditions. The Commissioner may determine to extend the Supervision timeframe dependent on the company's progress in abating the hazardous conditions or, if satisfactory progress has not been met, place the company in a more severe delinquency proceeding (i.e., seizure, conservation, rehabilitation, liquidation). The Commissioner may also decide to suspend, revoke or limit the company's certificate of authority to do business.
- Supervision does not vest control or title of the company's assets under the Commissioner. *[Consider other risk scenario specific comments such as for life and annuity insurers: "If confidentiality is breached it may cause a run on the bank scenario i.e., policy surrenders."]*

Operations of a Supervision

- The company continues to write and renew business and pay claims in the ordinary course of business subject to any corrective actions necessary to abate the causes of the hazardous financial condition.
- General creditors and vendors are also paid in the ordinary course of business.
- The company's board of directors and present management remain in place.
- The Supervisor would meet with company management to ensure they understood the supervision order and the hazardous conditions that needed to be abated. The Supervisor would request the company develop a corrective action to address each specific hazardous condition along with a projected implementation timeframe. The Supervisor would then have ongoing meetings with company management to monitor progress and also verify the results of the corrective actions.
- In Supervision there would be no changes to policy benefits or coverage.
- The Supervisor would be empowered to prohibit the insurer from certain actions without prior approval, such as: dispose, convey or encumber any of its assets or business in force; close bank accounts; lend or invest funds; terminate or enter into new reinsurance; transfer property; incur debt; merger or consolidate with another insurer.

Confidentiality and Notification/Communication

- The Supervisor would be responsible for providing updates to the Commissioner and impacted parties covered by the confidentiality provisions. *[Insert a comment on the confidentiality of supervision orders in this state, such as "Supervision orders are confidential, and the order may be shared with limited parties as designated by statute. Those parties include but are not limited to guaranty associations, reinsurers, insurance regulatory officials and debtors and creditors of the company and its affiliates. These parties are required to keep the Supervision confidential."]*
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable]*.
- The Commissioner would inform those parties *[or insert a list]* covered by the statute's confidentiality, as to the provisions of the Supervision order.
- Under Supervision, guaranty associations are not triggered. However, the Supervisor may discuss the Supervision with the guaranty associations, where the guaranty associations are covered by *[the state's confidentiality statute or confidentiality agreements]*. In Supervision, the notification to *[NOLGHA or NCIGF]* and the guaranty associations of the existence of a Supervision order acts as a notice of a potential receivership that may trigger coverage should the insurer's financial condition worsen, or the insurer does not successfully abate the conditions of the Supervision order and a more severe resolution action becomes necessary.

Oversight of Supervision

- In a Supervision, the Commissioner generally designates an internal or external party as supervisor (referred to as "Supervisor" in this section) to oversee and monitor the company's progress in developing and implementing corrective actions necessary to abate the hazardous financial conditions. The Supervisor interacts with company management and provides the Commissioner and interested parties with progress reports.

- The Commissioner may hire an external Supervisor to monitor and oversee the Supervision. *[Insert the state’s rule on compensation, such as “The amount of compensation would be dependent on the expertise and experience of the external Supervisor. The Commissioner may appoint an internal supervisor and those costs would be covered within the Department’s budget.”]*

2. ORDER OF SEIZURE OR CONSERVATION

Under [Insurance Code] an Order of Seizure [or in other state jurisdictions may refer to this as an Order of Conservation. Both referred to as “Seizure” in this section] is the next more severe step after Supervision in the hierarchy of delinquency actions. A Seizure is designed to make an immediate hands-on determination of the true financial condition of the company and then to make a recommendation to the Commissioner to preserve and protect its assets either by releasing the insurer or placing the insurer in Rehabilitation or Liquidation. Seizure allows the Commissioner to immediately take control over the disposition of company assets while the financial determination process is ongoing. The Commissioner immediately takes possession and control over the property, books, accounts and other records and physical premises.

The Order

- The Commissioner would request an ex-parte confidential order from [Name of Court]. The conditions for issuing a Seizure order reflect that there one or more statutory grounds justifying for a formal delinquency (i.e., Rehabilitation or Liquidation), or that the interests of policyholders, creditors or the public are endangered by a delay in entering such an action and therefore requires immediate action, or any other reason determined to be necessary by the Commissioner.
- The duration of the Seizure order is *[a specific time period or]* such time as the Court determines the Commissioner needs to determine the financial condition of the company. The Court may hold hearings from time to time to decide the status of the Seizure order. If the Commissioner does not commence a formal delinquency hearing after a reasonable period of time, the Court may vacate the Seizure order. The company may petition the Court at any time during the Seizure order for a hearing. Such hearings may be held privately in chambers. Generally, seizure orders are for less than six months.

Operations of a Seizure

- Similar to Supervision, the insurer continues to write and renew business and pay claims in the ordinary course of business. General creditors and vendors are also paid in the ordinary course of business. The company’s board of directors and present management remain in place. There would be no changes to policy benefits or coverage under a Seizure order.
- However, the Seizure order prohibits the insurer, its officers, managers, agents and employees from disposing of the insurer’s property and transacting business except with the Commissioner’s written consent or further court order.
- While there is more control of the disposal of assets under Seizure, the Seizure order does not give title of those assets to the Commissioner. The company’s current contractual obligations remain in place. *[If confidentiality is breached it may cause a run on the bank scenario i.e., policy surrenders or withdrawals.]*

Confidentiality and Notification/Communication

- *[If applicable in the state, insert confidentiality statement.]* Seizure orders are confidential, and the order may be shared with limited parties as designated by statute. Those parties may include but are not limited to guaranty associations, reinsurers, insurance regulatory officials and debtors and creditors of the company and its affiliates. These parties are required to keep the Seizure confidential.” The confidentiality of the seizure order is intended to allow the receiver to discharge the conservation, if appropriate, and return the insurer to normal business operations without public knowledge and the resultant harm to the insurer’s business.
- The Commissioner would inform those parties *[or insert a list]* covered by the statute’s confidentiality provisions of the Seizure order.
- Under a Seizure order, guaranty associations are not triggered for coverage. However, the appointed party may discuss the Seizure and any potential formal delinquency proceedings with the guaranty associations, where the guaranty associations are covered by *[the statute’s confidentiality or confidentiality agreements]*. *[Note that depending on the state law, if a court finds that a life and/or health insurer is financially impaired, such finding may be sufficient to trigger the involvement of life and health guaranty associations].*

Oversight of Seizure

- In a Seizure, the Commissioner generally designates an internal or external party to oversee and monitor the company’s operations (the party is often referred to as the “conservator” in some jurisdictions) and investigates the company’s financial condition. Because the company is enjoined from disposition of its property, the appointed party will have to approve any disposition of company assets including cash disbursements. The appointed party interacts with company management and provides the Commissioner and interested parties with progress reports.
- The appointed party would work with company management to make a determination of the financial condition of the company. The appointed party would identify those areas that may negatively impact the company’s financial condition. The appointed party would then have ongoing meetings with company management to discuss the financial condition of the company and also verify the results of the financial review. The appointed party would be responsible for providing updates to the Commissioner and impacted parties covered by the confidentiality provisions.
- The Commissioner may hire an external party to monitor and implement the Seizure order. The amount of compensation would be dependent on the expertise and experience of the external party. The Commissioner may appoint the *[Specify the title of department director of receivership or other position]* to implement the Seizure order and those costs would be covered *[Specify how costs are covered, such as “within the Department’s budget”]*.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable]*.

3. ORDER OF REHABILITATION

After Supervision and Seizure *[or Conservation]*, Rehabilitation is the next most severe delinquency proceeding. Rehabilitation is designed to generate a Rehabilitation plan that will either correct the difficulties that led to the insurer being placed in receivership and restore the company’s financial

condition to sound basis or transition the company's policyholder liabilities to financially sound insurers. The Deputy Rehabilitator(s) may determine the company cannot be rehabilitated. If that is the determination, then a petition for Liquidation will be filed with the court.

The Order

- [Insurance Code] allows the Commissioner to petition the Court for an order of Rehabilitation based on one or more of the criteria listed above including, but not limited to, the concern that allowing the company to transact business would be hazardous to policyholders, creditors and the public.
- Rehabilitation orders are public documents and are subject to judicial oversight by [Name of Court].
- The Rehabilitation order vests authority to marshal and take title of all assets of the insurer's estate with the Commissioner as Rehabilitator.
- During Rehabilitation, the receiver may look for possible buyers for the insurer or even books of business or may consider other options to restore profitability or minimize losses.
- There are a number of issues that may occur that can complicate a successful Rehabilitation, such as loss of essential personnel, inability to restructure non-policyholder contractual obligations, loss of asset values due to market conditions, litigation, reinsurer disputes, inability to find insurers to reinsure company policies on a satisfactory basis, unexpected liabilities under derivative or policy contracts, inadequate policy or claim reserves, rating downgrade due to the Rehabilitation order and inability of investment income to meet policy minimum guarantees as well as other matters.
- The length of time of a Rehabilitation is dependent on the complexity, financial condition, size of the company, and the development of a plan of rehabilitation. Rehabilitation can take multiple years to complete.

Operations of a Rehabilitation

- After the Court has issued the Rehabilitation order, the receiver would be placed in charge of running the day-to-day operations of the insurer.
- The Rehabilitation order would suspend the authority of the board of directors, managers and officers unless reappointed by the Commissioner. Some or all of the insurer's upper management could be terminated as determined by the receiver.
- All current legal proceedings and litigation against the company would be stayed for [number of days based on state's insurance code] and the Rehabilitation order would contain an injunction against filing new legal actions.
- The Rehabilitation order may include *[For this bullet suggest only including those items that may be included in the order which are material to the insurer, rather than an exhaustive list.]*:
 - Prohibit or severely limit all new business writings.
 - Require the insurer to modify or even cancel certain managing general agent ("MGA"), third-party administrator ("TPA") and general agency agreements.
 - Suspend claims payments and halt the transfer of cash or loan values on life insurance contracts.
 - Provide that reinsurance agreements may not be canceled, and that the insurer may not obtain any new reinsurance without the approval of the receiver.
 - Require recapitalization.
 - Restrict new investments or liquidate investments.

- *[Insert the state’s handling in rehabilitation of any material issues or risks that are specific to the insurer, such as the following]:*
 - The Rehabilitation order would most likely include a moratorium on cash surrenders or policy loans except in defined hardship matters. If the Rehabilitator sells or reinsurers a block of business with another insurer, an additional moratorium may be implemented before the policyholder can change insurers.
 - Because Rehabilitation is a formal delinquency action, counterparties to the company’s derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with [insurer], risks that [insurer] had hedged may disappear and expose [insurer] to adverse financial risks. [Insurer’s] credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.
 - If the company has any loans outstanding with the Federal Home Loan Bank (FHLB), the FHLB would be able to take possession of any collateral pledged as security for the loan amounts.
 - *[Describe the handling of significant assumed reinsurance business in receivership, e.g., if the US entity is a reinsurer or a direct writer with significant assumed book of business.]*
- *[This bullet applies to resolution plans involving life, annuity and health insurers.]* A Rehabilitation order would trigger guaranty association involvement and coverage under the definition of “impaired” insurer contained in their statutes. The guaranty association may guarantee, assume or reinsure any or all of the impaired insurer policies, provide additional funds to assume or reinsure the impaired insurer policies, provide substitute benefits in some cases for the impaired insurer and other actions.
- Proof of claim forms would need to be sent out for unpaid pre-rehabilitation liabilities. It is likely that other state insurance departments would seek to either revoke or suspend the company’s authority to transact business in that state.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable]*.
- Various matters will need to be filed with the Court for approval including legal settlements, payments to pre-rehabilitation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Rehabilitation

- The Commissioner may appoint one or more Deputy Rehabilitators. The *[Specify the title of any department director of receivership or other position]* is usually appointed as Deputy Rehabilitator or manages the Rehabilitators if they are outside consultants. Given the insurer’s size and complexity, the Deputy Rehabilitators would likely hire a rehabilitation team to assist in the Rehabilitation. The rehabilitation team would likely have specialists such as actuaries, investment specialists and others. *[Insert any needed specialists based on the insurer’s unique risk profile.]* An investment bank may be hired to assist in identifying potential purchasers of blocks of business, merger partners or sources of capital infusion.
- The *[name of the department’s Receivership or other Division]* has procedures in place for hiring outside specialists/outside Deputy Rehabilitators as well as a list of qualified vendors. The hiring of any outside consultants/specialists is subject to *[Specify state’s rules on hiring and*

compensation such as “the Receivership procurement procedures”] and their compensation is subject to Court approval. *[Specify the state’s legal structure for handling receivership matters, such as “The Attorney General usually handles receivership matters for the Commissioner”].*

- Because of [insurer’s] size and complexity, it may be necessary to hire outside legal counsel. There are a number of qualified law firms that have prior rehabilitation legal experience. Any outside legal counsel and their compensation would be subject to Court approval.
- *[Specify the state’s rules on funding of compensation, such as “Payment of any outside specialists, Deputy Rehabilitators and/or legal funds would be paid out of the Rehabilitation estate funds. The (Name of the department’s receivership director, if applicable) costs are funded by the Department subject to potential reimbursement by the Rehabilitation estate.”]*
- The Rehabilitator or Deputy Rehabilitators and the Rehabilitation team are responsible for the day-to-day operations of the company.
- The Deputy Rehabilitator(s) and the rehabilitation team would be responsible for drafting a plan of Rehabilitation subject to the Commissioner and the Court’s approval. The Rehabilitation Plan may include reorganization, reinsurance of various blocks of company business, merger or purchase or other options in order for the company to meet its obligations to policyholders and creditors. The Rehabilitation Plan will follow the creditor priorities as stated in [Insurance Code]. The Deputy Rehabilitators would seek the guaranty association input on any sale or reinsurance of company blocks of business. The Deputy Rehabilitators and the rehabilitation team would be responsible for communicating the plan of Rehabilitation to all interested parties.

4. ORDER OF LIQUIDATION

Liquidation is the most severe delinquency proceeding. Liquidation is designed to wind down and dissolve the company and distribute any remaining assets to its outstanding creditors.

[Insurance Code] allows the Commissioner to petition the Court for an order of Liquidation based on any ground for an order of Rehabilitation, that the insurer is insolvent or that the continued transaction of business would be hazardous to policyholders, creditors and the public.

The Order

- Liquidation orders are public documents and are subject to judicial oversight by [Name of the Court].
- The Liquidation order does vest title of the assets with the Commissioner as Liquidator.
- Liquidations are complicated by unexpected or prolonged litigation, federal tax issues, unexpected or inaccurate reserves for liabilities, assets valuation issues and collection of receivables especially reinsurance related receivables.
- The length of time of a Liquidation is dependent on the complexity, financial condition, and size of the company. Like Rehabilitation, a Liquidation can take multiple years to complete.

Operations of a Liquidation

- After the Court has issued the Liquidation order all new business writings would cease.
- *[Insert applicable insurance code that describes the effect of the order of liquidation upon contracts of the insolvent insurer, i.e., continuance in force, termination or cancelation of policies:]*
 - [Insurance code] provides that upon issuance of the order, all of the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of

- liquidation. The Liquidation order provides notice to policyholders, terminates policies and contracts where a guarantee of insurance is provided upon *[insert termination period]*.
- *[For life, annuity and health insurers.]* Life and health insurance policies and annuities shall continue in force for such a period and under such terms provided for by the guaranty associations. Those life, health and annuity products not covered by a guaranty association would terminate *[Insert termination period from state statute]*. The Liquidation order would most likely include a moratorium on cash surrenders or policy loans except in defined hardship matters. If the Liquidator sells or reinsurers a block of business with another insurer an additional moratorium may be implemented before the policyholder can change insurers.
 - *[Insert the state's handling in liquidation of any material issues or risks or unique policy types that are specific to the insurer that may require special consideration, such as the following:]*
 - Because Liquidation is a formal delinquency action, counterparties to the company's derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with *[insurer]*, risks that *[insurer]* had hedged may disappear and expose *[insurer]* to adverse financial risks. *[Insurer's]* credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.
 - If the company has any loans outstanding with the Federal Home Loan Bank, the Federal Home Loan Bank would be able to take possession of any collateral pledged as security for the loan amounts.
 - *[Insurance code]* excludes *[material policy types or business not covered]* from guaranty fund coverage.
 - *[Describe the handling of significant assumed reinsurance business in receivership, if the US entity is a reinsurer or a direct writer with a significant assumed book of business. e.g., exclusion from guaranty fund coverage; claims fall within general creditor class of priorities; limitations on setoffs.]*
 - The Liquidation order would terminate the authority of the board of directors and officers.
 - A Liquidation order would trigger guaranty association involvement and coverage under the definition of "insolvent" insurer contained in their statutes.
 - The Liquidation order would contain an injunction against filing new legal actions or pursuing current actions.
 - Proof of claim forms would need to be sent out for unpaid pre-liquidation liabilities.
 - It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in that state.
 - The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable]*.
 - The Deputy Liquidators would need to discuss the transition of policyholder administration and claims adjudication processes with the effected guaranty associations.
 - Various matters will need to be filed with the Court for approval including legal settlements, any distribution to liquidation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Liquidation

- The Commissioner may appoint one or several Deputy Liquidators. Given *[insurer's]* size and complexity, the Deputy Liquidators would likely hire temporary staff to assist them in the

Liquidation. The Deputy Liquidators may hire specialists such as actuaries, investment specialists and others to evaluate certain areas of the company. *[Insert any needed specialists based on the insurer's unique risk profile.]*

- The *[Specify the title of any department director of receivership or other position]* is usually appointed as Deputy Liquidator or manages the Deputy Liquidators if they are outside consultants. The *[Name of the department's Receivership or other Division]* has procedures in place for hiring outside specialists and outside Deputy Liquidators as well as a list of qualified vendors. The hiring of any outside consultants/specialists is subject to *[Specify state's rules on hiring and compensation such as "the Receivership procurement procedures"]* and their compensation is subject to Court approval. *[Specify the state's legal structure for handling receivership matters, such as "The Attorney General usually handles receivership matters for the Commissioner"]*. Because of *[insurer's]* size and complexity, it may be necessary to hire outside legal counsel. There are a number of qualified law firms that have prior liquidation legal experience. Any outside legal counsel and their compensation would be subject to Court approval. *[Specify the state's rules on funding of compensation, such as "Payment of any outside specialists, Deputy Liquidators and/or legal funds would be paid out of the Liquidation estate funds. The (Name of the department's receivership director, if applicable) costs are funded by the Department subject to potential reimbursement by the Liquidation estate."]*
- The Deputy Liquidator(s) would be responsible for the administration of the Liquidation estate with the goal of the fair and efficient handling of all Liquidation claims and the marshalling of assets to insure the maximum distribution for the Liquidation creditors. The Deputy Liquidators would distribute assets in accordance with the creditor priorities as stated in *[Insurance Code]*. The Deputy Liquidators would work with the guaranty association input on any sale or reinsurance of company blocks of business.

Guaranty Associations

[Due to differences in P&C vs. L&H guaranty funds, this section should be edited for the applicable guaranty fund based on the type of domestic insurer.]

- Under a Liquidation order, guaranty associations are triggered under certain conditions for insurers meeting the definition of insolvent insurers.
- Each guaranty association has limits on the amount of coverage they provide for each type of policy benefit as well as aggregate limits per policyholder. These amounts vary by state.
- The Deputy Liquidators would work with the guaranty associations to potentially reinsure or transfer the existing blocks of business to new insurers when possible, or run-off remaining blocks of business.
- The life and health guaranty association may guarantee, assume or reinsure any or all of the insolvent insurer's policies or provide additional funds to another carrier in an assumption of the business. Also, with the Commissioner's approval, the guaranty association may issue an alternative policy, modify a current policy, implement temporary policy moratoriums, or pay policy claims subject to coverage limits, among other actions.
 - *[Specific to life/annuity]* The guaranty associations may modify guaranteed or credited interest rates on certain policies.

POLICYHOLDER PROTECTION SCHEMES (AKA., GUARANTY FUNDS)

Guaranty associations provide a mechanism for the payment of covered claims under certain insurance policies, or to continue coverages, aimed to avoid excessive delays in the payment of claims and to the extent allowed by state statute, to minimize the financial loss to claimants or policyholders resulting from the insolvency of an insurer.

A states' guaranty association generally must cover resident claims of an insolvent insurer (placed in a liquidation proceeding) and may cover resident claims of an impaired insurer (placed in a rehabilitation proceeding and not an insolvent insurer). Benefit limits vary by state. [This state's] benefit limits are:

- *[Insert a summary of applicable state guaranty fund benefit limits by product type for this state].*
- Each States' guaranty association can be accessed by going to the [NOLHGA (nolhga.com) or NCIGF (ncigf.org)] website.

Further details on the coverage and eligibility requirements for coverage by the [this state's guaranty association] can be found at *[Insert name of attachment or website]*. A list of coverage and limitations of [this state's guaranty association] can be found at *[Insert name of attachment or website]*.

Where assets of the insurer's estate are determined to be insufficient and guaranty funds are triggered to pay benefits within statutory limits, guaranty associations may assess other member insurers under [Insurance code] for purposes of carrying out the duties of the association.

IMPLEMENTATION

Under [Insurance Code], only the Commissioner has the power to commence delinquency proceedings for a [this state] domestic insurance company. Immediately upon receiving an order of Rehabilitation or Liquidation from the court, the receiver will proceed to serve the proper papers to the entities that may hold assets of the estate to move authority over those assets to the receiver.

The receiver in cooperation with the [this state's guaranty association] will consider if outside expertise is necessary to appropriately continue the program. *[Specify the state's process for beginning the hiring process, such as requesting bids to determine the best qualified contractors.]*

The receiver will need to quickly obtain access to books, data and records of the insurer.

The receiver will need to quickly evaluate *[Specify any unique situations that will require immediate attention based on the insurer's risk profile, such as.*

- *The need to continue a derivatives program.*
- *Any rights of offset or collateral calls on assets of the estate, and the potential financial and legal impact.]*

The receiver will then assess other areas relevant to running the day-to-day operations of the insurer, such as ensuring the ability to continue essential services (e.g., assessing contracts with service providers), look for potential buyers for the company or books of business, staffing needs, products sales, reinsurance, etc.

COMMUNICATION STRATEGY

The Deputy Rehabilitator or Deputy Liquidator would be responsible for communications with all interested parties.

Immediately upon a determination by the Commissioner to seek rehabilitation or liquidation of [the insurer], the Commissioner will [*Specify the state's process for notifying other state offices (e.g., Attorney General) who may be involved in drafting a petition and order to be filed with the court.*]

Because Rehabilitation and Liquidation orders are public documents, it is essential that there be accurate and timely communications with all parties.

Parties to which timely communication is required include the NAIC, NOLGHA or NCIGF and state's guaranty association, states in which the company is licensed, state/federal/international regulatory agencies, agents, policyholders, reinsurers, creditors, management and employees, board of directors, and other federal agencies (as applicable), among others. [*Edit this list for this state's communication requirements.*]

[*Insert this state's process for public notice of Liquidation, e.g., published in a nationally distributed newspaper and sent to all interested parties; correspondence, press releases and/or internet accessible information; responsibility of agents to inform their clients of the liquidation directly; etc.*].

Consistent with the NAICs' *Troubled Insurance Company Handbook*, [this state] must be proactive in communicating with regulators including regulators in other states. [This state] will also immediately update [*the international group-wide supervisor (GWS), if not this state; or other Crisis Management Group (CMG) members, if the GWS is this state*] so that CMG members are informed of the proposed action.

Upon receiving court approval, the petition and order will be sent to other regulators including the [*international GWS, if not this state, to be distributed to CMG members; or CMG members, if the GWS is this state*]. Rehabilitation or Liquidation orders and all relevant documents to the receivership will also be posted to the insurance department's website.

To expedite communications, policyholder and creditor notifications as well as correspondence to the guaranty associations and other state regulators may be prepared in advance of the actual filing of the receivership petition to the court. In addition, mailing lists are prepared, and publication is arranged, if legally required. Upon court approval of the receivership action, distribution of notice to the affected parties, and publication in media outlets, begins.

SUPPLEMENTAL MATERIALS

**RECEIVERSHIP & INSOLVENCY (E) TASK FORCE
SUMMER NATIONAL MEETING**

Monday, August 14, 2023
11:00 AM - 12:00 PM (Pacific)

CANTILO & BENNETT, L.L.P.

ATTORNEYS & COUNSELORS
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August 10, 2023

The Honorable James J. Donelon, Chair
The Honorable Glen Mulready, Vice Chair
Receivership and Insolvency (E) Task Force
C/O Jane Koenigsman
Sr. Manager - Life/Health Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

BY ELECTRONIC MAIL

RE: MODEL 540 COMMENTS

Dear Commissioners Donelon and Mulready and members of the Task Force:

Please accept this letter as my comments regarding the August 7, 2023 amendments to the Property and Casualty Insurance Guaranty Association Model Act (# 540) Exposure Draft proposed by the Receivership Law (E) Working Group (RLWG). The proposed amendments address two main issues: (1) a request by the Restructuring Mechanism (E) Working Group (RMWG) that the RLWG propose amendments to Model 540 if necessary to assure that implementation of Insurance Business Transfer (IBT) and Corporate Division (CD) transactions will not result in loss by policyholders of guaranty association protection, and (2) coverage of cybersecurity insurance, approved by the Executive (EX) Committee. I address only the first issue, regarding IBT and CD transactions. I offer no comment as to the second issue, related to cybersecurity insurance.

EXECUTIVE SUMMARY

With respect to the first issue, I submit respectfully that the proposed amendments (called Version 1 by the RLWG):

1. Go far beyond the charge to the Working Group,
2. Unnecessarily scale back guaranty association protection for policyholders in certain insolvencies unrelated to IBT and CD transactions by reversing amendments of Model 540 adopted by the NAIC in 2009,

Receivership and Insolvency (E) Task Force
August 10, 2023, page 2

3. Solely for that reason, are unduly complicated (amending 278 lines of text and comment in Model 540), and
4. Create illogical outcomes.

The proposed amendments contrast with amendments (called Version 2 by the RLWG) I offered for the same purpose that I submit respectfully:

1. Were much simpler (4 lines of amendment compared to 278 in Version 1),
2. Would accomplish fully the charge to preserve guaranty association coverage in IBT and CD transactions,
3. Would not roll back any coverage already adopted by the NAIC, and
4. Would not have created the illogical outcomes.

The details are provided below. In evaluating this issue, I would suggest that the Task Force pose the following questions to the Working Group:

1. Would Version 2's 4-line amendment accomplish fully the preservation of guaranty association coverage in IBT and CD transactions requested by the RMWG?
2. What advantage does the adopted Version 1's 278-line proposed amendment provide?
3. Would the proposed Version 1 reverse amendments adopted the NAIC in 2009?
4. If so, who proposed this reversal to the Working Group and who charged the Working Group with taking on an amendment for this reversal?
5. On what empirical data is the Working Group basing its recommendation for this reversal and scale back in guaranty association coverage?

BACKGROUND

Last summer, the RMWG requested that the RLWG propose amendments to Model 540, if necessary to assure that implementation of IBT and CD transactions, will not result in loss by policyholders of guaranty association protection. That was the entire charge to the RLWG. Two competing proposals were submitted to RLWG by a drafting group appointed for that purpose. The first (Version 1) was drafted by Barbara Cox and Rowe Snider - associated with the National Conference of Insurance Guaranty Funds (NCIGF) - and Robert Wake of the Maine Bureau of Insurance. Concerned about issues presented by this proposal, I offered a separate proposal (Version 2). After several discussions and edits, the RLWG voted to forward Version 1, but not Version 2, to this Task Force.

I submit respectfully that this Task Force should not adopt Version 1 and should not recommend its adoption to the E Committee. There are three principal reasons for this conclusion.

First, the proposal adopted by the RLWG deliberately goes far beyond the RMWG charge, choosing to also address a self-appointed issue regarding guaranty association coverage of "assumed claims". This additional issue was not referred to it by the Task Force or the RMWG and is unrelated to assuring the continuity of guaranty association protection for policyholders in IBT and CD transactions.

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Second, Version 1 creates a mechanism for reversing amendments to Model 540 adopted by the NAIC in 2009 that provide guaranty fund coverage for policyholders in “assumed claims” transactions (described in more detail below). Neither this Task Force nor the RMWG requested that the RLWG address this matter, let alone reverse amendments approved by the NAIC in 2009. The Working Group took on this task *sua sponte*. Not only is there no reason to “peel back” this policyholder coverage in order to assure continued protection in the case of IBTs and CDs, I submit that there is no defensible public policy in support of this reduction in policyholder coverage.

Third, Version 1 is very complicated and contemplates editing 278 lines in the Model Act text and comments. It would delete 180 lines of current text and 15 lines of current comment, add 75 lines of new text and 5 lines of new comment, and amend another 3 lines of text. In contrast, Version 2 accomplishes fully the goal of the referral, but only requires editing 4 lines of the Model Act to do so. Among other things, this unnecessary complexity will make it more difficult for individual departments to propose these changes to their own legislatures. This complexity is made necessary only by the effort to roll back “assumed claims” coverage. As demonstrated by Version 2, accomplishing the referral’s goals is much, much simpler.

Further, in scaling back guaranty fund coverage for assumed claims, Version 1 would inject new potential problems and ambiguities into Model 540. For example, Version 1:

1. Proposes to delete language (Subsection D) that already goes a long way in assuring continuity of guaranty fund coverage in the case of IBTs and CDs. In fact, it is likely that policyholders would retain guaranty fund coverage in most IBT and CD transactions without making ANY change to Model 540. But if language is desired to avoid any uncertainty, the four lines of Version 2 would accomplish this goal.
2. Gives rise to illogical outcomes. For example, consider this scenario:
 - a. Insurer A assumes a workers compensation block, (including open workers compensation claims), from a self insured trust in year 1;
 - b. In years 2 through 15, Insurer A pays premium taxes and guaranty association assessments on the workers compensation policies assumed with the block, including those under which open claims had arisen that were also assumed;
 - c. In year 16, Insurer A becomes insolvent.
 - d. Under Version 1, those assumed workers compensation claims would not be covered by the guaranty funds because the policy had not been issued originally by a member insurer. See Version 1, section G(1). It would make no difference that Insurer A will have been paying premium taxes and assessments on these policies for fifteen years.
 - e. Moreover, at that point, the assumed claim and policy are likely to be all but indistinguishable from Insurer A’s other policies and claims. Yet, Version 1 will create two classes of business, one covered the other not, though they be otherwise largely indistinguishable.

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3. In response to my opposition to scaling back assumed claims coverage, the drafters of Version 1 then added a new optional section G(3) intended to revive the coverage they removed in section G(1). Notably, this optional section is opposed by NCIGF. See June 20, 2023, letter from NCIGF to RLWG. Of course, there is no justification for the convoluted complexity of the 278 line amendment that takes away assumed claims coverage in section G(1) and then adds it back in section G(3) unless the hope is that, as NCIGF advocates, section G(3) will not be adopted.

The full text of Version 1, as adopted by RLWG, is included beginning at page 7 of the August 3 materials for the Task Force's August 14 meeting in Seattle. Despite my request, Version 2 and my comments are not included in those materials. I thank NAIC staff for distributing them now.

PROPOSED VERSION 2

Here is the entire text of Version 2, what I propose as the amendment of Model 540 to assure the continuity of guaranty association coverage for policyholders in an IBT or CD transaction. The proposed edits are underlined and in blue print.

H. *"Covered claim" means the following:*

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...*

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

In my effort to be as helpful to the RLWG as possible, I did note that Model 540 does not define IBT or CD transactions and offered a suggestion for doing so if it were deemed desirable.

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

To be clear, however, this definition is an optional suggestion, unrelated to the assumed claims issue and not strictly necessary to achieve the stipulated purpose.

During the discussions of my proposed Version 2, the Chair observed that, since many states have not adopted the assumed claims provisions added to Model 540 in 2009, Version 2 might not make sense in those states. That is true because Version 2 (like Version 1) was intended to amend Model 540 as it exists currently. However, given the importance of preserving guaranty association coverage in IBT and CD transactions in every state, regardless of whether they had adopted the 2009 amendments, I offered an alternative to Version 2, that could be used in states that have not adopted the 2009 assumed claims amendment:

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...*

I also offered two other two alternatives (not salient to this discussion) that would have enabled states to adopt Version 2 to preserve coverage for IBT and CD transactions depending on whether or not they also wanted to include guaranty association coverage for transactions in which the recipient company is not a member insurer. Because that essentially would mean that the recipient company would not be a licensed insurer, it is difficult for me to conceive of circumstances in which commissioners would want blocks of insurance for consumers (those implicating guaranty association coverage) transferred to them.

What is important is that all of the alternative iterations of Version 2 I offered the RLWG have the same virtue as the basic proposal: they only envision limited (3 or 4 lines) edits to Section H(1). Thus, no matter what its preference, under Version 2, a state could accomplish very simply the referral's goal of preserving coverage in the case of IBTs or CDs, whether or not they had adopted the 2009 assumed claims amendments.

The simple explanation for the difference between these competing proposals is that, unlike my Version 2, NCIGF's Version 1 is structured to permit the NAIC to reverse course now and remove the assumed claims coverage added in 2009. If it were not for that new goal, there would be no reason to prefer the 287 line edits of Version 1. That new goal, of course, was not part of the charge to the Working Group.

This point merits a bit of further explanation. Version 2 DOES enable an individual state to provide guaranty association coverage for IBT and CD transactions WITHOUT assumed claims coverage. Where it differs from Version 1, adopted by the Working Group, is that the latter enables amendment of the Act to ELIMINATE EVEN THE POSSIBILITY of assumed claims coverage for states adopting the Model. I submit respectfully that there is no public policy justification for this *sotto voce volte-face*.

THE ASSUMED CLAIMS COVERAGE

What is the assumed claims coverage that has given rise to this spirited debate? The 2009 amendments adding that coverage were the result of the Virginia receivership for Reciprocal of America (ROA), a workers compensation and professional liability insurer doing business primarily in the southeast. In the 1990s, when the workers compensation market tightened and rates increased, a number of institutional ROA workers compensation insureds moved their coverage to existing or newly formed self insured vehicles. By the turn of the millennium, when the market softened, those blocks were once again assumed by ROA in assumption reinsurance, loss portfolio transfers, or similar transactions. In 2003, ROA was placed in receivership and eventually in liquidation. A number of guaranty associations declined to provide coverage for claims arising under these blocks because they had been assumed from non-member insurers. Even more, they objected to the liquidator using estate assets to pay those same claims, asserting that they were not entitled to policyholder priority and therefore could not be paid from estate assets until guaranty association had been fully reimbursed for their payment of covered claims. The issue was litigated vigorously in Virginia courts, resulting in a ruling that these claims were obligations to policyholders just as those arising under policies issued directly by ROA. See August 24, 2005, Final Order of the Virginia State Corporation Commission, attached. While an appeal was lodged from this order, it was later abandoned. See December 22, 2005, Withdrawal of Appeal, also attached.

This litigation proved expensive for the ROA receivership and extremely injurious and disruptive to injured workers whose workers compensation benefits were interrupted by the guaranty association challenge. In an effort to avoid repetition, in 2004 the Virginia General Assembly adopted amendments to Virginia Code Section 38.2-1603, the “covered claims” definition of the Virginia Property and Casualty Insurance Guaranty Association Act (the Virginia version of Model 540). The amendments specified that assumed claims, such as those at issue in ROA, were within the scope of guaranty association coverage.

There followed efforts to accomplish the same result for the entire country, which took the form of the amendment of Model 540 adopted by the NAIC in 2009 over vigorous opposition from the NCIGF. Without speculating as to the opposition or other cause for this, it is true that few states have since adopted these amendments, just as even fewer states have done so for the Insurance Receivership Model Act (Model 555), adopted by the NAIC in 2005. Nonetheless, as of this writing, Models 540 and 555 represent the judgment of the NAIC as to how insurance insolvencies should be managed.

THE RENEWED ATTACK

Under the banner of “coverage neutrality”, the NCIGF has seized on the IBT/CD referral to the RLWG as the opportunity to renew its attacks on the assumed claims coverage incorporated by the NAIC in 2009. What is remarkable, of course, is that the assumed claims coverage issue has nothing to do with preservation of guaranty association protection for policyholders in IBT and CD transactions. Arguably, Model 540 already does that without the need for any amendment at all. It does so precisely because of the amendments adopted in 2009, though they were intended for the

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narrower circumstances than in controversy. This much I pointed out to the RLMG on November 9, 2022, when I suggested that,

“[a]t most, if one wanted to adopt a “belt and suspenders” approach, the language in Section D(2) (or subsection (3) of Alternative 2) could be amended as follows:

***An assumption reinsurance or other transaction in which all of the following occurred:*”**

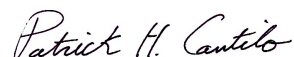
Among the responses to this argument, was that few states had adopted the 2009 amendments. That led me to propose the simple 4-line Version 2 that could be used in states that had not adopted the assumed claims language to assure that IBT and CD transactions would not result in loss of guaranty association protection.

So, what is really at issue in today’s debate is whether the Task Force, without having been asked to do so, wants to propose to the E Committee and then to the NAIC that it revoke its 2009 decision to provide in Model 540 the possibility of guaranty association coverage to claimants like the ROA workers compensation insureds described above. I submit respectfully that there is no defensible public policy that would be served by such an about face. I urge this Task Force to continue putting policyholder interests at the top of its list of priorities and adopt my proposed Version 2 in response to the RMWG referral.

As usual, my firm and I are not compensated for our contributions to the deliberations of the Task Force. We do not, in this matter, represent the interests of any constituency other than our effort to protect policyholders who are otherwise largely unrepresented in these discussions. The views I express are strictly my own and not offered on behalf of any client or organization. They are informed generally by my experience with troubled insurers during the last four decades, and specifically by my work on behalf of policyholders of failed insurers. I would be happy to answer any questions about these matters.

I thank you for your kindness in considering my comments.

Very truly yours,



Patrick H. Cantilo

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 24, 2005

APPLICATION OF

RECIPROCAL OF AMERICA and
THE RECIPROCAL GROUP

CASE NO. INS-2003-00239

For a Determination Whether Certain Workers'
Compensation Insurance Policy Payments May be
Made to Claimants Formerly Covered by SITs and GSIAs

FINAL ORDER

On July 11, 2003, the Deputy Receiver of Reciprocal of America¹ filed an Application for Order Authorizing the Continuation of Workers' Compensation Disability Payments by Reciprocal of America and The Reciprocal Group for Workers' Compensation Claims Denied Coverage by State Guaranty Associations ("Application") in Case No. INS-2003-00024. Therein, the Deputy Receiver of ROA sought an order from the State Corporation Commission ("Commission") authorizing him to continue payment of medical and recurring partial or total disability payments for workers' compensation claims that were assumed by ROA through assumption reinsurance, or similar transactions, and denied or likely to be denied coverage by the applicable state guaranty associations.²

In the Application, the Deputy Receiver of ROA asserted that the guaranty associations of the applicable states have refused, or likely will refuse, to make certain workers' compensation insurance policy payments for workers' compensation claims that ROA assumed from Self-Insured Trusts ("SITs") in Alabama, Arkansas, Kentucky, and Missouri and Group Self-

¹ Reciprocal of America and The Reciprocal Group are collectively referred to herein as "ROA."

² Application at 1.

DOCUMENT CONTROL
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Insurance Associations ("GSIAs") in Mississippi, North Carolina, Tennessee, and Virginia (collectively referred to as the "Assumed Businesses") as a result of assumption reinsurance or similar transactions ("Assumed Claims").³ The Deputy Receiver of ROA noted that the Assumed Claims likely will not be paid because the Assumed Businesses were not member insurers and/or the policies under which the claims arose were not ROA policies. The payments purportedly totaled approximately \$125,139 weekly.

The Deputy Receiver of ROA further contended that the insureds of the Assumed Businesses are direct insureds of ROA and, due to the necessity for continued payment by the recipients thereof, requested authorization from the Commission to continue making such payments.⁴ The Deputy Receiver of ROA classified the Agreements as "assumption reinsurance."⁵ The Deputy Receiver of ROA further asserted that the livelihood of many injured workers is dependent upon continued receipt of the payments and that a discontinuation of such payments would cause the recipients to suffer a substantial hardship.⁶ Accordingly, the Deputy Receiver of ROA sought an order from the Commission authorizing the continued payment of workers' compensation insurance policy claims assumed by ROA through assumption reinsurance or similar transactions and denied or likely to be denied coverage by the applicable state insurance guaranty associations.

On August 14, 2003, the Commission entered an Order Scheduling Hearing on Application, and on August 18, 2003, the Commission entered an Order Clarifying Previous

³ Such Assumed Claims and assets of the Assumed Businesses were purportedly assumed by ROA through merger agreements or different forms of assumption agreements ("Agreements"). Application at 4.

⁴ Id.

⁵ Id. at 6-7.

⁶ Id. at 9. The Deputy Receiver stated that payments to approximately 450 injured workers are at stake. Id. at 10.

Order ("Orders"). In the Orders, the Commission scheduled a hearing for September 17, 2003, to determine whether the insureds of the Assumed Businesses are direct insureds of ROA and therefore a direct responsibility of ROA or, if not, whether such insureds' claims should be treated as "hardship" claims. The Commission further ordered that the Deputy Receiver of ROA is not directed or authorized to make any workers' compensation insurance policy payments to claimants of the SITs or GSIA's until further order of the Commission.

A number of other parties, including the SDRs of the Tennessee Companies,⁷ the Virginia Property and Casualty Insurance Guaranty Association ("VPCIGA"), the Indiana Insurance Guaranty Association, the Kansas Insurance Guaranty Association, the Mississippi Insurance Guaranty Association, the Tennessee Insurance Guaranty Association, and the Texas Property and Casualty Insurance Guaranty Association (collectively, "Guaranty Associations"),⁸ the Coastal Region Board of Directors and the Alabama Subscribers it represents ("Coastal"), the Kentucky Hospitals,⁹ and the Virginia Workers' Compensation Commission's Uninsured

⁷ The Special Deputy Receivers of Doctors Insurance Reciprocal ("DIR"), Risk Retention Group ("RRG"), American National Lawyers Insurance Reciprocal ("ANLIR"), RRG, and The Reciprocal Alliance ("TRA"), RRG are referred to herein as the "SDRs." DIR, ANLIR, and TRA are referred to herein collectively as the "Tennessee Companies."

⁸ The Guaranty Associations no longer include the Texas Property and Casualty Insurance Guaranty Association, which was permitted to withdraw from this proceeding on April 27, 2004.

⁹ The "Kentucky Hospitals" include Appalachian Regional Healthcare, Caverna Memorial Hospital, Clinton County Hospital, Crittenden Health System, Cumberland County Hospital, Gateway Regional Medical Center, Hardin Memorial Hospital, Highlands Regional Medical Center, Jane Todd Crawford Hospital, Lincoln Trail Hospital, Livingston Hospital & Healthcare Service, Marcum & Wallace Memorial Hospital, Marshall County Hospital, Monroe County Medical Center, Murray-Calloway County Hospital, Ohio County Hospital, Owensboro Mercy Health System, Pattie A. Clay Hospital, Pineville Community Hospital, Regional Medical Center/Trover Clinic Foundation, Rockcastle Hospital, St. Claire Medical Center, T.J. Samson Community Hospital, Twin Lakes Regional Medical Center, and Westlake Regional Hospital.

Employers' Fund ("UEF")¹⁰ all joined this proceeding and have participated in some fashion, either in support of, or in opposition to, the Application.

The Commission held a hearing on this matter on September 17, 2003. Briefs were subsequently filed by the Deputy Receiver of ROA, the Guaranty Associations, the VPCIGA, Coastal, the Kentucky Hospitals, and the UEF.

On November 12, 2003, the Commission entered an Order, in which it directed the Deputy Receiver of ROA to pay the Assumed Claims insofar as they constitute indemnity and wage-replacement payments but did not authorize the payment of physician or hospital bills. In the same Order, the Commission assigned the determination of whether the SITs and GSIA's or employers thereof constitute "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 ii of the Code of Virginia¹¹ ("Code") to a hearing examiner and docketed the proceeding as Case No. INS-2003-00239.¹²

On January 8, 2004, the Commission entered an Order on Reconsideration, in which we denied the Guaranty Associations' request that we reverse our November 12, 2003 Order. The Commission also denied their request to suspend the execution of that Order pending an appeal.

¹⁰ On September 17, 2003, the Virginia Workers' Compensation Commission ("VWCC") filed a Motion to Intervene. Therein, the VWCC asserted that the UEF, which is administered by the VWCC, may become a significant creditor of ROA. On October 2, 2003, counsel for the VWCC and UEF filed a letter in which he stated that the VWCC's pleadings in this case were filed for the VWCC solely in its capacity as the administrator of the UEF, and not in its role as an adjudicative body. He stated his intention to submit future pleadings on behalf of the UEF, rather than the VWCC. The Commission granted the Motion to Intervene on October 16, 2003. For convenience of reference, the Commission will refer to the "UEF" in the remainder of this Order when discussing the "VWCC" or the "UEF."

¹¹ Statutory references are to the Code of Virginia.

¹² All three commissioners agreed with the decision to refer the underlying question involving § 38.2-1509 B 1 ii of the Code to a hearing examiner. One commissioner dissented from the decision to permit disbursements from the ROA estate to pay the Assumed Claims while such question was pending.

We reinstated our Order dated November 12, 2003, effective as of January 8, 2004.¹³ Hence, the Deputy Receiver of ROA was authorized to pay the Assumed Claims insofar as they constitute indemnity and wage-replacement payments as of January 8, 2004.¹⁴

Subsequent to the referral of this case to a hearing examiner and without objection from any party, this proceeding was expanded to include, in addition to the nine agreements involving workers' compensation coverage, two agreements covering other liability coverage.¹⁵ Unlike with the workers' compensation insurance policy payments, the Deputy Receiver of ROA did not seek to make any payment on the liability policy Assumed Claims but noted that there were approximately 128 such claims.¹⁶ The assumed workers' compensation SITs were the Healthcare Workers Compensation Self-Insured Fund (Alabama) ("HWCF"), the Arkansas Hospital Association Workers' Compensation Self-Insured Trust ("AWCT"), Compensation Hospital Association Trust (Kentucky) ("C-HAT"), and MHA/MSA Compensation Trust (Missouri) ("MHA/MSA"). The assumed liability SITs were the Alabama Hospital Association Trust ("A-HAT") and the Kentucky Hospital Association Trust ("K-HAT"). The assumed workers' compensation GSAs were MHA Private Workers' Compensation Group (Mississippi) ("MHA

¹³ By Order entered on December 2, 2003, the Commission prohibited the Deputy Receiver of ROA from making any payments pursuant to the November 12, 2003 Order until it had ruled on the Guaranty Associations' Petition for Rehearing or Reconsideration.

¹⁴ One commissioner dissented from the January 8, 2004, Order permitting payments to be made from the ROA estate prior to a decision being rendered in the INS-2003-00239 case.

¹⁵ See Amendment to Application for Order Authorizing the Continuation of Workers' Compensation Disability Payments by Reciprocal of America and The Reciprocal Group for Workers' Compensation Claims Denied Coverage by State Guaranty Associations ("Amendment") filed by the Deputy Receiver of ROA on January 21, 2004; and Order entered on January 29, 2004, in which the Commission accepted the Amendment to the Application and directed the hearing examiner to also consider and make a determination as to whether or not the liability assumed claims of ROA constitute claims of "other policyholders arising out of insurance contracts," in accordance with § 38.2-1509 B 1 ii of the Code. "Assumed Claims" hereinafter will include both the liability assumed claims and the workers' compensation assumed claims.

¹⁶ Amendment at 6.

Private"), MHA Public Workers' Compensation Group (Mississippi) ("MHA-Public"), SunHealth Self-Insurance Association of North Carolina ("SunHealth"), THA Workers' Compensation Group (Tennessee) ("THA"), and Virginia Healthcare Providers Group ("HPG").

The Guaranty Associations and the VPCIGA pursued an appeal of the November 12, 2003, and January 8, 2004, Orders to the Supreme Court of Virginia, which dismissed their appeal on July 9, 2004.¹⁷ The litigation before the hearing examiner continued while such appeal was pending. An evidentiary hearing was convened on September 22, 2004, and continued for six days thereafter. The Deputy Receiver of ROA, the Guaranty Associations, the VPCIGA, the Kentucky Hospitals, Coastal, the SDRs of the Tennessee Companies, the UEF, the Children's Hospital of Alabama, the Bureau of Insurance, and Richard W.E. Bland all participated in the hearing in one form or another. Post-hearing briefs were filed by the Deputy Receiver of ROA, the Kentucky Hospitals, Coastal, the UEF, the VPCIGA, and the Guaranty Associations.

On April 21, 2005, the hearing examiner filed his report ("Report"). The 130-page Report contains an exhaustive summary of the record of this proceeding, as well as the hearing examiner's discussion of the legal issues involved in this case, along with his findings and recommendations. The hearing examiner made the following findings and recommendations:

- (1) Virginia substantive law should control in this case to avoid exposing the ROA receivership estate to a myriad of possible conflicting state laws, to provide for the equitable payment of claims and distribution of the assets of the ROA estate among creditors of the same class no matter where the creditors may reside, and to provide for the orderly administration and wind down of the ROA estate;
- (2) Virginia law recognizes that entities such as the SITs and GSIA's transact the business of insurance, but are exempt from regulation as insurance companies under Title 38.2 of the

¹⁷ The Supreme Court of Virginia found that the two aforesaid Orders were not final Orders and dismissed the appeals without prejudice. Indiana Ins. Guar. Ass'n v. Gross, 268 Va. 220 (2004).

- Code of Virginia, except as specifically provided for in statutes adopted by the General Assembly;
- (3) The Commission is not bound by the erroneous legal conclusions of a member of the staff in the Bureau of Insurance;
 - (4) There is no basis for judicially estopping ROA and the SITs and GSIA's from arguing that they were self-insured trusts or group self-insurance associations that issued contracts of insurance providing coverage for their employer-members' liability or workers' compensation risks;
 - (5) The employer-members of SITs and GSIA's pooled their risk of loss for the purpose of transferring an individual employer-member's risk of loss to the group;
 - (6) The SITs and GSIA's were a type of reciprocal insurer in which the employer-members were both the insurer and the insured;
 - (7) The arrangement in which HWCF provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (8) The arrangement in which A-HAT provided its employer-members medical professional liability, general liability, and personal injury liability coverage was an insurance contract under Virginia law;
 - (9) The arrangement in which C-HAT provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (10) The arrangement in which K-HAT provided its employer-members hospital professional and general liability coverage was an insurance contract under Virginia law;
 - (11) The arrangement in which MHA Public provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (12) The arrangement in which MHA Private provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (13) The arrangement in which THA provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (14) The arrangement in which HPG provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (15) The arrangements in which AWCT and MHA/MSA provided their employer-members workers' compensation liability coverage were insurance contracts under Virginia law;
 - (16) The fortuity and known loss doctrines are inapplicable in this case;

- 17) The Acquisition of Assets and Assumption of Liabilities and Merger Agreements effected an assumption reinsurance transaction in which ROA assumed the then existing insurance obligations of the SITs, GSIAs, and their employer-members on the policies of insurance that had been written by the SITs and GSIAs;
- 18) A novation occurred in which ROA was substituted as the insurer of the former insurance obligations of the SITs, GSIAs, and their employer members;
- 19) The Assumed Claims are "claims of other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 ii of the Code; and
- 20) The Deputy Receiver of ROA may pay the workers' compensation Assumed Claims at 100% without creating an unlawful preference.

The hearing examiner also concluded that the arrangement in which SunHealth provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law,¹⁸ even though he omitted such conclusion from his list of findings and recommendations. We thus treat it as an additional finding for purposes of our analysis. The hearing examiner recommended that the Commission adopt his findings, direct the Deputy Receiver of ROA to pay the workers' compensation Assumed Claims at 100%, and direct the Deputy Receiver of ROA to pay the Liability Assumed Claims at the same percentage as the claims of the Guaranty Associations and the VPCIGA.¹⁹

On April 26, 2005, the VPCIGA filed a Consented to Joint Motion for Extension of Time to File Responses and Objections to Hearing Examiner's Report ("Joint Motion"). On April 28, 2005, the Commission entered an Order Extending Time for Filing Comments, in which it

¹⁸ See Report at 116.

¹⁹ Report at 130. On July 20, 2004, the Deputy Receiver of ROA filed his Application for Approval of Agreement to Stay Proceedings and Tolling Agreement, in which he requests, among other things, the Commission to approve payment by the Deputy Receiver of ROA of claims of ROA direct policyholders and insureds at a 17% percentage, subject to certain limitations, conditions, and exclusions. That case is currently before a hearing examiner. See *Application of Reciprocal of America and The Reciprocal Group For Approval of Agreement to Stay Proceedings and Tolling Agreement*, Case No. INS-2004-00244 ("Case No. INS-2004-00244").

granted the Joint Motion and provided all parties with an extension to file comments on the Report until June 1, 2005.

Comments to the Report were filed by the VPCIGA, the Guaranty Associations, Coastal and the Kentucky Hospitals (comments filed jointly), and the Deputy Receiver of ROA. Generally, the VPCIGA and the Guaranty Associations requested that the hearing examiner's findings and recommendations be rejected, while the Kentucky Hospitals, Coastal, and the Deputy Receiver supported the hearing examiner's findings and recommendations. We have thoroughly considered the entire record in this proceeding.

NOW THE COMMISSION, having considered the evidence and arguments of the parties, the pleadings, the Report and the comments thereto, and the applicable law, finds as follows. We agree with the hearing examiner that the Assumed Claims, and thus the claims of the SITs and GSIA's or employers thereof, constitute "claims of other policyholders arising out of insurance contracts," pursuant to § 38.2-1509 B 1 ii of the Code. We do not agree, however, that the Code permits us to pay the Assumed Claims at 100%. Unfortunately, we find that we are constrained by the law to pay the Assumed Claims, so that such payment is "apportioned without preference." Accordingly, the Assumed Claims may not be paid until such time as the payment percentage is finalized and approved in Case No. INS-2004-00244. If and when such payment percentage is approved by the Commission, the Assumed Claims may be paid a like percentage. Accordingly, we adopt findings 1, 5-15,²⁰ and 19. We reject finding 20, as we believe it to be inconsistent with applicable law. We take no action with respect to findings 2-4 and 16-18 as they are not necessary to our decision in this case.

²⁰ We also adopt the additional finding regarding SunHealth. See note 18 and accompanying text.

Discussion

In our November 12, 2003, Order, we ordered that "[t]he determination of whether the SITs and GSIA's or employers thereof constitute 'other policyholders arising out of insurance contracts' pursuant to § 38.2-1509 B 1 ii is hereby assigned to a Hearing Examiner and is assigned Case No. INS-2003-00239." Thus, we agree with the hearing examiner that "the issue of whether the Assumed Claims are 'covered claims' may be saved for another day," and do not decide such issue here.²¹ The narrow question that we referred to the hearing examiner has spawned nearly two years of litigation before this Commission.

Section 38.2-1509 B 1 ii of the Code provides, in pertinent part, that "[t]he Commission shall disburse the assets of an insolvent insurer as they become available in the following manner: 1. Pay, after reserving for the payment of the costs and expenses of administration, according to the following priorities: . . . (ii) claims of the associations for "covered claims" and "contractual obligations" as defined in §§ 38.2-1603 and 38.2-1701 and *claims of other policyholders arising out of insurance contracts apportioned without preference. . .*" (emphasis added). We must determine if the SITs and GSIA's or employers thereof constitute "policyholders arising out of insurance contracts" to determine whether they fall within this category of the asset disbursement scheme for insolvent insurers crafted by the General Assembly.

We first determine whether the contracts between and among the SITs and GSIA's and employers thereof constitute "insurance contracts." Neither Chapter 15 nor Chapter 1 of

²¹ Report at 127. We also do not decide here whether or not the Commission has jurisdiction to determine the "covered claims" issue.

Title 38.2 of the Code contains a definition for "policyholder" or "insurance contracts."²² We find the hearing examiner's analysis employing the tests in American Surety Co. v. Commonwealth, 180 Va. 97 (1942) and Group Hospitalization Medical Service, Inc. v. Smith, 236 Va. 228 (1988), to be convincing. Both of those cases provide the essential terms of a contract of insurance. "The essential terms of a contract of insurance are (1) the subject matter to be insured; (2) the risk insured against; (3) the commencement and period of the risk undertaken by the insurer; (4) the amount of insurance; and (5) the premium and time at which it is to be paid." 180 Va. at 105, 236 Va. at 230-231. As aptly explained by the hearing examiner, each of the coverage documents issued by the SITs and the GSIA's to their member-employers satisfied the American Surety and Group Health tests.²³ Accordingly, we find that those agreements constituted "insurance contracts," as those words are used in § 38.2-1509 B 1 ii of the Code.

The VPCIGA and the Guaranty Associations contend, however, that, the Commission must first determine that insurance exists before it even gets to the American Surety and Group Hospitalization tests for determining whether an insurance contract exists.²⁴ We agree that there must be insurance for an insurance contract to exist. However, we disagree with the Guaranty Associations' and the VPCIGA's arguments that no insurance existed here.

Section 38.2-100 of the Code provides a definition for insurance:

'Insurance' means the business of transferring risk by contract wherein a person, for a consideration, undertakes (i) to indemnify another person, (ii) to pay or provide a specified or ascertainable amount of money, or (iii) to provide a benefit or service upon the

²² Section 38.2-100 of the Code does provide that "[w]ithout otherwise limiting the meaning of or defining the following terms, 'insurance contracts' or 'insurance policies' shall include contracts of fidelity, indemnity, guaranty and suretyship." Because of the language "[w]ithout otherwise limiting the meaning of or defining," we must search elsewhere in order to define "insurance contracts" in the context of § 38.2-1509 B 1 ii of the Code.

²³ See Report at 114-117.

²⁴ See, e.g., Response and Objections of VPCIGA to Report of Hearing Examiner, at 14.

occurrence of a determinable risk contingency. . . . 'Insurance' shall not include any activity involving an extended service contract that is subject to regulation pursuant to Chapter 34 (§ 59.1-435 et seq.) of Title 59.1 or a warranty made by a manufacturer, seller, lessor, or builder of a product or service.

Unlike the exclusion of warranties from this definition, the General Assembly chose not to exclude specifically any of the types of contracts at issue in this case.

The essence of the definition is a contract by a *person* to indemnify or pay another upon the occurrence of a determinable risk contingency. We believe it important that the General Assembly chose to use the word "person" here, rather than "insurer." Thus, we do not take a position on whether the SITs or GSIA's were "insurers" under any provision of the Code, as it is unnecessary for us to do so to find that "insurance" existed here.²⁵ An "insurer" is not a necessary party to an "insurance contract" under § 38.2-1509 B 1 ii of the Code.

What is required is a transfer or shifting of the risk. See Lawyers Title Ins. Corp. v. Norwest Corp., 254 Va. 388, 390, 392 (1997) (Supreme Court of Virginia affirmed Commission's determination that Title Option Plus was not insurance and stated that a "shifting of the risk is the essence of insurance."); Hilb, Rogal and Hamilton Co. v. DePew, 247 Va. 240,

²⁵ We have reviewed a number of cases in reaching our conclusion, including authorities cited by the parties. We read the Iowa Supreme Court's decision in Iowa Contractors Workers' Compensation Group v. Iowa Ins. Guar. Ass'n, 437 N.W.2d 909 (Iowa 1989) to be inapposite to our conclusion. There, the Supreme Court of Iowa found, among other things, that a self-insured group was not an "insurer" under Iowa law. The result of such finding, of course, was that the Iowa Insurance Guaranty Association was liable for certain claims. 437 N.W.2d at 916. We decline to adopt the Supreme Court of Iowa's reasoning to the extent the court determined that no risk is transferred unless all of the risk is transferred. See, 437 N.W.2d at 917.

Similarly, in South Carolina Property and Cas. Ins. Guar. Ass'n v. Carolinas Roofing and Sheet Metal Contractors Self-Insurance Fund, 446 S.E.2d 422 (S.C. 1994), the Supreme Court of South Carolina found that the self-insured roofers' fund was an "insurer" under that state's law. The court's analysis differed from the Iowa court's in that the Supreme Court of South Carolina found that the members of the group self-insurer did transfer a portion of their risk. 446 S.E.2d at 425.

In California Plant Protection, Inc. v. Zayre Corp., 659 N.E.2d 1202 (Mass. App. Ct. 1996), the court found that the self-insured group was not an "insurer" and was therefore entitled to guaranty fund protection. Id. at 1205. We are not required to decide in this case whether the SITs or GSIA's constitute an "insurer" under our law.

248 (1994) ("Such shifting of the risk is the essence of insurance."). We find that such a risk transfer or shift took place here.

We do not believe that the existence of joint and several liability served to nullify any risk transfer that occurred among the members' pooling of their liabilities. Nor does the fact that the members could have been assessed under their policies nullify the transfer or shifting of risk. We find the hearing examiner's discussion to be persuasive in this regard. While we decline to adopt *in toto* the reasoning of the Supreme Court of South Carolina or the Supreme Court of Iowa, we agree that, in Virginia, insureds may be assessed under an insurance policy without altering the policy's essential nature as an insurance contract.

We find further support for our decision in the Court of Appeals of Maryland's decision in Maryland Motor Truck Ass'n Workers' Compensation Self-Insurance Group v. Property & Cas. Ins. Guar. Corp., 871 A.2d 590 (Md. 2005), a decision filed after the hearing examiner filed his report, but before the deadline for filing comments in this case.

In Maryland Motor Truck, the Court of Appeals of Maryland, its highest court, was faced with the question of whether the Maryland Motor Truck Association Workers' Compensation Self-Insurance Group ("MMTA") was an "insurer" under Maryland law. If the MMTA was an "insurer," the Property and Casualty Insurance Guaranty Corporation ("PCIGC") was not responsible for paying the claims of the members of the MMTA, which had an excess insurance policy with Reliance National Indemnity Company, an insurance company declared insolvent by a Pennsylvania court. The members of the MMTA were each jointly and severally liable for the workers' compensation obligations of the group and its members that were incurred during their period of membership.²⁶

²⁶ 871 A.2d at 592.

In discussing differences between self-insurance with only one entity insuring itself, and group self-insurance, with multiple members, the Maryland Court of Appeals stated,

[i]n reality, because in that situation there is no spreading of the risk for that part of a loss that is either within a deductible or over the policy limit, the policyholder is more likely *non*-insured for that segment. As we shall explain later, that is not necessarily the case with group self-insurance. There, the retained risk is transferred from the individual (member) to the group and is spread throughout the group. The member may share with the other members joint and several liability for the overall, aggregate combinations of the group, but is relieved of any direct obligation for payment of particular claims made against it. That is much more akin to the nature and concept of insurance than to that of non-insurance.

871 A.2d at 596 (emphasis in original). The Maryland Court of Appeals continued by analyzing the contract and concluded that "[t]he mere fact that the members retain joint and several liability for any remaining obligations of the [self-insured] Group does not suffice to preclude the Agreement from constituting an insurance contract. . . . Such an arrangement—joint and several liability for a deficiency and the right to recover part of the surplus funds in the form of dividends—is a traditional characteristic of assessment mutual insurance companies." *Id.* at 598.

The Court of Appeals of Maryland found that, because the contracts were insurance contracts, the self-insured group was an "insurer," and the PCIGC was not responsible for the claims under Maryland law. While we are not determining the precise question of whether the SITs or GSIAAs constitute an "insurer," and specifically decline to do so here, we find the reasoning of the Court of Appeals of Maryland persuasive as it relates to the determination that the underlying contracts were insurance contracts. Simply put, we do not believe that the existence of joint and several liability, when analyzed in the context of the remainder of the contracts among the members and the SITs and GSIAAs, nullifies the fact that risk was shifted or transferred. The VPCIGA argues that "[t]his agreement by each member to assume an obligation

it did not otherwise have and to pay and discharge the liability of every other member cannot be characterized as a transfer of risk."²⁷ We think the opposite is true. Each member assumed an obligation it did not otherwise have (accepted risk) and agreed to pay and discharge the liability of every other member (accepted risk). By the same token, each member transferred a portion of its risk to the group, while retaining or receiving back a portion of, or possibly all, of such risk upon the occurrence of certain contingencies. Nothing in the definition of "insurance" in the Code, or case law from the Supreme Court of Virginia, supports the notion that, without a complete transfer or shift of all the risk, no risk is transferred at all. We think, to the contrary, that sufficient indicia of risk transfer or shift was present here for the contracts to be insurance contracts.

Having determined that risk was transferred or shifted and shared or pooled among and between the members and the SITs and GSIA's, we then apply the American Surety and Group Hospitalization tests to determine whether the contracts were insurance contracts under Virginia law. In this regard, we agree with the hearing examiner's analysis and findings that all 11 of the SITs' and GSIA's' coverage documents constituted "insurance contracts."²⁸ Finally, we believe that the Assumed Claims are those of "policyholders." In this regard, while the "policyholders" may have been the employers-members of the SITs and GSIA's rather than a third-party claimant or employee, we believe the language "arising out of" is broad enough to encompass the Assumed Claims.²⁹ Having found that the contracts between and among the SITs and GSIA's

²⁷ Response and Objections of VPCIGA to Report of Hearing Examiner, at 20.

²⁸ Report at 114 -117, 128-129 (findings and recommendations 7-15). See also Report at 116 and note 18 and accompanying text, *supra*, regarding SunHealth.

²⁹ The parties did not spend much, if any, time disputing whether the employers-members were "policyholders" under § 38.2-1509 B 1 ii of the Code. While the employers-members were technically the "policyholders" under the contracts, see Atkinson v. Penske Logistics, LLC, 268 Va. 129, 135 (2004) ("... 'named insured' is the policyholder."), we think it is patently obvious, and the parties apparently agreed, that the employees thereof were

and their employers-members were "insurance contracts," and that the Assumed Claims constituted claims of "policyholders arising out of insurance contracts," we find it unnecessary to decide whether the Agreements constituted assumption reinsurance or whether a novation occurred. Accordingly, it is also unnecessary for us to decide whether ROA assumed "known losses" through the Agreements.

Apportioned without preference

The remaining pertinent language is that the Commission must pay "the claims of other policyholders arising out of insurance contracts *apportioned without preference*." Section 38.2-1509 B 1 ii of the Code (emphasis added). We cannot agree with the hearing examiner here that we have the authority to pay the Assumed Claims at 100%. Hence, the Assumed Claims may not be paid until a decision is rendered in the INS-2004-00244 case and then only at the percentage arrived at in such case.³⁰

The hearing examiner concluded that the General Assembly's preference for paying the full amount of a workers' compensation claim that is a "covered claim" under § 38.2-1606 A 1 a i of the Code indicates that the General Assembly "never intended that one group of workers' compensation policyholders of an insolvent insurer should receive 100% payment of their

also "policyholders" as they were the beneficiaries of the contracts. The language "arising out of" appears to be broad enough to include such claimants as "policyholders." See Trex Co., Inc. v. ExxonMobil Oil Corp., 234 F. Supp. 2d 572, 576 (E.D. Va. 2002) ("In the insurance context 'arising out of' is broader than 'caused by,' and ordinarily means 'originating from,' 'having its origin in,' 'growing out of,' 'flowing from,' or 'incident to or having connection with.'"); St. Paul Fire and Marine Ins. Co. v. Insurance Co. of North America, 501 F. Supp. 136, 138 (W.D. Va. 1980) (same, applying Virginia law).

³⁰ We recognize, and are not unmindful of the fact, that the injured workers may suffer a serious hardship as a result of our decision. We also recognize the apparent inequity in certain workers' compensation claimants receiving 100% of their claim (those that are eventually deemed "covered claims" under § 38.2-1606 A 1 a i of the Code) while others (for example, those impacted by our decision today) receive a substantially smaller percentage. Without deciding the "covered claim" issue, we note that the priority scheme for workers' compensation claimants in Chapter 16 of Title 38.2 of the Code could have been utilized in the disbursement scheme in Chapter 15 of Title 38.2 of the Code. The General Assembly, however, for whatever reason, chose not to do so.

claims; while an identical group of workers' compensation policyholders from the same insolvent insurer might receive less than 100% payment of their claims."³¹ We do not agree with the hearing examiner's *in para materia* analysis, however, as we believe that Chapters 15 and 16 of Title 38.2 of the Code, while related, pertain to different matters.

Section 38.2-1509 of the Code is part of a carefully crafted scheme for handling the disbursements of the assets of an insolvent insurer's estate, while § 38.2-1606 deals with the duties and powers of the Virginia Property and Casualty Insurance Guaranty Association. Section 38.2-1509 B of the Code controls the manner in which the Commission will pay claims out of the estate of the insolvent insurer. See Swiss Re Life Co. America v. Gross, 253 Va. 139, 146 (1997). That statute does not provide for the payment of one class of policyholders at 100%, while another policyholder receives whatever percentage may be paid by the estate as "available." Instead, it provides that all policyholder claims are to be "apportioned without preference."

The General Assembly has enumerated the order in which claimants of the insolvent insurer's assets may be paid, and we may not deviate from such legislative scheme. "When a legislative enactment limits the manner in which something may be done, the enactment also evinces the intent that it shall not be done another way." Grigg v. Commonwealth, 224 Va. 356, 364 (1982). We are not permitted to exercise our discretion here to override the General Assembly's priority scheme, because of the General Assembly's policy judgment set forth in an

³¹ Report at 127.

entirely different chapter of Title 38.2 of the Code.³² Had the General Assembly wanted to incorporate a super-priority for workers' compensation policyholders in Chapter 15 of the Code, it could have done so.³³ The legislature's determination instead that the assets are to be paid to satisfy the "claims of other policyholders apportioned without preference" is a clear command not to create exceptions for certain policyholders.

Conclusion

We find that the Assumed Claims are "claims of other policyholders arising out of insurance contracts." We also conclude that such claims must be "apportioned without preference" in accordance with the priority scheme established by the General Assembly set forth in § 38.2-1509 of the Code. Hence, we adopt findings 1, 5-15,³⁴ and 19 of the Report. We reject finding 20, as we believe it to be inconsistent with applicable law. We take no action with respect to findings 2-4 and 16-18 as they are not necessary to our decision in this case.

Accordingly, IT IS ORDERED THAT:

(1) The Application of the Deputy Receiver of ROA is APPROVED, except as modified herein.

³² If we ultimately determine that the Assumed Claims are "covered claims," as have the North Carolina Industrial Commission and the North Carolina Court of Appeals, see, Bowles v. BCJ Trucking Services, Inc., I.C. No. 821763 (North Carolina Ind. Comm'n, July 17, 2003) (Opinion of Douglas Berger, Deputy Commissioner), *aff'd*, Bowles v. BCJ Trucking Services, Inc., I.C. No. 821763 (North Carolina Indus. Comm'n, April 16, 2004) (2-1 decision by full commission), *aff'd*, Bowles v. BCJ Trucking Services, Inc., 615 S.E.2d 724 (N.C. Ct. App. 2005); In re: SunHealth GSIA/The Reciprocal Group, I.C. Nos. 402156, 467439, 822818, 734242, 902560, 426774, 705360, 616611, 734300 & 944966 (N.C. Indus. Comm'n, July 19, 2004), then the injured employees ultimately may receive 100%. We make no such determination today as the question of whether the "Assumed Claims" are "covered claims" is not before us.

³³ The General Assembly created such a super-priority for workers' compensation claimants in § 38.2-1606 of the Code.

³⁴ We also adopt the additional finding regarding SunHealth. See note 18 and accompanying text.

(2) The Assumed Claims constitute "claims of other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 ii of the Code.

(3) The Deputy Receiver may not pay the Assumed Claims until such time as a payment percentage is determined by the Commission in Case No. INS-2004-00244.

(4) This matter is closed and the papers herein be passed to the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to all persons on the official Service List in this matter. The Service List is available from the Clerk of the State Corporation Commission, c/o Document Control Center, 1300 East Main Street, First Floor, Tyler Building, Richmond, Virginia 23219.

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December 22, 2005

Via Hand Delivery

Joel H. Peck, Esquire
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Richmond, Virginia 23219

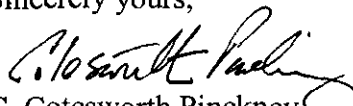
Re: Application of Reciprocal of America and the Reciprocal Group; For a Determination Whether Certain Worker's Compensation Insurance Policy Payments May be Made to Claimants Formerly Covered by SITs and GSIA's
Case No. INS-2003-00239; Notice of Withdrawal of Appeal

Dear Mr. Peck:

Enclosed for filing in the above-referenced matter are the original and fifteen copies of a Notice of Withdrawal of Appeal which has been executed in counterparts by counsel for the Guaranty Associations, the Virginia Association, the Alabama Claimants and the Kentucky Hospitals.

Thank you for your assistance in this matter.

Sincerely yours,


C. Cotesworth Pinckney

Enclosures

cc: Gregory P. Deschenes, Esquire
Wiley F. Mitchell, Jr., Esquire
Greg E. Mitchell, Esquire

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COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

APPLICATION OF)
)
RECIPROCAL OF AMERICA and)
THE RECIPROCAL GROUP)
) Case No. INS-2003-00239
For a Determination Whether Certain Workers')
Compensation Insurance Policy Payments)
May be Made to Claimants Formerly)
Covered by SITs and GSIA's)

NOTICE OF WITHDRAWAL OF APPEAL

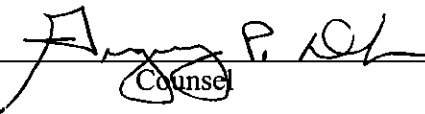
The Indiana Insurance Guaranty Association, Kansas Insurance Guaranty Association, Mississippi Insurance Guaranty Association and Tennessee Insurance Guaranty Association (the "Guaranty Associations"), the Virginia Property and Casualty Insurance Guaranty Association (the "Virginia Association"), the Coastal Region Board of Directors and the Alabama Subscribers (the "Alabama Claimants") and the Appalachian Regional Healthcare, Clinton County Hospital, Crittenden Health System, Cumberland County Hospital, Gateway Regional Medical Center, Hardin Memorial Hospital, Highlands Regional Medical Center, Livingston Hospital & Healthcare Service, Marcum & Wallace Memorial Hospital, Marshall County Hospital, Monroe County Medical Center, Murray-Calloway County Hospital, Ohio County Hospital, Owensboro Mercy Health System, Pattie A. Clay Hospital, Pineville Community Hospital, Regional Medical Center/Trover Clinic Foundation, Rockcastle Hospital, St. Claire Medical Center, T.J. Samson Community Hospital, Twin Lakes Regional Medical Center, and Westlake Regional Hospital (the "Kentucky Hospitals") each filed with the Clerk of the State Corporation Commission a notice of appeal from the Final Order of the State Corporation Commission entered on August 24, 2005 in Case No. INS-2003-00239 (the "Order").

Each of the Guaranty Associations, the Virginia Association, the Alabama Claimants and the Kentucky Hospitals (collectively, the "Claimants") has agreed with each of the other Claimants, in consideration of the similar agreements of such other Claimants, that it will abandon its appeal from the Order.

ACCORDINGLY, each of the Claimants by counsel hereby gives notice of its withdrawal of its appeal from the Order. Each of the Claimants acknowledges that this Notice of Withdrawal of Appeal may be executed in any number of counterparts (and by different parties hereto in different counterparts) each of which when so executed and delivered shall be deemed to be an original and all of which taken together shall constitute but one and the same instrument.

Dated December 21, 2005.

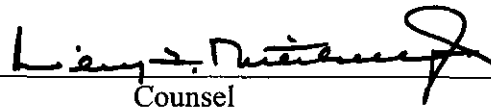
INDIANA INSURANCE GUARANTY
ASSOCIATION, KANSAS INSURANCE
GUARANTY ASSOCIATION, MISSISSIPPI
INSURANCE GUARANTY ASSOCIATION, and
TENNESSEE INSURANCE GUARANTY
ASSOCIATION

By 
Counsel

VIRGINIA PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION

By 
Counsel

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AND THE ALABAMA SUBSCRIBERS

By 
Counsel

THE KENTUCKY HOSPITALS

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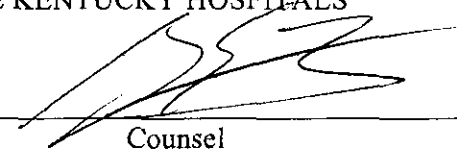
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CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of December, 2005, the original foregoing Notice of Withdrawal of Appeal executed in counterparts and fifteen copies thereof were delivered by

hand to:

Joel H. Peck, Esquire
Clerk of the Commission
State Corporation Commission
Tyler Building
1300 East Main Street
Richmond, Virginia 23219

and photocopies thereof were mailed by first class mail to:

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State Corporation Commission
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Indiana Insurance Guaranty Association,
Mississippi Insurance Guaranty Association and
Kansas Insurance Guaranty Association

A handwritten signature in cursive script, appearing to read "Gregory P. Deschenes", is written over a horizontal line.

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