FINANCIAL CONDITION (E) COMMITTEE

Draft Pending Adoption

Draft: 12/17/25

Financial Condition (E) Committee
Hollywood, Florida
December 11, 2025

The Financial Condition (E) Committee met in Hollywood, FL, Dec. 11, 2025. The following Committee members participated: Nathan Houdek, Chair (WI); Michael Wise, Co-Vice Chair (SC); Justin Zimmerman, Co-Vice Chair (NJ); Mark Fowler (AL); Michael Conway (CO); Michael Yaworsky represented by Alexis Bafofsky (FL); Doug Ommen and Carrie Mears (IA); Holly W. Lambert represented by Roy Eft (IN); Vicki Schmidt represented by Eric Turek (KS); Michael T. Caljouw (MA); Mike Chaney represented by David Browning (MS); Kaitlin Asrow represented by Bob Kasinow (NY); Judith L. French (OH); Cassie Brown and Jamie Walker (TX); and Scott A. White, Doug Stolte, and Dan Bumpus (VA). Also participating were: Philip Barlow (DC); Robert Wake (ME); Glenn Mulready (OK); and Elizabeth Kelleher Dwyer (RI).

1. Adopted its Nov. 20, Nov. 5, Oct. 7, and Summer National Meeting Minutes

Commissioner Houdek said the Committee met Nov. 20, Nov. 5, and Oct. 7. During these meetings, the Committee took the following action: 1) discussed the previously received Statutory Accounting 2024-06: Risk Transfer Analysis of Combination Reinsurance Contracts; and 2) adopted its 2026 proposed charges.

Director Wise made a motion, seconded by Commissioner Conway, to adopt its Nov. 20 (Attachment One), Nov. 5 (Attachment Two), Oct. 7 (Attachment Three), and Aug. 11 (*see NAIC Proceedings – Summer 2025, Financial Condition (E) Committee*) minutes. The motion passed unanimously.

2. Adopted the Reports of its Task Forces and Working Groups

Commissioner Houdek stated that the Committee typically adopts one motion to approve its task force and working group reports, which are considered technical, noncontroversial, and not significant by NAIC standards (i.e., they do not include model laws, model regulations, model guidelines, or items deemed to be controversial). He reminded Committee members that after the adoption of its votes, all the technical items included within the reports adopted will be sent to the NAIC Members for review shortly after the conclusion of the 2025 Summer National Meetings as part of the Financial Condition (E) Committee's technical changes report. Pursuant to the technical changes report process previously adopted by the Executive (EX) Committee and Plenary, the members will have 10 days to comment. Otherwise, the technical changes will be considered adopted by the NAIC and effective immediately.

With respect to the task force and working group reports, Commissioner Houdek asked the Committee: 1) whether there are any items that should be discussed further; and 2) whether there are other issues not up for adoption that are currently being considered by task forces or working groups reporting to the Committee that require further discussion. The response to both questions was no.

In addition to presenting the reports for adoption, Commissioner Houdek noted that the Financial Analysis (E) Working Group met Dec. 8, Oct. 23, and Oct. 2 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results. Additionally, the Valuation Analysis (E) Working Group met Dec. 8 and Oct. 9 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.

Commissioner Caljouw made a motion, seconded by Director Wise, to adopt the task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Financial Stability (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Valuation of Securities (E) Task Force; Mutual Recognition (E) Working Group; NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group (Attachment Four); the Restructuring Mechanisms (E) Working Group (Attachment Five) and Risk Focused Surveillance (E) Working Group (Attachment Six). The motion passed unanimously.

3. Adopted the Listing of Qualified Jurisdictions and Reciprocal Jurisdictions

Wake reported that the Mutual Recognition of Jurisdictions (E) Working Group met Oct. 21 in regulator-to-regulator session, pursuant to paragraph 6 of the NAIC Policy Statement on Open Meetings, to discuss the ongoing topics at the Working Group and perform the annual review of the qualified and reciprocal jurisdictions.

During the meeting, the Working Group reapproved the status of the seven existing qualified and reciprocal jurisdictions, including Bermuda, France, Germany, Ireland, Japan, Switzerland, and the United Kingdom (UK), and the three reciprocal jurisdictions that are not subject to an in-force "Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance" (UK Covered Agreement)—Bermuda, Japan, and Switzerland.

By law, the other four reciprocal jurisdictions of France, Germany, Ireland, and the UK automatically remain reciprocal jurisdictions so long as they are parties to covered agreements. These decisions followed committee support's review of the due diligence they had performed.

Additionally, at the meeting, the Working Group approved the Canadian Office of the Superintendent of Financial Institutions (OSFI) as a jurisdiction that recognizes and accepts the U.S. approach to group capital.

Eft made a motion, seconded by Director Wise, to adopt the listing of qualified jurisdictions and reciprocal jurisdictions (Attachment Seven). The motion passed unanimously.

4. Adopted the Listing of Jurisdictions that Recognize and Accept the GCC

Wake reported that during the same meeting of the Mutual Recognition of Jurisdictions (E) Working Group as previously noted, the Working Group also adopted a listing of jurisdictions that recognize and accept the NAIC group capital calculation (GCC), including approval of the Canadian OSFI as a jurisdiction that recognizes and accepts the U.S. approach to group capital.

Commissioner Conway made a motion, seconded by Walker, to adopt the listing of jurisdictions that recognize and accept the NAIC GCC (Attachment Eight). The motion passed unanimously.

5. Received Informal Oral Comments on the CLO Timeline

Commissioner Houdek directed the Committee to the collateralized loan obligations (CLOs) timeline (Attachment Nine) of possible actions that may be taken in 2026 by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group and the Invested Assets (E) Task Force, which was renamed through its 2026 charges as previously announced during the Committee's Nov. 20 call. Barlow noted that the Risk-Based Capital Investment Risk and Evaluation (E) Working Group would hold a meeting next week to hear an update from the American Academy of Actuaries (Academy) on its work on this project. There were no further comments or questions from interested regulators or parties.

6. Adopted the *Restructuring Mechanisms White Paper*

Commissioner Houdek reported that the Restructuring Mechanisms (E) Working Group had completed a white paper that outlines various issues related to the use of restructuring mechanisms, such as insurance business transfers (IBTs) and corporate divisions (CDs), which have gained increased attention in some states in recent years. He noted that the paper had been a work in progress for a number of years and ultimately was adopted by the working group without opposition on Dec. 1. Commissioner Houdek noted that, given there was no opposition for adoption at the Working Group level, he would consider a motion to adopt.

Wake said that the proposed white paper included editorial changes he made subsequent to its adoption by the Working Group. He noted that the editorial changes are intended to clarify the use of the term "personal lines," as regulators are interested in protecting all consumers. Director Dwyer and Commissioner Mulready, co-chairs of the Restructuring Mechanisms (E) Working Group, expressed their appreciation for the work done by regulators including Wake, Matt Gendron (RI), Jack Broccoli (CT), and numerous other parties that assisted in completing the Working Group's work.

Commissioner Houdek thanked Director Dwyer and Commissioner Mulready for their leadership and hard work, stating that he saw no reason the Committee should not consider adopting the paper, given that it had been unanimously adopted by the Working Group and the edits from Wake were clarifying.

Commissioner Caljouw made a motion, seconded by Director Wise, to adopt the *Restructuring Mechanisms White Paper* (Attachment Ten). The motion passed unanimously.

7. Adopted Statutory Accounting 2024-06: Risk Transfer Analysis of Combination Reinsurance Contracts as Modified by the Committee

Commissioner Houdek explained that this topic has been discussed extensively by the Committee since the Summer National Meeting, and as reported during the Committee's Nov. 20 meeting, he expected a vote to be taken.

Commissioner Brown stated that she appreciated the discussion and education that had taken place on this issue, as well as the regulator's and industry's commitment to further discussions and work. She noted that while she has heard that some states do not have a practice of using permitted practices for unique circumstances such as these, states will need to consider such practices to account for these transactions under this accounting. Additionally, companies will need to know how their regulator views such past transactions. For this reason, she sees value in further conversation and education regarding permitted practices including continued discussion on the most recent language presented by the industry in order to provide a way to account for these transactions when states do not normally issue permitted practices. She indicated that this is not a tool that Texas utilizes, as it supports the use of permitted practices when the domestic regulator deems such practices are appropriate, but it is supportive of the concept. She said that when, where, and how those discussions take place are at the discretion of the Committee.

Commissioner Fowler said he appreciates Commissioner Houdek's management of this situation, which allowed all parties to provide their input and consider various alternatives.

Commissioner Ommen said he echoes Commissioner Brown's comments on the possibility of additional discussion in the future. He stated that Iowa was supportive of additional guidance being discussed on permitted practices, as the NAIC has a year before this accounting is effective, but it is important to get started soon.

Director Fox stated her appreciation for the discussions that took place but emphasized some of her past comments, that when it comes to permitted practices, it is important for proper disclosure for the non-domestic states within the insurer's financial statements.

Commissioner Houdek noted that the Committee would send direction to the Statutory Accounting Principles (E) Working Group regarding the issues highlighted by Commissioners Brown and Ommen, subsequent to the national meeting.

Director Wise made a motion, seconded by Commissioner Ommen, to adopt Statutory Accounting 2024-06: Risk Transfer Analysis of Combination Reinsurance Contracts, as modified by the Committee to clarify that this should be accounted for as a change in accounting principle in accordance with *SSAP No. 3—Accounting Changes and Corrections of Errors* (Attachment Eleven). The motion passed unanimously.

8. Any Other Matters

Bakofsky provided the Committee with an update on the work of the Big Data and Artificial Intelligence (H) Working Group. The Working Group is continuing its development of the Artificial Intelligence (AI) Systems Evaluation Tool. The tool aims to help regulators efficiently collect information to assess potential risks associated with insurers' use of AI and will serve as a regulatory resource for examining the effectiveness of insurer AI governance programs. The tool is intended to supplement market and financial-related handbooks, allowing regulators to progressively investigate the extent and usage of AI in insurer operations, AI governance and testing protocols, potential high-risk applications, and data sources used in the development of AI systems. Four exhibits are incorporated into the tool, and questions can be tailored by regulators as needed. The tool and its exhibits are optional and intended to supplement market conduct, financial examinations, product reviews, and analysis procedures.

Bakofsky reported that the Working Group exposed it for a 60-day public comment period that ended on Sep. 5 and has been evaluating the feedback received from stakeholders. The group recently held a meeting on Nov. 19 to explain the feedback it received and the revisions made to the tool. The Working Group met on Dec. 7 to work through comments and suggested edits from interested parties in greater depth.

Bakofsky said that in 2026, the next version of the tool will be piloted by a few states to gather feedback on their experiences administering it. Through the pilot, the Working Group expects to gain insights into the tool's effectiveness, identify needed refinements, and assess whether current laws are sufficient or if an AI model law should be considered. More opportunities for stakeholder feedback on the tool will be offered.

Implementation of the tool could lead to referrals from the Working Group to the Market Regulation and Consumer Affairs (D) Committee and the Financial Condition (E) Committee, respectively, offering input on handbook updates for consideration. As the Working Group moves forward, reporting its progress to other NAIC committees allows for additional feedback and may support the efforts of other committees.

Commissioner Houdek thanked Wake for his years of service to state regulation, with this being his last NAIC national meeting.

Having no further business, the Financial Condition (E) Committee adjourned.

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Draft: 11/21/25

Financial Condition (E) Committee
Virtual Meeting
November 20, 2025

The Financial Condition (E) Committee met Nov. 20, 2025. The following Committee members participated: Nathan Houdek, Chair (WI); Justin Zimmerman, Co-Vice Chair (NJ); Michael Wise, Co-Vice Chair, Mark Fowler (AL); Michael Conway (CO); Michael Yaworsky represented by Carolyn Morgan (FL); Doug Ommen and Kevin Clark (IA); Holly W. Lambert represented by Roy Eft (IN); Vicki Schmidt represented by Chut Tee (KS); Michael T. Caljouw (MA); Mike Chaney represented by Chad Bridges (MS); Kaitlin Asrow represented by Bob Kasinow (NY); Judith L. French represented by Dale Bruggeman (OH); Cassie Brown (TX); and Scott A. White. Also participating was Anita Fox (MI).

1. Opening Statement from Committee Chair

Commissioner Houdek summarized the items on the agenda but noted that for the agenda item dealing with the Statutory Accounting Principles (E) Working Group 2024-06 *Risk Transfer Analysis on Combination Reinsurance Contracts* (2024-06), he did not plan on the Committee taking action during the call.

2. Receive and Discuss Comments on Exposed Alternative to 2024-06

Commissioner Houdek stated the Committee received four comment letters (Attachment One-A) on its previous exposure of an Alternative Proposal (Attachment One-B) to 2024-06. Clark introduced himself, explained his background including his time as an Accounting Director responsible for determining risk transfer for the insurance company, and detailed the comment letter from Iowa, Virginia, Minnesota, California, Kansas and Wisconsin financial regulators. He explained that life insurers hold a reserve liability on their balance sheets that represent the present value of future cash flows associated with insurance policies that they've written. Insurers are then required to hold assets against those reserves to fund those future obligations. Those obligations can also be transferred to other insurers using reinsurance. The most common way to do this is through proportional reinsurance where the reinsurer becomes responsible for all of the risks associated with that reinsurance policy. This is also often referred to as stepping into the shoes of the insurer. If all of the risks are transferred to the reinsurer, the ceding company eliminates the reserve liability from their balance sheet because its is now the reinsurer's obligation. You will also hear this elimination of the reserve referred to as a reserve credit. Appendix A-791 of the *Accounign Practices and Procedures Manual* contains the requirements for assessing whether all of the risks are transferred under proportional reinsurance. It contains a lot of specific requirements, but the basic principle is quite simple, which is that determining whether risk transfer has been met is really a process of ensuring that there can be no potential for the ceding company to become responsible for payments to the policyholder that are not reinsured by the reinsurer. Because the ceding company eliminates the reserve liability for reinsurance, any payments that that the insurer is responsible for would need to be made from the insurer's surplus. This would create a solvency risk that not accounting for under the regulator framework and is therefore prohibited under A-791. The issue with the combination coinsurance and Yearly Renewable Term (YRT) is that the coinsurance portion of the agreement appears to meet risk transfer when you view it in isolation, but when you combined it with the YRT and make it interdependent with another form of reinsurance , the effect is no longer the performance of a proportional reinsurance agreement and it can now result in payments being made from the insurers surplus. This is a violation of the requirements of A-791 as it's currently written. The clarifications adopted by the Statutory Accounting Principles (E) Working Group add this as an additional example of a contractual feature that has the potential to violate the principle of risk transfer.

The changes do not change the principles of risk transfer. Based upon the review that has been performed on Schedule S to identify contracts of concern, there are relatively few of these types of contracts in place and in only a small number of states. However, some of the agreements in place results in very large reserve credit that are likely not reflective of the risk actually transferred. This has the potential to be masking actual solvency concerns for individual companies. For that reason, the signers of the comment letter oppose any modifications to the adoption by the Statutory Accounting Principles (E) Working Group that would prevent domiciliary regulators from addressing solvency concerns with their insurers, which the signers of the comment letter believe the exposed alternative proposal does.

Clark discussed that the alternative proposal differentiates treatment of agreements based on whether they have been submitted to regulators. The comment letter discusses that if the submission of the contract in the alternative proposal was in the past, under the alternative such contracts would get at least two more years to comply with the risk transfer requirements. This appears to be the case whether there was any acknowledgement from the regulator ever looked at the agreements. It's important to note that most of these agreements are 3rd party agreements that do not require regulatory approval. It is common for regulators to be provided with reinsurance agreements for informational purposes, but it is uncommon for regulators to perform a detailed review of those agreements if they do not require approval. Therefore, the signers of the comment letter do not think submission to a regulator with no response received should have any bearing on when an agreement that fails risk transfer should be properly accounted for. The signers of the comment letter also do not think it is prudent to permit the solvency position of insurers to continue to be misstated for an additional three years. For agreements that were submitted to regulators at some point in the past and a formal response was received and that response did not disapprove the transaction, those agreements would be permanently grandfathered under the alternative proposal. Given the concern that the accounting for these agreements could be masking actual solvency issues, we also do not believe this is prudent. Additionally, it should be understood that a regulator not disapproving of entering into a transaction that does not require regulatory approval does not mean that the regulator is approving of a company's risk transfer analysis. Risk transfer analysis is the responsibility of the insurer, can be subject to review by regulators during exams, but unless an insurer specifically asks the regulator whether they concur with the company's risk transfer analysis and the regulator explicitly agrees a non-disapproval of a transaction should not be construed as an approval of the company's risk transfer analysis for that transaction. Even if a regulator does explicitly agree with the company's risk transfer analysis, it's important to note that reinsurance agreements and these combination YRT and coinsurance agreements are particularly very complex and the economic substance can be difficult to distill from the legal terms. The regulator previously reviewing an agreement and not identifying a concern the first time around should not prevent them from addressing a potential solvency concern now that more information is known. For these reasons, it's our view that the best way to address the particular circumstances for each insurer is for them to engage with their domiciliary regulator to determine the best solution to transition existing agreements. This may warrant regulators considering a permitted practice that would allow the transactions to be phased out in an orderly way while allowing the regulator to apply guardrails to ensure that the solvency position of the insurers is fairly stated. It would also result in the disclosure of impacts of any granted permitted practices which would allow those relying on the insurers statutory financial statements to understand the impacts. Commissioner Caljouw thanked Clark and the Iowa Insurance Division and the cosigners on the joint comment letter for presenting what he described as the best practical explanation of the issue.

Director Fox summarized her comments to the Committee. She emphasized that while Michigan is not a member of the Committee, she was concerned about the potential impact of the issue on non-domestic states of the companies that have these combination YRT and Coinsurance reinsurance contracts that do not transfer risk. She noted that the accounting issue doesn't have two sides, that the reinsurance agreement by definition is something that needs to transfer the risk and she appreciated the way Clark summarized the key issue being potential deprivation of surplus. She stated she also appreciated the points made by Clark on how such agreements that

have been reviewed by a state are not bound forever by their review and agreed with the suggestion that its up to the company to work with their domestic state to deal with the specific situation. Most importantly, as a non-domestic state, she emphasized the need for the permitted practice to be disclosed. She noted that the basis of the state based system is being able to rely on each other, and that can only be done when disclosures on these types of items are made. She stated her support for the action adopted by the Statutory Accounting Principles (E) Working Group and the ability of state permitted practices to be used on a contract by contract decision and not some old grandfathering or across the board exemption from a very basic statutory accounting issue.

Sheldon Summers (Claire Thinking, Inc.) summarized his background as a former California Department of Insurance actuary that worked on the original model regulation and subsequent question and answer section of A-791 more than twenty years ago. He also summarized the comments of Claire Thinking, Inc. He noted his comments were related to the addition to A-791 the use of cash flow testing under moderately adverse scenarios and assumptions as a means to demonstrate the transfer of risk. He noted that what is being discussed is a much lower standard than is currently required and inconsistent with the other accounting requirements in A-791. However, this point seems to be agreed by others at this point therefore reducing the need for him to raise more concerns related to this item.

Carrie Haughawout (American Council of Life Insurers—ACLI) stated her appreciation for the Committee's openness and collaboration on the issue, even on a topic that we know has been challenging for many. She further stated her appreciation and respect for the intent behind the proposals, but the ACLI main outstanding concerns remains the impact of retroactive application that we would believe would introduce uncertainty and affect the transparency and predictability for insurers long-term decisions. She noted that their discussions with many of the Committee members have been very constructive and that the ACLI has received valuable feedback and the ability to refine the ACLI draft to address both regulatory concerns that have been mentioned, but also the industry concerns. She noted the ACLIs commitment to work with the Committee to achieve the outcome and thanked everyone for their time and thoughtful feedback.

Commissioner Ommen stated his appreciation for all of the individuals involved in the process. He noted that Committee members aware of the transactions that might be impacted by 2024-06 and how some of those might be more challenging to address, but Iowa does view that permitted practices are the right way to have that balanced approach to make sure we are taking care of the issues as well as allowing the domestic regulator to be in a position to observe and consider the effects of these transactions. He offered that his staff's history of these issues may enable his staff to have discussions with any other states that have less experience and noted how that may allow a more consistent approach among states given that seems to be a fair request. Commissioner Caljouw thanked Commissioner Ommen and noted how there was nothing more important than the core function of regulators around solvency. He stated he looked forward to further discussion at the Fall National Meeting but stated he did want to make sure this issue doesn't create a system of regulator arbitrage between states where there is picking and choosing between states approaches. He felt there was a need to have a balance between the use of permitted practices on issues such as these where the impacted transactions are smaller and making sure a patchwork of states approaches is not created where it can be leveraged by the industry. He noted he didn't think that was the intent of anyone on this issue but this was something to be mindful of and hear more from others about the balance needed. He described that historically Massachusetts has not allowed permitted practices and he was reluctant to change that position for good reason nine times out of ten. Director Fox responded that she didn't believe the intent was that any state would have to use a permitted practice on this issue, although that authority has always existed, but believes states will use those in a very judicious manner.

Commissioner Houdek thanks everyone for the discussion and for being actively involved in the issues. He reminded everyone that 2024-06 was adopted by the Statutory Accounting Principles (E) Working Group and Accounting Practices and Procedures (E) Task Force at the Summer National Meeting and because a lot of

questions came up at those meetings, the determination was made to hold off on taking action to give Committee members more time to learn about the issue, ask questions, and just get more familiar with this complicated topic. However, because that has now taken place, the intention is that the Committee will take action on the issue at the Fall National Meeting. He encouraged everyone to use the time before then to get any outstanding questions answered by state staff or NAIC staff. Director Fox stated her appreciation to Commissioner Houdek for his thoughtful approach.

3. Introduce Timeline on Collateralized Loan Obligation (CLO) Actions

Commissioner Houdek summarized the timeline that had been developed on possible actions that are intended to be taken by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group and Invested Assets (E) Task Force with targeted adoption in 2026. He described that the timeline includes an approximate timeline of action on the structure changes to RBC for CLOs, which includes exposure of a proposal no later than the Spring National Meeting, but more likely in January or February. He noted that the approximate timeline on the factor includes exposure no later than April 30. He discussed authority the Capital Adequacy (E) Task Force had to extent the ultimate timeline for adoption, and also noted that if the factors can't be implemented in 2026, the Invested Assets Task Force will exposure the CLO modeling proposal in June or July of next year with the goal to have the CLOs modeled for year-end 2026. Commissioner Houdek noted that there would be time for comments at the Fall National Meeting.

4. Adopt Referrals on Cybersecurity Matters

Commissioner Houdek directed Committee members attention to the draft referrals put before the Committee in the interest of full transparency but noted the referrals were not put together as the result of any single discussion among regulators, but rather recent regulatory investigations of cybersecurity incidents. He stated that all regulators are aware that cybersecurity is an issue impacting all insurance companies and continues to be an area of focus for insurance regulators, primarily through the work of the Innovation Cybersecurity and Technology (H) Committee. However, financial regulators also have a responsibility to consider and evaluate an insurer's cybersecurity preparedness, as well as the potential impacts of cyber incidents on an insurer's financial solvency. These things are already considered in the evaluation of IT systems in a financial exam, but regulators also need to consider cybersecurity in conjunction with merger and acquisition reviews, as well as affiliated service agreements. A motion was made by Commissioner Zimmerman, and seconded by Commissioner Caljouw, to adopt the draft referrals and send them to the applicable working group. The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/2025_3Fall/112025 - E Committee Minutes.docx

STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
LANSING
ANITA G. FOX
DIRECTOR

October 27, 2025

Transmitted via Email:

Commissioner Nathan Houdek, E Committee Chair
Dan Daveline, NAIC

Re: Comments regarding the Co-YRT Risk Transfer Discussion Draft

Dear Commissioner Houdek:

Thank you for the opportunity to comment on the alternative proposal to the Statutory Accounting Principles (E) Working Group (SAPWG) Agenda Item 2024-06: Risk Transfer Analysis on Combination Reinsurance Contracts adopted at the 2025 NAIC Summer National Meeting and the additional language for A-791: Life and Health Reinsurance Agreements.

The Michigan Department of Insurance and Financial Services (Michigan) supports the language approved by SAPWG and the Accounting Practices and Procedures (E) Task Force (APPTF) at the 2025 NAIC Summer National Meeting. We also support adding language to ensure that changes resulting from the clarifications should be accounted for as a change in accounting principle as defined in SSAP No. 3 – Accounting Changes and Corrections of Errors.

Michigan views all other language proposed in the Co-YRT Risk Transfer Discussion Draft (discussion draft) as either unnecessary or inconsistent with the expectations approved by SAPWG. As discussed below, unless companies with existing contracts comply with these clarifications by December 31, 2026, there is a significant risk that regulators will be relying on misleading financial statements. We believe this effective date allows sufficient time for existing agreements to be identified and discussed with the company's domestic regulator.

Statutory accounting has always required all reinsurance agreements to transfer risk in order to receive reinsurance accounting treatment. If it were to be subsequently determined that risk was not transferring but was nonetheless reported using reinsurance accounting, statutory accounting requires the correction to be made when identified. These contracts should be treated no differently.

To add some color to our comments above, Michigan believes that the proposed language in the discussion draft does not allow for timely corrections in the financial statements. As proposed, the financial statements that have been reviewed but not approved or disapproved by the domiciliary regulator could be misleading for two additional years. Further, the language provides for full exemption from the clarifications under certain circumstances. We believe this is inappropriate. If the reinsurance contract is fully exempt, non-domestic regulators may never know that these contracts exist and understand the related solvency impact on the financial

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statements. Non-domestic regulators must be aware of the financial condition of companies licensed, or applying for licensure, in their respective states. In short, if all of the proposed changes are adopted, a company's financial condition may be misleading by overstating reserve credits for many years. Undisclosed solvency impacts could mask material, underlying financial risks of which a regulator should be aware.

We understand that some jurisdictions have expressed concern about the language proposed by SAPWG based on the belief that these contracts were previously reviewed and approved by regulators and that applying this standard to such contracts would be unfair. It is important to note, however, that some such contracts may not have been disclosed or reviewed and as such were not actually approved. Grandfathering in contracts that do not transfer risk and that have not been disclosed or reviewed would essentially be approving contracts that were never approved, at least for the next two years to the potential detriment to solvency.

We are also aware that there may be circumstances in some jurisdictions such that disallowing an existing contract may be detrimental to that particular market. This can be dealt with on an individual basis by the appropriate regulator without allowing an across-the-board exemption. One method to disclose the impact while also providing regulatory flexibility would be through the use of a permitted practice. A permitted practice would allow each domestic regulator to determine how it would like to address the transaction. Importantly, the permitted practice must be disclosed in the financial statements, allowing all non-domiciliary regulators to understand the financial impact of that permitted practice for companies writing in, or applying to write in, that state or jurisdiction.

In summary, we do not believe that the proposed language is needed and do not support the changes in the discussion draft. The SAPWG-approved language allows sufficient time for insurance companies and domestic regulators to work together on appropriate next steps for existing agreements and ensures that the financial statements will more accurately reflect the financial condition of companies. If additional time is needed beyond the proposed effective date, states still have other avenues to provide this additional time.

We appreciate your consideration of these comments.

Sincerely,

Anita G. Fox
Director

November 3, 2025

Commissioner Nathan Houdek, Chair
Financial Condition (E) Committee
National Association of Insurance Commissioners

Dear Commissioner Houdek,

On behalf of the undersigned financial regulators, all of whom have been directly involved in the development and discussions surrounding Agenda Item 2024-06 as they have occurred at the Valuation Analysis (E) Working Group ("VAWG") and the Statutory Accounting Principles (E) Working Group ("SAPWG"), we submit the following comments on the "Co-YRT Risk Transfer Discussion Draft" ("Alternative Proposal") as exposed during the October 7, 2025 meeting of the Financial Condition (E) Committee ("E Committee").

General Comments

Appendix A-791 addresses the requirements for risk transfer for proportional reinsurance. If the requirements are met, the reserves held by the ceding company are reduced proportionally, meaning the ceding company no longer holds any reserves for the share of the underlying policies that have been reinsured. Because the ceding company no longer holds any reserves, Appendix A-791 requires that the ceding company transfers all of the significant risks of the reinsured business to the reinsurer. If there is any payment that could be required of the ceding company that is not covered by the reinsurer, that payment would have to come out of surplus since the cedant holds no reserves for it. This would create a solvency risk that is not accounted for under the regulatory framework.

While there are a number of specific criteria included in Appendix A-791, each provision is there to support a very basic principle: if there is the potential for payments to be made out of surplus, then risk transfer has not been satisfied.

The combination coinsurance and yearly renewable term ("Co-YRT") agreements are structured in a way that causes the coinsurance to have the appearance of transferring risk when viewed in isolation. However, when it is contractually tied to a nonproportional form of reinsurance, YRT, it no longer performs as proportional reinsurance and very clearly violates the principle of Appendix A-791. This is because there is the potential for payments out of surplus.

While there appear to be relatively few of the Co/YRT agreements of concern in place, several have very significant reserve credits that are likely not reflective of the actual risk transferred. This has the potential to be masking significant solvency concerns at individual companies. Regardless of the intent of companies that have such agreements in place, it is the responsibility of insurance regulators to ensure that insurers domiciled in their states remain solvent. They can only fulfill this responsibility if they have the ability to work with companies to identify if there is a concern and have the flexibility to address the situation as the facts and circumstances warrant. Accordingly, we strongly oppose any adoption by the NAIC of any proposal that restricts the ability of states to do this.

Treatment of Existing Contracts

The Alternative Proposal makes distinction for treatment based on whether an agreement has been submitted to a regulator, and whether or what response is received from the regulator. We are not clear whether this refers to a submission at some point in the past, or a new submission following adoption of this agenda item. Our feedback depends on clarifying this point. Therefore, we are providing feedback under both interpretation alternatives:

Past.Submission

We do not support grandfathering existing contracts on the basis of a submission to the domiciliary regulator prior to concerns being raised nationally with regard to these Co/YRT transactions. It is the responsibility of state regulators to ensure that insurers remain solvent to pay policyholder claims. Reinsurance agreements, and these Co/YRT agreements in particular are very complex and the economic substance can be difficult to distill from the legal terms. A regulator previously reviewing an agreement and not identifying the concern the first time around should not prevent them from addressing a potential solvency concern now that more information is known.

While we do not support any element of the Alternative Proposal if based on a past submission, we would offer the following additional comments:

- It is not clear what constitutes a “submission”. If the agreement was emailed to anyone with an insurance department email address, does that constitute a submission regardless of whether there was any acknowledgement by the regulator?
- There is a proposed separate date for agreements “reviewed” but for which no response was received. It is unclear what this means. How would an insurer know an agreement has been reviewed if no response was received? Most of these

agreements are not affiliated and do not require insurance department approval. It is not common practice for insurance departments to review reinsurance agreements that do not require approval, even if one was sent to the department for informational purposes.

Current.Submission

If the proposed language is clarified to require submission for regulatory review subsequent to adoption of the agenda item, allowing regulators to address any potential solvency concerns that they have, we would not oppose the proposal with the following comments:

- We would propose having the effective date of 12/31/2026 regardless of whether an agreement is submitted for review. Given the small number of subject agreements and states involved, this is ample time to allow for regulator review. It is not prudent to allow the solvency position of insurers to be misreported for three more years.
- We would propose adding language to make clear how any agreements that are approved or non-disapproved should be treated in Cash Flow Testing (e.g. including reinsurance costs and anticipated recaptures).

We would also note that we do not find this Alternative Proposal to be substantively different than the approach of working with domiciliary regulators, using permitted practices as needed, as was recommended when the agenda item was unanimously adopted by SAPWG. It appears to be the same process, only not using the term "permitted practice". As a result, while we do not oppose the Alternative Proposal with these recommended edits, we prefer the approach adopted unanimously by SAPWG and 34(yes)-2(no) by the Accounting Practices and Procedures (E) Task Force.

<u>Proposed Addition to Appendix A-791</u>

It is our understanding that the point of contention that has been raised for discussion at E Committee is for the treatment of existing contracts affected by the clarifications adopted at SAPWG. Therefore, it is unclear why changes to Appendix A-791 are being proposed. If the authors of the Alternative Proposal wish to propose changes to Appendix A-791, there is an established process to submit such requests via a "Form A" at SAPWG.

Nevertheless, we would offer the following comments with regard to the proposed language:

- The proposed language represents a dramatic departure from long-standing risk transfer standards.

- The proposed language would have the effect of overriding and making obsolete, all statutory reserving standards. Under this language, an insurer could enter into a reinsurance agreement lacking any commercial substance, that has no possibility of providing any reinsurance benefits and conclude that it transfers risk so long as the company only reduces reserves to a point that passes cash flow testing ("CFT"). If this were allowed, there would soon be no insurers holding statutory reserves, which would further beg the question of why bother setting such standards.
- The statement that "A reinsurance agreement does not deprive the ceding company of surplus if reserves are shown to be sufficient on this basis" is illustrative of the misapplication of risk transfer standards that appears to have led to the Co/YRT contracts that are of concern. Capping reserve credits through Cash Flow Testing does not prevent a deprivation of surplus.
- Risk transfer standards were developed to ensure that insurers only reduce reserves for reinsurance agreements if the reinsurer is responsible for funding any losses for the risks transferred. Reserves are not to be reduced if there is a possibility, other than for default of the reinsurer, that the cedant will be responsible for payment. This is because the cedant would not be holding reserves for such payments, requiring the payment to be made out of surplus.
- The reinsurance agreements of concern are not intended to provide reinsurance benefits, except in tail scenarios. Therefore, under the proposed CFT standard, any losses in excess of a moderately adverse scenario until the attachment point of the reinsurance is breached (a scenario designed to be far in excess of moderately adverse), would come from the ceding company's surplus. This is a direct violation of the entire spirit and explicit requirements for reinsurance risk transfer.

Thank you for your consideration of these comments.

Sincerely,

Kevin Clark, Vice Chair, Statutory Accounting Principles (E) Working Group
Chief Accounting and Reinsurance Specialist
Iowa Insurance Division

Ben Slutsker, Member, Life Actuarial (A) Task Force
Director of Life Actuarial Valuation
Minnesota Department of Commerce

Douglas C. Stolte, Member, Statutory Accounting Principles (E) Working Group
Deputy Commissioner – Financial Regulation
Virginia Bureau of Insurance

Kim Hudson, CFE, CPA, Member, Statutory Accounting Principles (E) Working Group
Financial Surveillance Branch
California Department of Insurance

Amy Malm, CPA, CFE, Member, Statutory Accounting Principles (E) Working Group
Chief Financial Regulator
Wisconsin Office of the Commissioner of Insurance

Tish Becker, Member, Accounting Practices and Procedures (E) Task Force
Director, Financial Surveillance
Kansas Department of Insurance

November 14, 2025

Commissioner Nathan Houdek
Chair, Financial Condition (E) Committee
National Association of Insurance Commissioners

Re: Co-YRT Risk Transfer Discussion Draft

Dear Commissioner Houdek:

Thank you for the opportunity to provide comments to the NAIC's Financial Condition (E) Committee regarding the Co-YRT Risk Transfer Discussion Draft, which was exposed during the Committee's October 7 meeting. Please note that my comments only reflect my own opinion and not necessarily those of my past or present employer or of any professional organization.

The Discussion Draft includes a recommendation that a paragraph be added to Appendix A-791 of the Accounting Practices and Procedures Manual to use cash flow testing, with consideration of moderately conservative scenarios and assumptions, as a means to demonstrate the transfer of risk. This is not the statutory standard that exists for satisfying life reinsurance risk transfer requirements and is in conflict with several of the provisions in Appendix A-791. For example, Accounting Requirement 2.b of Appendix A-791 does not allow (for reinsurance credit to be recognized) a reinsurance agreement to permit the ceding company to be deprived of surplus upon the occurrence of some event. It does not matter whether such event would be considered to be a moderately adverse scenario or assumption, and therefore such an event may not be reflected in cash flow testing if it falls under the category of being more than moderately conservative. Accounting Requirement 2.c does not allow the ceding company to reimburse the reinsurer for negative experience. A treaty that required the ceding company to reimburse the reinsurer for negative experience that was more than moderately conservative would not comply with this Accounting Requirement, but it may pass cash flow testing since the reimbursement would not be reflected. Accounting Requirement 2.e does not permit the possible payment by the ceding company to the reinsurer of amounts that are not from income of the reinsured policies; this is not limited to moderately adverse scenarios. These are just a few examples to show that a reinsurance agreement that is not compliant with one or more Accounting Requirements could still pass risk transfer under the proposed addition to Appendix A-791. Simply because it may be challenging to determine risk transfer under a combination Co/YRT treaty, particularly when the policies on which mortality risk is transferred under the YRT reinsurance agreement contain other significant risk factors that are not reinsured, is not a good reason to use a methodology to determine risk transfer that would not be appropriate for other reinsurance agreements subject to Appendix A-791, such as a coinsurance agreement.

Sincerely,

Sheldon Summers, FSA, MAAA
Actuary
Claire Thinking, Inc.

cc: Dan Daveline, NAIC

ACLI
Financial Security for Life

November 14, 2025

Mr. Nathan Houdek, Chairman
Financial Condition (E) Committee
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Request for Comments on Co-YRT Risk Transfer Discussion Draft

Submitted Electronically

Dear Mr. Houdek:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on the exposed Co-YRT Risk Transfer Discussion Draft. ACLI provided the Discussion Draft for the committee's consideration in the spirit of partnership and has continued to solicit feedback in the same spirit. With that in mind, we offer the following comments and recommendations on the Discussion Draft proposal:

1. ACLI suggests removing the phrase "prior to execution" from the section introducing staged effective dates. This phrasing could be interpreted to preclude regulatory review and approval of amended agreements.

2. ACLI suggests that agreements that have been reviewed and subsequently determined to be fraudulent or misrepresented would not be eligible for exemption from the clarifications of existing guidance.

3. ACLI recommends revisions to account for states in which filings are deemed approved in the absence of explicit regulatory response.

4. ACLI recommends removing the section addressing Appendix A-791. It was intended to clarify the evaluation of risk transfer related to combination reinsurance agreements as a whole. However, after discussing regulatory concerns with the proposed methodology ACLI believes it distracts from the main point that changes should be applied prospectively.

A version of the Discussion Draft reflecting these clarifications is attached as an appendix. If the NAIC Financial Condition (E) Committee is inclined to adopt the exposure draft titled 20*24-06 – Risk Transfer Analysis of Combination Reinsurance Contracts (SAPWG 2024-06)* that was put

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forward by the Statutory Accounting Principles (E) Working Group, then ACLI suggests that SAPWG 2024-06 be amended with the terms in the attached revised Discussion Draft.

Sincerely,

Carrie Haughawout
Senior Vice President, Life Insurance & Regulatory Policy
carriehaughawout@acli.com.
(202) 624-2049

Appendix: Co-YRT Risk Transfer Discussion Draft

Language could be included with the following conditions in SSAP 61 regarding existing Co-YRT agreements based on regulatory review and approval, notwithstanding allegations of fraud or misrepresentation:

- Effective 12/31/2026, existing agreements that have not been submitted to the domiciliary regulator will be subject to the clarifications of existing guidance adopted in August 2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19.
- Effective 12/31/2028, existing agreements that have been submitted but for which no response has been documented (excluding states where filings are deemed approved in the absence of explicit regulatory response) will be subject to the clarifications of existing guidance adopted in August 2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19.
- Existing agreements that have been reviewed and approved or not disapproved by the insurance regulatory authority in the ceding insurer's domiciliary state, with such approval or non-disapproval documented and retained by the ceding insurer or evidenced by a lack of comments in states where filings are deemed approved in the absence of explicit regulatory response, will be fully exempted from the clarifications of existing guidance adopted in August 2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19.
- A change resulting from this clarification shall be accounted for as a change in accounting principle as defined in *SSAP No. 3-Accounting Changes and Corrections of Errors.*

Co-YRT Risk Transfer Discussion Draft

Background

The Statutory Accounting Principles (E) Working Group (SAPWG) exposed a referral received from the Valuation Analysis Working Group (VAWG) at the 2024 Spring National Meeting. The referral (2024-06) raised concerns that companies are taking too large of a reserve credit on reinsurance contracts with interdependent features that directly or indirectly compensate the reinsurer between features, thus offsetting risk transfer.

SAPWG proposed updating SSAP 61 and Appendix A-791. Of significant concern to the industry, the proposal was to be applied to existing reinsurance agreements.

The Life insurance industry has been working with SAPWG regulators since the proposal was first exposed in March 2024. We have held numerous meetings with individual regulators as well as members of both SAPWG and the Life Actuarial Task Force (LATF). In addition, we included this item in our previous SLSG talking points and in our NAIC preview.

At the NAIC Summer National meeting there was significant discussion on this item and SAPWG voted this proposal out unanimously, effective immediately for all new agreements and with a 12/31/2026 effective reporting date and retroactive applicability to all existing contracts.

It then proceeded to the Accounting Practices and Procedures Task Force (APPTF), where there was additional discussion. The proposal was approved but with two no votes at that task force, Ohio and Indiana – specifically because it was fully retroactive.

Subsequently there have been two regulator-only E Committee meetings to consider the proposal. A public meeting has been scheduled for October 7 during which the E Committee may vote to approve the proposal from APPTF/SAPWG.

Discussion Draft

Language could be included with the following conditions in SSAP 61 regarding existing Co-YRT agreements based on regulatory review and approval prior to execution:

- Effective 12/31/2026, existing agreements that have not been submitted to the domiciliary regulator will be subject to the clarifications of existing guidance adopted in August 2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19.
- Effective 12/31/2028, existing agreements that have been reviewed but for which a response (i.e., approval or non-disapproval) has not been received from the domiciliary regulator will be subject to the clarifications of existing guidance adopted in August

2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19.

- The reinsurance transaction has been reviewed and approved or not disapproved by the insurance regulatory authority in the ceding insurer's domiciliary state, with such approval or non-disapproval documented and retained by the ceding insurer. Such agreements will be fully exempted from the clarifications of existing guidance adopted in August 2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19.
- A change resulting from this clarification shall be accounted for as a change in accounting principle as defined in *SSAP No. 3-Accounting Changes and Corrections of Errors.*

Furthermore, the following addition could be included in A-791 to clarify risk transfer for combination contracts:

- In the absence of other clearly defined risk transfer criteria, such as when evaluating combination contracts with interdependent features, standalone cash flow testing is one way to demonstrate that reinsurance transactions do not deprive the ceding company of surplus and thus transfer risk. An effective demonstration will include all cash flows related to the reinsurance agreement(s), in particular interdependent features such as aggregate experience refunds. Additionally, it will consider moderately conservative scenarios and assumptions that are consistent with the asset adequacy testing supporting the ceding company's actuarial memorandum. A reinsurance agreement does not deprive the ceding company of surplus if reserves are shown to be sufficient on this basis, or if the agreement is shown to reduce or limit a reserve deficiency that would otherwise exist.

  Q&A

  Q: Does this standalone analysis eliminate the need to include these agreements in annual cash flow testing?

  A: No, material reinsurance agreements should be included in asset adequacy analysis.

Draft: 11/10/25

Financial Condition (E) Committee
Virtual Meeting
November 5, 2025

The Financial Condition (E) Committee met Nov. 5, 2025. The following Committee members participated: Nathan Houdek, Chair (WI); Justin Zimmerman, Co-Vice Chair (NJ); Michael Wise, Co-Vice Chair, and Geoffrey Bonham (SC); Mark Fowler represented by Sanjeev Chauduri (AL); Michael Conway represented by Rolf Kaumann (CO); Michael Yaworsky represented by Jane Nelson (FL); Doug Ommen represented by Carrie Mears (IA); Holly W. Lambert represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Michael T. Caljouw (MA); Mike Chaney represented by Chad Bridges (MS); Kaitlin Asrow represented by Bob Kasinow (NY); Judith L. French represented by David Cook (OH); Cassie Brown (TX); and Scott A. White represented by Doug Stolte (VA).

1. Adopted its 2026 Proposed Charges

Commissioner Houdek stated the purpose of the meeting was to consider adoption of the Committee's proposed 2026 charges, which were exposed for a public comment period that ended Oct. 2. He noted that the exposed charges included those of the Committee and the working groups that report directly to it. He added that, separately, each of the task forces that report to the Committee adopted their own charges, except for the new Invested Assets (E) Task Force, whose 2026 charges were adopted at the Summer National Meeting. The combined charges were presented to the Committee for adoption, recognizing that the Committee has the authority to further modify the charges of the task forces. Commissioner Houdek referred meeting participants to the 2026 proposed charges and the three comment letters (Attachment Two-A) received on the charges.

Colin Masterson (American Council of Life Insurers—ACLI) summarized the views of ACLI members. He noted that they understand the need for some of the groups under the Committee's jurisdiction to deal with thematic issues or trends. However, since those issues and themes are often complex and at the forefront of market trends that relate to the industry more broadly, there may be times when the publishing of post-meeting information could be beneficial. This would be especially valuable for any significant initiatives referred to the group to ensure that such referrals are as informative and comprehensive as possible. Therefore, when appropriate, and without sharing specific or otherwise confidential information, the Committee should consider putting within its charges explicit notice of which groups function typically in this fashion while also stating that notices and summaries will be provided following such calls in accordance with the NAIC Policy Statement on Open Meetings.

Commissioner Houdek stated that he was not inclined to make any changes to the charges to address the ACLI's comments. He stated that during the start of every in-person Committee meeting, he would list the dates the Financial Analysis (E) Working Group and Valuation Analysis (E) Working Group met since the last national meeting in regulator-to-regulator session. He stated that similar reporting exists for the parent group for other working groups that have a focus on confidential information, such as the Reinsurance Financial Analysis (E) Working Group and Receivership Financial Analysis (E) Working Group. He noted that reporting this information has been NAIC practice for some time. He also said that when other groups occasionally meet in regulator-to-regulator session, the meetings are often already reported out by the respective groups, but in a different way. He said there is typically a note that the group is meeting in regulator-to-regulator session pursuant to a specific paragraph or paragraphs of the NAIC Policy Statement on Open Meetings. Commissioner Houdek indicated that there has already been some discussion on this topic regarding the Invested Assets (E) Task Force for 2026, given the confidential meetings that are expected to occur specifically relating to the Investment Analysis (E) Working Group. As indicated in the past, the intention is to provide regular updates about when the Task Force holds meetings and a summary of the discussion, to the extent allowed, given the confidential nature of the information

discussed. The Committee has also decided that, after a period of time, it is willing to assess and revise how the new Task Force and the three new working groups operate.

Jay Muska (American Property Casualty Insurance Association—APCIA) stated that APCIA members generally support the proposed charge for the Reciprocal Exchanges (E) Working Group, but they did have one substantive concern in addition to some edits to better reflect existing regulatory authority to cover all transactions between the Attorney-in-Fact (AIF) and the subscribers policy to reflect the different contractual arrangements in existence. The one area of concern was with the uncertainty associated with the term "modest profit," given that the definition of such could range from minor to medium. Additionally, it deviates from the current fair and reasonable language in the *Insurance Holding Company System Regulatory Act* (#440), *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), and *Statement of Statutory Accounting Principles (SSAP) No. 25—Affiliates and Other Related Parties*. He noted that changes were needed to avoid creating an unlevel playing field between reciprocal exchanges and other insurers.

Commissioner Houdek responded that the purpose of the Reciprocal Exchanges (E) Working Group is to ensure that Model #440 and Model #450, as well as other relevant guidance, are clear that AIF fees paid to manage and provide services to a reciprocal exchange are fair and reasonable. He specifically noted that the goal is to ensure the guidance is clear that AIF fees should be calculated on a cost basis, plus a reasonable service charge. Commissioner Houdek stated that he did not think the APCIA disputed that intent. He noted that in response to one of the APCIA comments, he was fine with replacing the words "modest profit" in the draft charge with "reasonable profit." He also noted that the charge itself is not intended to prevent the Working Group from producing any necessary clarifications in Models #440 and #450 along these lines. He said that with respect to the APCIA's suggestion to increase the scope to include other agreements, he was concerned that the Working Group would lose focus if the scope was expanded at this time.

Commissioner Houdek said that it is important to remain focused on the issue of fair and reasonable AIF fees. He suggested that the Working Group can always bring back any other issues that arise during its discussions and request approval to address those issues in the future. He added that everyone should keep in mind the language of SSAP No. 25, which states that amounts charged for services should be based either on current market rates or on allocations of costs, but does not specify "current market value." SSAP No. 25 also states that fees are intended to pay for services rendered and do not result in a transfer of excessive payments or profits from an insurer to the AIF. Commissioner Houdek reiterated he was fine replacing "modest profit" with "reasonable profit," but was not inclined to support any further changes to the charges.

Colleen Scheele (National Association of Mutual Insurance Companies—NAMIC) noted her agreement with the concerns raised by the APCIA, including the language dealing with modest profit, and noted that Commissioner Houdek had proposed an edit to that. She added that since reciprocal exchanges were not a new form of property/casualty (P/C) insurance and their long-standing market, which is already tethered to state law, any edits to be made are examined for unintended consequences for the market and regulations that are currently in place.

Commissioner Houdek stated that no one on the call could provide any additional information on the Risk Management Corporation's (RMC's) comments, but he wanted to respond to some of them. He stated that the proposed working group was not being used to create a new mandate to ensure AIF fees must be fair and reasonable, as Model #440 already has that requirement in place. He clarified that the formation of the working group was intended to codify this intent in Model #440. Additionally, SSAP No. 25 has long held that AIF fees paid by reciprocal exchanges must be considered fair and reasonable. He noted that it was his understanding that fees to manage and service a reciprocal exchange by an AIF are not paid by individual subscribers to the AIF. Rather, they are paid by the reciprocal exchange from the premium income the reciprocal earns for writing the business.

Consequently, they are subject to fair and reasonable standards. Commissioner Houdek noted that he believed the APCIA comments already reflected that. He also noted that he did not support any further changes to the proposed charges. Commissioner Caljouw stated his agreement with Commissioner Houdek on the changes to address the comments.

Commissioner Caljouw made a motion, seconded by Eft, to adopt the proposed charges (Attachment Two-B) with the change to replace “modest profit” with “reasonable profit” in the Reciprocal Exchanges (E) Working Group’s charges. The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.

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September 29, 2025

Nathan Houdek
Chair, NAIC Financial Condition (E) Committee

Re: (E) Committee's 2026 Proposed Charges

Dear Chair Houdek:

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide feedback on the NAIC Financial Condition (E) Committee's proposed 2026 charges.

We are generally supportive of the Committee's charges for the upcoming year and although we do not have any specific edits to provide on the exposure document, ACLI would recommend greater regulatory transparency with regard to the regulatory-only meetings where merited.

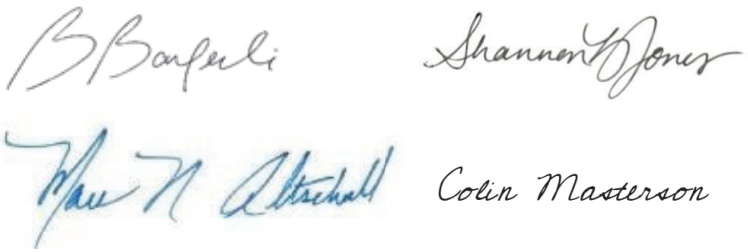
As we stated similarly in our July 21, 2025, comments on the VOSTF reorganization, ACLI recognizes the need for (E) Committee and the groups under its jurisdiction to have regulator-to-regulator and non-public meetings especially in cases where they will be looking at individual company data and information that is otherwise confidential. We also understand that several of these typically regulator-only groups are not policy-setting bodies and will likely refer emerging thematic issues or trends to other NAIC working groups or task forces. To make these meetings

and processes as effective as possible for all stakeholders involved, some level of public transparency related to these issues is warranted. Since these emerging issues and themes are often complex and at the forefront of market trends that relate to industry more broadly, there may be times when the publishing of post-meeting information could be beneficial. This would especially be of value for any significant initiatives that are referred to other groups, so that such referrals are as informative and comprehensive as possible.

Therefore, when appropriate, and without sharing any company-specific or otherwise confidential information, the (E) Committee should consider putting within their charges explicit notice of which groups and functions typically require meeting in this fashion while also stating that notices and summaries will be provided following such calls in accordance with the NAIC Open Meetings policy.

Thank you once again for the opportunity to provide this feedback and we look forward to additional discussion soon.

Sincerely,



cc: Dan Daveline, NAIC

October 2, 2025

VIA ELECTRONIC SUBMISSION

Dan Daveline
NAIC
ddaveline@naic.org

RE: Draft 2026 charges for the Financial Condition (E) Committee

Dear Mr. Daveline:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the proposed preliminary draft 2026 charges for the Financial Condition (E) Committee. APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members include companies of all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

Generally, APCIA believes the draft charges for E Committee are appropriate. Our only concern is with part of the wording in the charge for the Reciprocal Exchanges (E) Working Group.

The proposed charge is as follows:

> Modify the NAIC *Insurance Holding Company System Regulatory Act* (Model #440) and/or the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to clarify that regardless of definitions of control and affiliation, fees charged by insurers from the attorney in fact are subject to fair and reasonable standards and subject to approval by the Commissioner and under no circumstances should they exceed the cost of such services plus a modest profit.

APCIA agrees with the charge to clarify in Model #440 and #450 as well as that the fees charged by the attorney in fact are subject to the fair and reasonable standards. APCIA believes that these types of agreements are currently subject to approval by the Commissioner based on the current language in the model act. However, APCIA is mainly concerned with the additional language "under no circumstances should they exceed the cost of such services plus a modest profit". The phrase could be considered to modify the fair and reasonable standard since, "modest profit", is ambiguous and could lead to different interpretations by Commissioners. The fair and reasonable standard and the current guidance allows for both cost of services and current market value of services which is appropriate. The inclusion of this language could create an uneven playing field between insurers whereby an attorney in fact agreement could be rejected by a Commissioner when the fees are in line with the current market value. No such "modest profit" standard applies to the agreements applicable to insurers in an insurance holding company system who are not organized as reciprocal insurers.

We also suggest broadening the language to include all transactions regarding service agreements between attorney in fact and the reciprocal exchanges and eliminate "subject to approval by the

Commissioner" since the power already exists. Here is the proposed amended charge with highlighted additions and marked strikeouts:

> Modify the NAIC *Insurance Holding Company System Regulatory Act* (Model #440) and/or the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to clarify that regardless of definitions of control and affiliation, transactions regarding service agreements between ~~fees charged by insurers from~~ the attorney in fact and the ~~subscribers or policyholders of the~~ reciprocal insurance exchange are subject to agreements between the parties and to fair and reasonable standards ~~and subject to approval by the Commissioner and under no circumstances should they exceed the cost of such services plus a modest profit~~.

APCIA recognizes that these agreements are not all structured the same and that it might be difficult to determine the appropriate cost allocations and the associated current market prices for these types of services. If this is an area of concern for regulators, it may be beneficial to add a charge to develop guidance for regulators on how to interpret the fair and reasonable standard as well as current market value in this context.

Should you have any questions, please do not hesitate to contact the undersigned, Jay Muska, at jay.muska@apci.org. Thank you for your consideration.

Sincerely,

John (Jay) Muska, CFA, CPA
Vice President of Accounting and Financial Issues
American Property and Casualty Insurance Association

cc: D. Keith Bell
Chair, APCIA Financial Management and Risk Committee

RECIPROCAL ATTORNEY-IN-FACT, INC.
(RAF)

October 2, 2025

Via E-Mail

Mr. Dan Daveline
National Association of Insurance Commissioners
ddaveline@naic.org

Re: Draft 2026 Charges for the Financial Condition Committee

Mr. Daveline:

As the Chief Executive Officer of both Reciprocal Management Corporation ("RMC"), the Attorney in Fact ("AIF") for Citizens United Reciprocal Exchange ("CURE"), and Reciprocal Attorney-In-Fact ("RAF"), the AIF for New Jersey Physicians United Reciprocal Exchange ("NJ PURE"), please accept this comment on the proposed preliminary draft 2026 charges for the Financial Condition (E) Committee. My concern rests primarily with the charge for the Reciprocal Exchanges (E) Working Group

As I understand it, the formation of the Reciprocal Exchanges (E) Working Group arose out of certain concerns raised in the Chief Financial Regulator Forum ("Forum") last fall, where participants discussed the increased formation of reciprocal exchanges and how to evaluate the "fairness and reasonableness" of the fees charged by the AIFs for those reciprocals. The Forum apparently felt that it might be difficult for an individual subscriber to evaluate the reasonableness of fees charged for the services provided, and the Forum also expressed concern that the AIFs may try to increase their fees by underpricing or accepting too much risk.

Respectfully, I believe the Forum's concerns were unwarranted, and that the proposed charge to the Reciprocal Exchanges (E) Working group is overbroad, unnecessary, and inapposite with the business model of reciprocal exchanges. First, the AIF fees are clearly stated in the respective Powers of Attorneys ("POAs") that are reviewed by the regulatory agencies and agreed to and signed by the individual subscriber. Second, the relationship between those individual subscribers and the AIFs are not related party transactions that require heightened scrutiny. Third, the business model of reciprocals is the exact opposite of that contemplated by the Forum. AIFs are incentivized to grow their reciprocals organically, not by engaging in schemes related to pricing or risk.

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Finally, I understand that APCIA is also submitting a comment letter regarding the proposed charge to the Reciprocal Exchanges (E) Working Group. RMC and RAF largely agree with APCIA's statements that not all relationships between reciprocal exchanges and AIFs are structured in the same manner, and that regulatory review, if required by applicable law, should be limited to transactions involving service agreements between a reciprocal and its AIF.

I respectfully request that the Financial Condition (E) Committee consider these comments, which are set forth in more detail below, when determining the necessity and scope of the charge to the Reciprocal Exchanges (E) Working Group.

A. AIF FEES ARE CLEARLY STATED.

As a prerequisite for an individual to obtain insurance from a reciprocal, the subscriber must execute an unrelated party contract with the AIF—the POA—that segregates the AIF from the not-for-profit reciprocal exchange. The subscriber's rights and obligations are: a) statutorily prescribed; and b) clearly set forth in the POA, a form which is filed with the respective Department of Insurance and which must be approved as a precondition to forming an exchange in every state. If a regulator believes AIF Fees are not fair and reasonable during that thorough review process, they have the ability to take appropriate actions prior to licensing. A potential subscriber can easily compare the premium paid to the reciprocal and AIF Fee paid to the AIF, which is just a percentage of that premium, with the fees and premiums charged by insurance companies.

The AIF cannot unilaterally change the POA fees. If it changes the POA, each subscriber has the opportunity to decide whether or not to continue coverage. Moreover, with respect to each exchange, the respective regulatory agency is well-aware of the amount of the AIF Fee, given that it is and always has been clearly set forth in the POA. There is nothing unclear or secretive about the process.

It is also imperative to note that, from a macro perspective, if the AIF Fee is too high, a potential subscriber can simply choose another insurer. This is because an increase in the AIF Fee, which is an expense, will artificially inflate premiums so that an adequate portion is retained by the insurer. If premiums rise, the market will dictate that consumers look elsewhere. This reality underscores why regulatory scrutiny of AIF fees is unwarranted. Premiums in the market are already subject to competitive pressures, and consumers exercise their freedom to shop for coverage as they do with other financial products. Insurance is among the most frequently compared and shopped-for products in the United States. To disregard the free-market mechanism in favor of imposing oversight only on reciprocals, while exempting stock and mutual companies, is both unfounded and difficult to justify.

B. PAYMENT OF THE AIF FEES PURSUANT TO THE POA IS NOT A RELATED PARTY TRANSACTION.

As you know, Statement of Statutory Accounting Principal ("SSAP") No. 25 governs accounting and disclosures for transactions between affiliates and related parties, which it defines as "entities that have common interest as a result of ownership, control, affiliation or by contract." SSAP No. 25(4). Per SSAP No. 25, an AIF for a reciprocal exchange is considered a related party to the Exchange,[1] and transactions between the Exchange itself and the AIF may be subject to SSAP No. 25. Thus, it is appropriate to review those fees to determine if they are fair or reasonable.

However, payment of the AIF Fee by the subscriber does not involve any transaction between the AIF and the Exchange itself. Only the subscriber and the AIF are parties to the POA; the Exchange is not a party to the agreement. The individual subscriber, not the Exchange, pays the AIF Fee to the AIF after signing the POA. In some situations, the Exchange simply collects and forwards the AIF Fee to the AIF; effectively acting as a passthrough clearinghouse. Regardless, the individual subscriber and the AIF remain independent.

Thus, the payment of the AIF Fee involves a transaction between the AIF and the individual subscribers—consumers looking for insurance coverage—who wish to obtain insurance through the Exchange. This is an arm's length transaction between two willing and unaffiliated entities. The AIF does not control the individual subscriber's decision to accept the terms, which are set forth in the POA. The subscriber decides if the fee is reasonable. No heightened scrutiny by regulators is needed.

This is key because such unilateral control is a fundamental trait of a related party transaction. See, e.g., SSAP No. 25, 4 (referring to common control, ownership or affiliation); Schering-Plough Corp. v. United States, 651 F. Supp.2d 291, 244-45 (D.N.J. 2001) (noting for tax purposes that parties are not acting at arm's length where one had the ability to control the other); Altor, Inc. v. Sec. of Labor, 498 Fed. Appx. 145, 148-49 (3d Cir. 2012) (noting that common operation, management and control refuted arm's length transactions). See Delaney v. Dickey, 244 N.J. 460, 488 (2020) (noting that in an arm's length transaction both parties are "free to negotiate mutually acceptable contractual terms pursuant to their individual best interests").

If the AIF controlled the Exchange and the terms to which each policyholder agreed, it could unilaterally alter the fees/other terms and simply impose a new POA on the Exchange. It cannot. Instead, the AIF would need to amend the form of the POA, submit it to the appropriate regulator, and obtain the individual subscribers'

[1] A given reciprocal's collective group of subscribers is referred to as the "Exchange."

signatures. In other words, the individual subscriber is not and cannot be compelled to participate or commit to the new POA. Thus, the subscriber's payment of the AIF Fee bears none of the characteristics of transactions between related entities that are subject to SSAP No. 25.

Here, the POA—by virtue of both the voluntary execution by each individual subscriber and its transparent terms, including the management fee—requires the mutual assent of two unrelated and uncontrolled parties. The subscriber and the AIF are both "willing parties" that are not under the compulsion to buy or sell and are willing to participate in the contract. That is the definition of an arm's length transaction. SSAP No. 25(13).

In summary, while the Exchange is a related party to the AIF, the POA is not an agreement in which the AIF binds the Exchange. It is a contract between the unrelated subscribers who voluntarily apply, pay and join the Exchange, entered into for the purpose of compensating the unrelated AIF to manage their risk *after* they enter the Exchange. This is simply *not* a related party transaction, where one party binds or controls both ends of a contract. Unrelated subscribers *always have* the free choice to find another insurance policy and are not controlled by the AIF to pay for the fully disclosed fees. If AIFs do a poor job and their AIF fees are too high, premiums become too high, and the open market dictates that such inefficiencies would lead subscriber policyholders to buy insurance elsewhere. The natural "checks and balances" of an arm's length transaction exist when there are bona fide, unrelated parties agreeing to contract.

C. THERE IS NO POTENTIAL TO INCREASE FEES BY DECREASING PRICES OR INCREASING RISK.

The Forum also expressed concern that an AIF may try to increase its fees by underpricing or accepting too much risk. This is unwarranted.

Reciprocal Exchanges cannot have outside stockholders who, in turn, can be enticed to profit from policyholders, because reciprocals are not-for-profit, and they generate additional capital organically from their insureds. In summary, a reciprocal Exchange operation is a fundamental self-help form of insurance, where a management company manages the operations of the Exchange on behalf of the unsophisticated policyholders who simply want a lower cost insurance policy to cover their risk.

As a result, the standalone financial solvency requirements for reciprocal Exchanges are more stringent than those required of traditional stock companies (i.e., liquidity ratio requirements for certain capital levels to be maintained above the standards required of other insurance entities). For example, New Jersey's Reciprocal Exchange Act contains intentionally arduous and demanding standards

to ensure the financial health of the reciprocal and its subscribers. In addition to general solvency requirements, it subjects reciprocal Exchanges to a "liquidity test," which requires them to maintain a prescribed level of cash and investments compared to certain liabilities at all times. Any decrease below that level automatically requires the attorney-in-fact to contribute its own funds to make up the deficit, to avoid the immediate liquidation of the reciprocal. N.J.S.A. 17:50-5. No similar requirements exist for other insurance entities.

Thus, no incentive exists for the AIF to increase its fee revenue by underpricing or accepting too much risk. If the Exchange is not financially stable, the AIF must commit funds to stabilize it. Therefore, the AIF's financial incentive is simply to make the Exchange grow so the AIF can make profits. The only way to grow an Exchange is to provide better service or better rates than the competition. Both of these motives align with what a policyholder wants—better service and better rates. In this regard, the market serves as an important safeguard for Exchanges and their AIFs. An AIF that underprices or accepts too much risk will eventually be forced to raise rates to pay claims as they come due. If those rates are no longer favorable to the consumer, they will simply buy another insurance product. No person is "held hostage" by the AIF's actions. Indeed, AIFs act as a fiduciary for both the Exchange and individual subscribers, meaning that AIFs have a legal duty to act in the best interest of subscribers and the Exchange as a whole. Exchanges are examined by regulators frequently and all fees, costs, and expenses are accounted for and fully known. Again, there is nothing unclear or secretive about the process. In contrast, in a traditional stock company, the executives of the company are primarily focused on one item for their compensation—namely profits. The desire to make profits from their policyholders does not always align with the desires of the policyholders, which is why reciprocal Exchanges are considered the most altruistic forms of insurance. Thus, the Forum's concern about the motivation of the AIFs is unwarranted.

Despite the above, I am aware of significant concerns from AIFs and others in the regulated community that regulators—and now the NAIC—are aggressively pursuing AIFs over the alleged "fairness and reasonableness" of AIF fees under the guise of SSAP No. 25. By transforming SSAP No. 25 – a mere accounting reporting guideline for how each insurer must report "related party transactions" in a uniform manner – into a governing statute, regulators are not simply making a minor change to their regulatory powers. On the contrary, they are using SSAP No. 25 to create a new mandate requiring all AIF fees must be at reasonable and market rates. In other words, regulators are asserting they have a new unilateral right to determine what is "reasonable or market rate" for AIFs to charge for their fees regardless of the stated and explicitly agreed upon rate in the POA, which is freely entered into between unrelated subscribers and the AIF on an arms' length basis. These actions are not founded in statute, and interfere with AIFs' ability to contract with subscribers, in potential violation of federal and state laws. More importantly, regulators have sought to determine the "reasonable or market rate" for AIF fees AFTER the fiscal

year is finalized, and have asserted the power to force an AIF to return AIF fees to the Exchange–threatening all profits of the AIF in a post-year of service environment. I believe such actions are unlawful and potentially violate the U.S. Constitution by, among other things, undoing a binding contract entered into between two unrelated parties and interfering with the rights of citizens to freely contract. As the NAIC is aware, regulators do not have the same authority to "claw back" the profits of stock insurance companies, yet have asserted this drastic expansion of authority over reciprocals and their AIFs. The appropriate implementation of SSAP No. 25 in this regard, as an *accounting reporting guideline*, would be to recategorize the reporting of a "related party transaction," not to demand the return of funds.

In conclusion, I appreciate the Financial Condition (E) Committee's consideration of RMC's and RAF's position on these issues as it determines the necessity and scope of the charge to the Reciprocal Exchanges (E) Working Group.

Very truly yours,

Eric S. Poe, Esq., CPA
Chief Executive Officer
Reciprocal Management Corp.
Reciprocal Attorney-In-Fact

Adopted by the Executive (EX) Committee and Plenary, Dec. 11, 2025
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025

2026 Charges

FINANCIAL CONDITION (E) COMMITTEE

The mission of the Financial Condition (E) Committee is to be the central forum and coordinator of solvency-related considerations of the NAIC relating to accounting practices and procedures; blanks; valuation of securities; financial analysis and solvency; multistate examinations and examiner and analysis training; and issues concerning insurer insolvencies and insolvency guarantees. In addition, the Committee interacts with the technical task forces.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Financial Condition (E) Committee** will:
   A. Monitor all of the changes to the annual/quarterly financial statement blanks and instructions, risk-based capital (RBC) formulas, *Financial Condition Examiners Handbook*, *Accounting Practices and Procedures Manual* (AP&P Manual), *Financial Analysis Handbook*, *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), NAIC model laws, NAIC accreditation standards, and other NAIC publications.
   B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Financial Stability (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; and Invested Assets (E) Task Force.
   C. Oversee the implementation of the NAIC's "Framework for Regulation of Insurer Investments – A Holistic Review," ensuring that updates or reviews of the Risk-Based Capital (RBC) framework align with the Framework's principles and take into consideration insurers evolving role of the insurance sector in financing the economy and reducing the protection gap.
   D. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
   E. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues that industry subsequently escalates to the Committee.

2. The **Financial Analysis (E) Working Group** will:
   A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
   B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods, and action(s).
   C. Support, encourage, promote, and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
   D. Increase information-sharing and coordination between state insurance regulators and federal authorities, including through representation of state insurance regulators in national bodies with responsibilities for system-wide oversight.

FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

3. The **Group Capital Calculation (E) Working Group** will:
   A. Continually review and monitor the effectiveness of the group capital calculation (GCC), and consider revisions, as necessary, to maintain the effectiveness of its objective under the U.S. solvency system.
   B. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments, and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.

4. The **Group Solvency Issues (E) Working Group** will:
   A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group solvency-related issues.
   B. Critically review and provide input and drafting on IAIS material dealing with group supervision issues and identify best practices in group supervision emerging from the IAIS Supervisory Forum.
   C. Continually review and monitor the effectiveness of the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), and consider revisions, as necessary, to maintain effective oversight of insurance groups.

5. The **Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup** of the Group Solvency Issues (E) Working Group will:
   A. Continue to provide and enhance an enterprise risk management (ERM) education program for state insurance regulators in support of the ORSA implementation.
   B. Continually review and monitor the effectiveness of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) and its corresponding *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual); consider revisions as necessary.

6. The **Mutual Recognition of Jurisdictions (E) Working Group** will:
   A. Oversee the process for evaluating jurisdictions, and maintain a listing of jurisdictions that meet the NAIC requirements for recognizing and accepting the NAIC GCC.
   B. Maintain the *NAIC List of Qualified Jurisdictions* and the *NAIC List of Reciprocal Jurisdictions* in accordance with the *Process for Evaluating Qualified and Reciprocal Jurisdictions*.

7. The **NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group** will:
   A. Continually review the *Annual Financial Reporting Model Regulation* (#205) and its corresponding implementation guide; revise as appropriate.
   B. Address financial solvency issues by working with the AICPA and responding to AICPA exposure drafts.
   C. Monitor the federal Sarbanes-Oxley (SOX) Act of 2002, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB), and other financial services regulatory entities.
   D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

8. The **National Treatment and Coordination (E) Working Group** will:
   A. Increase utilization and implementation of the *Company Licensing Best Practices Handbook*.
   B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
   C. Continue to monitor the usage and make necessary enhancements to the Form A Database.
   D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.
   E. Make necessary enhancements to promote electronic submission of all company licensing applications.

9. The **Reciprocal Exchanges (E) Working Group** will:
   A. Modify the NAIC *Insurance Holding Company System Regulatory Act* (Model #440) and/or the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to clarify that regardless of definitions of control and affiliation, fees charged by insurers from the attorney in fact are subject to fair and reasonable standards and subject to approval by the Commissioner and under no circumstances should they exceed the cost of such services plus a reasonable profit.

10. The **Restructuring Mechanisms (E) Working Group** will:
    A. Evaluate and prepare a white paper that:
       i. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
       ii. Summarizes the existing state restructuring statutes.
       iii. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
       iv. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
       v. Identifies and addresses the legal issues associated with restructuring using a protected cell.
    B. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper.
    C. Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer, along with the adequacy of long-term liquidity needs. Also, develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration.
    D. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff.
    E. Review the various restructuring mechanisms, and develop, if deemed needed, accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group.

FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

11. The **Risk-Focused Surveillance (E) Working Group** will:
    A. Continually review the effectiveness of risk-focused surveillance, and develop enhancements to processes as necessary.
    B. Continually review regulatory redundancy issues identified by interested parties, and provide recommendations to other NAIC committee groups to address as needed.
    C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
    D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.

12. The **Risk Retention Group (E) Working Group** will:
    A. Operate in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, and in open session when discussing public RRG topics and policy issues.
    B. Monitor and evaluate the work of other NAIC committees, task forces, and working groups that may affect the filing requirements or compliance of RRGs (e.g., actions that affect compliance with the NAIC Financial Regulation Standards and Accreditation Program).
    C. Provide a forum for discussion of current and emerging RRG issues and topics.
    D. Interact with domiciliary regulators and registered states to assist and advise on the most appropriate regulatory strategies, methods, and action(s).
    E. Support, encourage, and promote efforts to address solvency concerns, including identifying adverse industry trends.
    F. Review and analyze annual and quarterly financial results.
    G. Provide ongoing maintenance and enhancements to the *Risk Retention and Purchasing Group Handbook* and related resources.
    H. Develop best practice guides on licensing and registering RRGs.
    I. Monitor federal activities related to RRGs, including legislation related to the Liability Risk Retention Act of 1986 (LRRA), and ensure all interested parties are informed.
    J. Monitor the resources available to domiciliary and non-domiciliary state insurance regulators of RRGs including educational programs or enhancements or the development of new resources.
    K. Develop or amend relevant NAIC model laws, regulations, and guidelines.

FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

13. The **Valuation Analysis (E) Working Group** will:
    A. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding principle-based reserves (PBR) and asset adequacy analysis, including actuarial guidelines or other requirements.
    B. Develop and implement a plan to coordinate PBR reviews/examinations for VM-20, VM-21, and VM-22.
    C. Review, on a targeted basis, asset adequacy analysis filings for *Actuarial Guideline LV—Application of the Valuation Manual for Testing the Adequacy of Reserves Related to Certain Life Reinsurance Treaties* (AG 55), and coordinate with states as appropriate.
    D. Review, on a targeted basis, asset adequacy analysis filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53), and coordinate with states as appropriate.
    E. Review, on a targeted basis, long-term care (LTC) reserve adequacy filings for *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51), and coordinate with states as appropriate.
    F. Provide a confidential forum to address questions/issues regarding PBR and asset adequacy analysis, as well as related reinsurance risk transfer issues, and make referrals, as appropriate, to other NAIC regulator groups.
    G. Refer questions/issues, as appropriate, to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the *Valuation Manual* or related actuarial guidelines.
    H. Assist NAIC resources in the use of models and other analytical tools to support the review of PBR/asset adequacy analysis.
    I. Make referrals, as appropriate, to the Financial Analysis (E) Working Group.
    J. Coordinate with the Reinsurance (E) Task Force, the Invested Assets (E) Task Force, and other NAIC task forces and groups to address issues, as appropriate.
    K. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson

Adopted by the Executive (EX) Committee and Plenary, 11, 2025
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Accounting Practices and Procedures (E) Task Force, August 13, 2025

2026 Charges

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

The mission of the Accounting Practices and Procedures (E) Task Force is to identify, investigate, and develop solutions to accounting problems with the ultimate goal of guiding insurers in properly accounting for various aspects of their operations; modify the *Accounting Practices and Procedures Manual* (AP&P Manual) to reflect changes necessitated by Task Force action; and study innovative insurer accounting practices that affect the ability of state insurance regulators to determine the true financial condition of insurers.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Accounting Practices and Procedures (E) Task Force** will:
   A. Oversee the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group.

2. The **Blanks (E) Working Group** will:
   A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
      i. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
      ii. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
      iii. Conform the various NAIC blanks and instructions to adopted NAIC policy.
      iv. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
   B. Continue to monitor state filing checklists to maintain current filing requirements.
   C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the *Annual Statement Instructions*.
   D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
   E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these taskforces.
   F. Coordinate with the applicable task forces and working groups as needed to avoid duplication of reporting within the annual and quarterly statement blanks.
   G. Consider proposals presented that would address duplication in reporting, eliminate data elements, financial schedules and disclosures that are no longer needed, and coordinate with other NAIC task forces and working groups if applicable, to ensure revised reporting still meets the needs of regulators.
   H. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
   I. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE *(Continued)*

3. The **Statutory Accounting Principles (E) Working Group** will:
   A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new U.S. generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures
   (E) Task Force.
   B. At the discretion of the Working Group chair, develop comments on exposed U.S. GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
   C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the *Valuation Manual* VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other *Valuation Manual* requirements. This process will include the receipt of periodic reports on changes to the *Valuation Manual* on items that require coordination.
   D. Obtain, analyze, and review information on permitted practices, prescribed practices, or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

NAIC Support Staff: Robin Marcotte

Adopted by the Executive (EX) Committee and Plenary, 11, 2025
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Capital Adequacy (E) Task Force, June 30, 2025

2026 Charges

CAPITAL ADEQUACY (E) TASK FORCE

The mission of the Capital Adequacy (E) Task Force is to evaluate and recommend appropriate refinements to capital requirements for all types of insurers.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Capital Adequacy (E) Task Force** will:
   A. Evaluate application of the Risk-Based Capital (RBC) formula and emerging "risk" issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   C. Evaluate relevant historical data, and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.
   D. Continually review the RBC instructions, blanks and forecasting and revise as appropriate.

2. The **Health Risk-Based Capital (E) Working Group**, **Life Risk-Based Capital (E) Working Group**, and **Property and Casualty Risk-Based Capital (E) Working Group** will:
   A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than May 15 of the reporting year, and any proposal that affects a non-structural change to the RBC Blanks, RBC factors and/or instructions must be adopted no later than June 30 of the reporting year. Adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by June 30 and result in an amended change may be considered by and adopted by July 30, where the Capital Adequacy (E) Task Force votes to pursue by two-thirds consent of members.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised *Accounting Practices and Procedures Manual* (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC's RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results, and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.

CAPITAL ADEQUACY (E) TASK FORCE *(Continued)*

3. The **Longevity Risk (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.

4. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.

5. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S. catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
   D. Evaluate the RBC results inclusive of a catastrophe risk charge.
   E. Refine instructions for the catastrophe risk charge.
   F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
   G. Evaluate other catastrophe risks for possible inclusion in the charge.

6. The **Risk-Based Capital Investment Risk and Evaluation (E) Working Group** will:
   A. Perform a comprehensive review of the RBC investment framework for all business types, which could include:
      1. Evaluating relevant historical data and applying defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to current asset risk structure and factors (e.g. C-1o and C1-cs).
      2. Facilitating coordination and alignment among NAIC committees/task forces/working groups related to its work in reviewing current asset risk framework.
      3. Assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies; i.e., those companies at action levels.

7. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
   B. Review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations.
   C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates.
   D. Support the implementation of an economic scenario generator for use in statutory reserve and capital calculations.
   E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

NAIC Support Staff: Eva Yeung

Adopted by the Executive (EX) Committee and Plenary, Dec. 11, 2025
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Examination Oversight (E) Task Force, September 29, 2025

EXAMINATION OVERSIGHT (E) TASK FORCE

The mission of the Examination Oversight (E) Task Force is to monitor, develop, and implement tools for the risk- focused surveillance process. For financial examinations and analysis, this includes maintenance of the *Financial Condition Examiners Handbook* and the *Financial Analysis Handbook* to provide guidance to examiners and analysts using a risk-focused approach to solvency regulation and to encourage effective communication and coordination between examiners, analysts, and other regulators. In addition, the mission of the Task Force is to: monitor and refine regulatory tools of the risk-focused surveillance process, including Financial Analysis Solvency Tools (FAST) such as company profiles and the FAST ratio scoring system; oversee financial examiner and analyst use of electronic software tools; monitor the progress of coordination efforts among the states in conducting examinations and the sharing of information necessary to solvency monitoring; establish procedures for the flow of information between the states about troubled companies; maintain an effective approach to the review of information technology (IT) general controls; and monitor the timeliness of financial examinations.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Examination Oversight (E) Task Force** will:
   A. Accomplish its mission using the following groups:
      i. Electronic Workpaper (E) Working Group.
      ii. Financial Analysis Solvency Tools (E) Working Group.
      iii. Financial Examiners Coordination (E) Working Group.
      iv. Financial Examiners Handbook (E) Technical Group.
      v. Information Technology (IT) Examination (E) Working Group.

2. The **Electronic Workpaper (E) Working Group** will:
   A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
   B. Monitor state insurance regulator use of TeamMate+ to proactively identify best practices and improvements to the application, as necessary.

3. The **Financial Analysis Solvency Tools (E) Working Group** will:
   A. Provide ongoing maintenance and enhancements to the *Financial Analysis Handbook* and related applications for changes to the NAIC annual/quarterly financial statement blanks, for input from other regulators, and for the work of, or referrals from, other NAIC committees, task forces, and working groups to develop enhancements to risk-focused analysis and monitoring of the financial condition of insurance companies and groups.
   B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools developed to assist in conducting risk-focused analysis and monitoring the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.

EXAMINATION OVERSIGHT (E) TASK FORCE *(Continued)*

C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.

4. The **Financial Examiners Coordination (E) Working Group** will:
   A. Develop enhancements that encourage the coordination of examination activities regarding holding company groups.
   B. Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods, and actions regarding financial examinations of holding company groups.
   C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
   D. Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS).

5. The **Financial Examiners Handbook (E) Technical Group** will:
   A. Continually review the *Financial Condition Examiners Handbook* and revise, as appropriate.
   B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk- assessment process by developing additional guidance and exhibits within the *Financial Condition Examiners Handbook*, including consideration of potential redundancies affected by the examination process, corporate governance, and other guidance as needed to assist examiners in completing financial condition examinations.
   C. Coordinate with the Financial Analysis Solvency Tools (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Coordinate with the IT Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the *Financial Condition Examiners Handbook* related to the charges of these specific working groups.

6. The **Information Technology (IT) Examination (E) Working Group** will:
   A. Continually review, develop, and revise guidance in the *Financial Condition Examiners Handbook* and other related tools, as needed, to address information technology risks.
   B. Coordinate with the Cybersecurity (H) Working Group to monitor cybersecurity trends, including emerging and/or ongoing vulnerabilities, and develop guidance within the *Financial Condition Examiners Handbook* or other tools, if deemed necessary, to support IT examiners.

NAIC Support Staff: Bailey Henning

Adopted by the Executive (EX) Committee and Plenary, Dec. 11, 2025
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Financial Stability (E) Task Force, October 17, 2025

2026 Charges

FINANCIAL STABILITY (E) TASK FORCE

The mission of the Financial Stability (E) Task Force is to consider issues concerning domestic or global financial stability as they pertain to the role of state insurance regulators.

Ongoing Support of NAIC Program, Products, or Services

1. The **Financial Stability (E) Task Force** will:
   A. Manage the macroprudential supervisory component of the NAIC financial solvency framework.
      i. Monitor the U.S. insurance industry's macroprudential risk levels.
      ii. Maintain macroprudential regulatory tools.
      iii. Identify data gaps and enhanced disclosure needs for the statutory financial statement and/or other reporting mechanisms.
      iv. Propose enhancements and/or additional supervisory measures to the Financial Condition (E) Committee or other relevant committees, and consult with such committees on implementation.
   B. Monitor U.S. macroprudential policy issues, and respond as appropriate.
      i. Support and work with the state insurance regulator representative to the Financial Stability Oversight Council (FSOC) to address confidential FSOC or other federal agency macroprudential work.
      ii. Participate in public FSOC or other federal agency macroprudential work.
   C. Monitor international macroprudential policy issues, and participate/respond as appropriate.
      i. Coordinate with the International Insurance Relations (G) Committee to address International Association of Insurance Supervisors (IAIS) or other international macroprudential work.

2. The **Macroprudential (E) Working Group** will:
   A. Oversee the implementation and maintenance of the Liquidity Stress Testing Framework (LST Framework).
   B. Monitor domestic and global activities including those enumerated in the "Plan for the List of Macroprudential Working Group (MWG) Considerations document.
   C. Execute the original Macroprudential Initiative (MPI) projects related to counterparty disclosures and capital stress testing.
   D. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions.
   E. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators' ability to monitor industry trends from a macroprudential perspective.
   F. Oversee the documentation of the NAIC's macroprudential policies, procedures, and tools.
   G. Provide the Task Force with updates to IAIS and other international initiatives as needed.

NAIC Support Staff: Tim Nauheimer

Adopted by the Executive (EX) Committee and Plenary, Dec, 11, 2025
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Receivership and Insolvency (E) Task Force, July 30, 2025

2026 Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

The mission of the Receivership and Insolvency (E) Task Force is to be administrative and substantive as it relates to issues concerning insurer insolvencies and insolvency guarantees. Such duties include, without limitation: 1) monitoring the effectiveness and performance of the state administration of receiverships and the state guaranty fund system; 2) coordinating cooperation and communication among state insurance regulators, receivers, and guaranty funds; 3) monitoring ongoing receiverships and reporting on such receiverships to NAIC members; 4) developing and providing educational and training programs in the area of insurer insolvencies and insolvency guarantees to state insurance regulators, professionals, and consumers; 5) developing and monitoring relevant model laws, guidelines, and products; and 6) providing resources for state insurance regulators and professionals to promote efficient operations of receiverships and guaranty funds.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Receivership and Insolvency (E) Task Force** will:
   A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
   B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
   C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB), and other related groups on issues regarding international resolution authority.
   D. Monitor, review, and provide input on federal rulemaking and studies related to insurance receiverships.
   E. Provide an ongoing review of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook), other related NAIC publications, and the Global Receivership Information Database (GRID), and make any necessary updates.
   F. Monitor the work of other NAIC committees, task forces, and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
   G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referrals by other groups.

2. The **Receivership Financial Analysis (E) Working Group** will:
   A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote, and coordinate multistate efforts in addressing problems.
   B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise on the most appropriate regulatory strategies, methods, and/or action(s) regarding potential or pending receiverships.

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE *(Continued)*

3. The **Receivership Law (E) Working Group** will:
   A. Review and provide recommendations on any issues identified that may affect states' receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions; insurer insolvencies; federal rulemaking and studies; international resolution initiatives; or the work performed by or referred from other NAIC committees, task forces, and/or working groups).
   B. Discuss significant cases that may affect the administration of receiverships.

NAIC Support Staff: Jane Koenigsman

Adopted by the Executive (EX) Committee and Plenary, Dec. 11, 2025
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Reinsurance (E) Task Force, August 11, 2025

REINSURANCE (E) TASK FORCE

The mission of the Reinsurance (E) Task Force is to monitor and coordinate activities and areas of interest that overlap to some extent the charges of other NAIC groups—specifically, the International Insurance Relations
(G) Committee.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Reinsurance (E) Task Force** will:
   A. Provide a forum for the consideration of reinsurance-related issues of public policy.
   B. Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.
   C. Coordinate with the Mutual Recognition of Jurisdictions (E) Working Group on matters regarding reinsurance.
   D. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
   E. Monitor reinsurance-related activities of other task forces and working groups at the NAIC.
   F. Consider any other issues related to Model #785, Model #786, and Model #787.
   G. Monitor the development of international principles, standards, and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup, and the Reinsurance Transparency Group.
   H. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
   I. Continue to monitor the impact of reinsurance-related international agreements, including the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (EU Covered Agreement) and the "Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance" (UK Covered Agreement).

REINSURANCE (E) TASK FORCE *(Continued)*

2. The **Reinsurance Financial Analysis (E) Working Group** will:
   A. Operate in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified or Reciprocal Jurisdiction Reinsurers.
   B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
   C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities, or individuals.
   D. Support, encourage, promote, and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified or reciprocal jurisdiction reinsurers.
   E. Provide analytical expertise and support to the states with respect to certified reinsurers, reciprocal jurisdiction reinsurers, and applicants.
   F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
   G. Ensure the public passporting website remains current.

NAIC Support Staff: Jake Stultz/Dan Schelp

Adopted by the Executive (EX) Committee and Plenary, August 13, 2025
Adopted by the Financial Condition (E) Committee, July 28, 2025

2026 Proposed Charges

INVESTED ASSETS (E) TASK FORCE

The mission of the Invested Assets (E) Task Force is to provide regulatory leadership and expertise to establish and maintain all aspects of the NAIC's analysis of insurer invested assets. This includes Overseeing the work of the Investment Analysis (E) Working Group, the Investment Designation Analysis (E) Working Group, and the Credit Rating Providers (E) Working Group. Provide a forum for education from various parties to regulators on investment products, their performance, and the financial risks for regulatory policy purposes, as well as how regulators may address such risks. Understand new or evolving investment products that may possess characteristics that pose unique risks to insurers and the industry and coordinate with different NAIC groups of the Financial Condition (E) Committee or other NAIC groups, if necessary, to develop, implement, or advise on investment-related solvency policy changes (e.g., accounting, risk-based capital [RBC], etc.) or procedures within their analysis and examination of insurers subject to such risks.

Ongoing Support of NAIC Programs, Products or Services

1. The **Investment Analysis (E) Working Group (INVAWG)** will:
   A. Monitor the risks associated with all types of invested assets, including collateral loans, mortgage loans, real estate, and Schedule BA investments.
   B. Analyze the details of new or evolving investment products or new investment characteristics that could pose unique risks to insurers and provide recommendations to the Task Force on investment-related solvency policy changes to be made in conjunction with other NAIC groups of the Financial Condition (E) Committee.
   C. Analyze insurers and groups that hold new, evolving, or riskier investments and advise the state of domicile on applicable risks, either directly or through coordination with the Financial Analysis (E) Working Group or Valuation Analysis (E) Working Group. Where applicable, utilize NAIC staff from the Securities Valuation Office and Structured Securities Group and Capital Markets Bureau to assist the Working Group with these deliverables.
   D. Oversee a revised portfolio analysis product from NAIC staff, the CMB Research agenda, and analytical investment reports produced by NAIC for the public.
   E. Oversee the NAIC's implementation of revised systems designed to improve the availability of various investment data points from existing NAIC databases while also identifying and providing NAIC staff who support this group with at least one investment software package that facilitates portfolio analysis and portfolio modeling.
   F. Monitor information technology and data resource needs to ensure data can be retrieved efficiently and effectively.
   G. Develop best practice examples of supervisory plans that monitor complex investments where the company and the regulator oversee company-designed risk dashboards on their riskier investment areas/or risk mitigation tracking.

INVESTED ASSETS (E) TASK FORCE *(Continued)*

2. The **Investment Designation Analysis (E) Working Group (IDAWG)** will:
   A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.
   B. Maintain and revise *the Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to provide solutions for investment-related regulatory issues for existing or anticipated investments.
   C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the *Accounting Practices and Procedures Manual* (AP&P Manual), as well as financial statement blanks and instructions, to ensure that the P&P Manual reflects regulatory needs and objectives.
   D. Provide effective direction to the NAIC's mortgage-backed securities modeling firms and consultants.
   E. Identify potential improvements to the credit filing and designation processes, including formats and electronic system enhancements.
   F. Coordinate with the Invested Assets (E) Task Force, Investment Analysis (E) Working Group, and other NAIC working groups and task forces to formulate recommendations and make referrals to other NAIC regulator groups to ascertain that the purpose and objective of guidance in the P&P Manual is reflective in the guidance of other groups and that the expertise of other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual. Implement additional and alternative ways to measure and report investment risk.

3. The **Credit Rating Provider (E) Working Group** will:
   A. Identify potential improvements to the filing exempt (FE) process (i.e., using credit rating provider ratings to determine an NAIC designation) through ongoing implementation of the CRP due diligence framework to ensure greater consistency, uniformity, and appropriateness to achieve the NAIC's financial solvency objectives.
   B. Implement policies resulting from the CRP due diligence framework related to NAIC's staff administration of rating agency ratings used in NAIC processes, including staff discretion over the applicability of their use in its administration of FE.
   C. Coordinate with the Investment Designation Analysis (E) Working Group on issues identified from the maintenance of the CRP due diligence framework.

NAIC Support Staff: Mark Sagat

Draft: 10/10/25

Financial Condition (E) Committee
Virtual Meeting
October 7, 2025

The Financial Condition (E) Committee met Oct. 7, 2025. The following Committee members participated: Nathan Houdek, Chair (WI); Michael Wise, Co-Vice Chair (SC); Justin Zimmerman, Co-Vice Chair (NJ); Mark Fowler (AL); Michael Conway (CO); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen (IA); Holly W. Lambert represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Michael T. Caljouw (MA); Mike Chaney represented by Chad Bridges (MS); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French (OH); Cassie Brown represented by Jamie Walker (TX); and Scott A. White (VA). Also participating was Amy Malm (WI).

1. Exposed an Alternative Proposal to Statutory Accounting Principles (E) Working Group Agenda Item 2024-06

Commissioner Houdek stated that the original focus of the meeting was to consider adoption of Statutory Accounting Principles (E) Working Group agenda item 2024-06: Risk Transfer Analysis on Combination Reinsurance Contracts. He advised that the Working Group and the Accounting Practices and Procedures (E) Task Force had adopted the revisions detailed in the agenda item to *Statement of Statutory Accounting Principles* (*SSAP) No. 61—Life, Deposit-Type, and Accident and Health Reinsurance* at the Summer National Meeting. At that time, the Committee deferred action to allow time to better understand the background and adopted revisions. He stated that since the Summer National Meeting, the Committee has conducted two regulator-to-regulator meetings to receive information on this topic. Both meetings were in line with the NAIC open meetings policy, allowing for consultation with NAIC staff related to technical guidance and discussion on specific companies. During the first regulator-to-regulator meeting, representatives of the American Council of Life Insurers (ACLI) were invited to participate and share information.

Commissioner Houdek stated that although the plan was to consider the Working Group's agenda item 2024-06 for adoption during this meeting, an alternative proposal was recently received. The proposal was distributed in advance to the Committee, interested regulators, and interested parties, and he invited Director French to present the proposal.

Director French stated that this risk transfer topic has generated a lot of discussion with good arguments on all sides of the issue, resulting in robust debate. She stated that many regulators have been interested in finding a middle ground—one that would provide needed discretion to regulators but also provide needed certainty to insurers that have these combination contracts. Director French stated that the ACLI had provided the Co-Yearly Renewable Term (YRT) Risk Transfer Discussion Draft, a proposal that accomplishes the following: 1) provides different effective dates depending on whether agreements have been submitted to the domiciliary regulator and the status of those submissions; 2) exempts agreements that have already been approved; and 3) provides additional clarity around demonstrating risk transfer. Director French stated that she is not prepared to vote or even support this proposal at this time, as further time is needed to assess and discuss, but that she is prepared to offer it for exposure so regulators can discuss it thoroughly. She stated that after comments are received, consideration could occur on the revisions that should be adopted.

Walker stated that the proposal addresses reinsurance agreements that have been approved but does not provide clarity for when regulators disapprove a contract and the timing around those disapproved agreements. She also stated concerns with language that would block a regulator from reviewing a transaction based on what had been provided in the past, citing a need to be consistent in the regulation of domestic insurers. She then stated that the proposed edits to *A-791: Life and Health Reinsurance Agreements* are concerning, as what is proposed creates a

different standard and definition of risk transfer for a combination contract compared to a non-combination contract, noting that this could create unintended consequences. Walker stated that if the A-791 discussion proceeds, it should be referred to the Working Group for a technical review.

Commissioner Houdek stated that after the proposal is exposed and the comments received are considered, the Committee could decide whether action should be taken at the Committee level or if a referral to the Working Group would occur.

Malm stated that she had similar comments as Walker, but an additional question was how the proposal would be interpreted in determining submissions to the domiciliary state. She stated that reinsurance agreements could be shared during an examination or other meetings when discussions or procedures are being addressed by a contract examiner instead of state insurance department staff. She stated that clarity should be considered for actual application.

Commissioner Ommen further inquired about the process, asking whether the exposure would be inviting comments from regulators or if another process would be utilized to solicit regulator comments. He also inquired whether another meeting would occur to discuss the comments received. Commissioner Houdek stated that if exposed, there would be a public comment period for all stakeholders, including regulators, industry representatives, and other interested parties. He stated that NAIC staff would collect the comments with a subsequent Committee meeting to discuss those comments. He stated that a 30-day public comment period would provide the opportunity to review comments at an interim meeting and then consider action at the Fall National Meeting.

Director French made a motion, seconded by Commissioner Fowler, to expose the Co-YRT Risk Transfer Discussion Draft for a 30-day public comment period ending Nov. 7. The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.

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Draft: 12/2/25

NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group
Virtual Meeting
December 1, 2025

The NAIC/AICPA (E) Working Group of the Financial Condition (E) Committee met Dec. 1, 2025. The following Working Group members participated: Doug Stolte, Chair (VA); Diana Sherman, Vice Chair (PA); Sayaka Dillon (CA); Rylynn Brown (DE); Kevin Clark (IA); Kristin Hynes (MI); Shannon Schmoeger (MO); Andrea Johnson (NE); Ned Cataldo (NH); David Cook (OH); and Johanna Nickelson (SD).

1. Adopted Updated Sound Practice Documents

Stolte stated that during its July 28 meeting, the Working Group discussed a referral received from the Chief Financial Regulator Forum related to issues that regulators are experiencing in gaining access to external audit workpapers in support of financial examinations. As a result of those discussions, the Working Group agreed to form a drafting group consisting of both state regulators and audit firm representatives to propose updates to existing sound practices documents that address the concerns raised.

The drafting group was led by Nickelson and Dave Osborn (EY) and included participants from the following states and firms: Connecticut, the District of Columbia, Missouri, Ohio, Pennsylvania, and Virginia, as well as Crowe LLP, EisnerAmper LLP, Johnson Lambert LLP, KPMG LLP, and RSM US LLP.

The drafting group met Oct. 20, Sept. 29, and Aug. 27 to discuss the issues identified and propose edits to the two different sound practices documents maintained in this area. Updates were first developed for the NAIC's *AICPA Four-Step Process for Use by Regulators* (Attachment Four-A). Stolte stated that the most significant revisions proposed to this document include expanding the national firm representative listing from 10 to more than 30 of the top firms conducting statutory insurance company audits. Additionally, minor revisions were proposed to update the description of the recommended four-step process.

The drafting group also developed updates to the *Best Practices: Insurance Regulator Access to Audit Documentation* document maintained by the AICPA (Attachment Four-B). Stolte stated that the updates to this document are more significant, including both revisions to existing sound practices and the development of several new sound practices to address concerns communicated in the referral.

Nickelson stated that the changes to both documents should address the concerns identified in the referral and lead to improved communication between state insurance regulators and audit firm representatives. Osborn thanked the members of the drafting group for their work and noted that the sound practices identified are recommendations for audit firms to follow and are not binding.

Bruce Jenson (NAIC) provided an overview of the most significant changes proposed to both documents, including clarifications related to which workpapers are subject to regulator review and states' abilities to sign or acknowledge auditor disclosure letters. In addition, sound practices for audit firms were developed or updated related to workpaper access, workpaper format, and auditor disclosure. Sound practices for regulators were developed or updated related to notification, meetings, scope, communication, and coordination.

Hynes made a motion, seconded by Clark, to adopt the proposed revisions to the sound practice documents and approve them for posting to the NAIC website.

2. Discussed Plans for an Educational Webinar

Stolte stated that, with the updated sound practice guidance and the significant expansion of the list of national audit firm representatives, there is a need to educate both the new firm representatives and state insurance regulators on the new guidance. Stolte recommended scheduling a webinar to provide training on the new guidance and asked for feedback on this proposal, including the best time to schedule the webinar.

Cook stated that the webinar should be held before the completion of statutory audit reports in 2026, which are generally due June 1 in each state. Osborn stated that the audit firm representatives have an upcoming meeting where they can discuss this further, but he recommended holding the webinar toward the end of February 2026.

Jenson stated that NAIC committee support would begin developing slides for an ongoing webinar and then work with Nickelson and Osborn to identify presenters and schedule the session.

3. Discussed Audit Procedures for Private Credit Assets

Stolte stated that state insurance regulators have identified a trend of increased holdings of private assets in insurer company portfolios, which can be more challenging for the company and its external auditor to value and evaluate for other-than-temporary impairment (OTTI). Stolte stated that it could be helpful for regulators to hear from AICPA members on the procedures they use during their annual statutory audits to evaluate these assets, whose value is often based on Level 3 (unobservable) inputs. Stolte asked whether the certified public accountant (CPA) firm representatives could put together a presentation on their audit approach in this area for state insurance regulators in 2026.

Osborn stated that the firm representatives can discuss this topic at their upcoming meeting and get back to the Working Group on this issue. Osborn stated that the timing for a presentation on this topic might work better after the 2026 Spring National Meeting.

Stolte thanked the firm representatives for considering this topic and indicated that there are other NAIC groups with an interest in this topic that could be invited to the presentation when it is scheduled.

Having no further business, the NAIC/AICPA (E) Working Group adjourned.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

AICPA Four-Step Process for Use by Regulators

The NAIC/AICPA Working Group supports the AICPA's four-step process described below for regulators who are experiencing difficulty in obtaining access to CPA workpapers, have questions with respect to the CPA's individual engagement to perform a statutory audit, or have concerns about the work performed by the CPA. For additional information and best practices in this area, please see the AICPA's "Best Practices: Insurance Regulator Access to Audit Documentation" publication.

The financial regulator should initially work through the company to obtain access to the work papers of the company's external auditor. Should the financial regulator deem additional action is required in obtaining access to the audit workpapers, after informing the appropriate management, it is suggested that the financial regulator contact the following individuals in this suggested order while keeping the company informed of ongoing developments, as needed:

1. The engagement partner
2. The designated national Firm representative (see **Attachment A** for a current listing of contacts for participating firms)
3. Chair of the insurer's Audit Committee
4. State Board of Accountancy, Ethics (or Qualitative Review) Committee, or other regulatory bodies deemed appropriate

The AICPA process, excepting step 4, would be informal, non-authoritative, and non-binding. The process is intended to be additive to the current remedies available to regulators. The benefits of the additive process is to help enhance communication between regulators and independent certified public accountants, improve the effectiveness of obtaining access to audit working papers on a timely basis, and assist in strengthening the quality of statutory audits. The AICPA is committed to continually communicating to practitioners the requirement per Section 13: *Definition, Availability and Maintenance of the Independent Certified Public Accountants Work Paper*, of the NAIC Model Audit Rule, to provide access to audit working papers and audit related correspondence as defined by statute or regulation.

In 2022, the NAIC/AICPA Working Group voted to adopt an optional Contract Examiner Attestation Template to notify the CPA firm of contracted individuals participating in the statutory examination that should receive access to audit workpapers. The template has been included here as **Attachment B**.

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Attachment A – National Accounting Firm Representatives
(Updated as of 10/28/25)

Firm Name	Contact Person	Email	Phone #
Aprio LLP	Nathan Robnett	nathan.robnett@aprio.com	405.410.7597
Armanino LLP	Todd Goldenhersh	todd.goldenhersh@armanino.com	314.983.1205
Baker Tilly US LLP	Daniel E. Buttke	Daniel.buttke@bakertilly.com	920.739.3348
Bauknight, Pietras & Stormer PA	Bryan Hudson	bhudson@bps.cpa	803.771.8943
BDO USA PA	Nicole Sioson	nsioson@bdo.com	703.351.4225
Brown Plus	Scott Esworthy	scottesworthy@brownplus.com	717.761.7171
Buffamante Whipple Buttafaro PC	Mike D. Staley	mds@bwbcpa.com	716.701.7642
Cain Ellsworth & Company LLP	Abby De Zeeuw	adezeeuw@cainellsworth.com	712.324.4614
Carr, Riggs & Ingram LLC	Joseph May	jmay@criadv.com	601.853.7050
Cherry Bekaert LLP	Adriana Ponce Cain	aponce@cbh.com	904.718.2464
CliftonLarsonAllen LLP	Dan Bauer	dan.bauer@claconnect.com	612.215.1807
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Eide Bailly LLP	Ryan Donahue	rdonahue@eidebailly.com	701.476.8826
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Ernst & Young LLP	Dave Osborn	Dave.osborn@ey.com	708.990.0137
Forvis Mazars LLP	James Garner	Jim.garner@us.forvismazars.com	214.505.4368
Grant Thornton LLP	Dana Wilson	Dana.wilson@us.gt.com	860.781.6703
JLK Rosenberger LLP	Bill Rosenberger	brosenberger@jlkrllp.com	818.334.8624
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KPMG LLP	Olga Roberts	olgaroberts@kpmg.com	203.247.6796
LBMC PC	Paul W. Demastus	Paul.demastus@lbmc.com	615.309.2229
Plante & Moran PLLC	John Fritz	John.Fritz@plantemoran.com	312.980.3354
PricewaterhouseCoopers LLP	Jon Mattera	jon.mattera@pwc.com	516.661.7066
RSM US LLP	Nate Seacrist	Nate.seacrist@rsmus.com	216.622.1093
Shores, Tagman, Butler & Company PA	Spenser Budde	sbudde@shorescpa.com	407.872.0744 ext. 202
Strohm Ballweg LLP	Tom Dawson	tdawson@strohmballweg.com	608.821.6308
Thomas Howell Ferguson PA	Christopher Howell	chowell@thf-cpa.com	850.321.3135
Wipfli LLP	John Erwin	john.erwin@wipfli.com	470.342.6044

Firms with multiple offices performing statutory audits of regulated insurance entities that wish to designate or update their national firm representative should contact NAIC representatives at financialexams@naic.org.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Attachment B – Contract Examiner Attestation Template [Optional]

The purpose of this Attestation is to establish that the following personnel were retained by [DEPARTMENT OF INSURANCE] pursuant to the authority provided in [INSERT CITATION FOR ADOPTION OF MODEL LAW ON EXAMINATIONS #390 § 4D]. The personnel are working on a contract basis as examiners and should be provided access to external audit workpapers as they are subject to the confidentiality requirements provided in [INSERT CITATION FOR ADOPTION OF MODEL LAW ON EXAMINATIONS #390 § 5]:

Name	Title	Contract Firm

Contract personnel are bound in writing to maintain the statutory confidentiality of examination workpapers. They have agreed to use such workpapers solely in connection with the examination project for which they are contracted. Contract personnel are prohibited from disclosing or transmitting the confidential material except as expressly authorized by the Department.

In accordance with [INSERT CITATION FOR ADOPTION OF ANNUAL FINANCIAL REPORTING MODEL REGULATION #205], every insurer required to file an audited financial report shall require the accountant to make available for review by Insurance Department examiners, all work papers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer.

[OPTIONAL: In addition, Contract personnel have been informed that any exploitation of confidential materials for purposes of a competitive advantage will constitute a breach of contract.]

The undersigned represents that (s)he has duly executed this Attestation, for and on behalf of _____; that (s)he is the _____(Title) of _____ and that (s)he is authorized to execute and file such document. The undersigned further represents that (s)he is familiar with such document and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

[Signature of Authorized Individual]

[Printed Name]
[Title]
[Date]

AICPA NAIC Task Force

Best Practices: Insurance Regulator Access to Audit Documentation

November 17, 2025

This document is an other auditing publication, as defined in AU-C section 200, *Overall Objectives of the Independent Auditor and the Conduct of an Audit in Accordance With Generally Accepted Auditing Standards (AICPA, Professional Standards)*. Other auditing publications have no authoritative status; however, they may help the auditor understand and apply generally accepted auditing standards. In applying the auditing guidance included in an other auditing publication, the auditor should, exercising professional judgment, assess the relevance and appropriateness of such guidance to the circumstances of the audit. The auditing guidance in this document has been reviewed by the AICPA Audit and Attest Standards staff and published by the AICPA and is presumed to be appropriate. This document has not been approved, disapproved, or otherwise acted on by a senior technical committee of the AICPA.

Best Practices: Insurance Regulator Access to Audit Documentation

NAIC Model Audit Rule

Section 13: *Definition, Availability and Maintenance of the Independent Certified Public Accountants Work Papers*, of the NAIC Model Audit Rule ("MAR") defines audit workpapers and requires that independent certified public accountants (external auditors) provide access to or copies of audit documentation when requested by insurance regulators. That guidance is as follows:

> Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.
>
> Every insurer required to file an audited financial report pursuant to this regulation, shall require the accountant to make available for review by insurance department examiners, all workpapers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the insurance department or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit workpapers and communications until the insurance department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.
>
> In the conduct of the aforementioned periodic review by the insurance department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the department.

Generally Accepted Auditing Standards

Interpretation No. 1, "Providing Access to or Copies of Audit Documentation to a Regulator," of AU-C Section 9230, *Auditing Interpretations of Section 230*, contains the following

interpretation[fn 1] related to providing access to or copies of audit documentation to a regulator:

> **.01** *Question*—Paragraph .19 of section 230, *Audit Documentation*, states that "the auditor should adopt reasonable procedures to maintain the confidentiality of client information." However, auditors are sometimes required by law, regulation, or audit contract [fn2] to provide a regulator, or a duly appointed representative, access to audit documentation. For example, a regulator may request access to the audit documentation to fulfill a quality review requirement or to assist in establishing the scope of a regulatory examination. Furthermore, as part of the regulator's review of the audit documentation, the regulator may request copies of all or selected portions of the audit documentation during or after the review. The regulator may intend, or decide, to make copies (or information derived from the audit documentation) available to others, including other governmental agencies, for their particular purposes, with or without the knowledge of the auditor or the client. When a regulator requests the auditor to provide access to (and possibly copies of) audit documentation pursuant to law, regulation, or audit contract, what steps may the auditor take?
>
> **.02** *Interpretation*—When a regulator requests access to audit documentation pursuant to law, regulation, or audit contract, the auditor may take the following steps:
>
> a. Consider advising the client that the regulator has requested access to (and possibly copies of) the audit documentation and that the auditor intends to comply with such request. [fn3]

[fn1] In accordance with paragraph .27 of AU-C section 200, the auditor should consider applicable interpretive publications in planning and performing the audit. Paragraph .A86 of AU-C section 200 states that, "[i]nterpretive publications are not auditing standards. Interpretive publications are recommendations on the application of GAAS in specific circumstances, including engagements for entities in specialized industries. An interpretive publication is issued under the authority of the ASB after all ASB members have been provided an opportunity to consider and comment on whether the proposed interpretive publication is consistent with GAAS. Auditing interpretations of GAAS are included in AU-C sections. AICPA Audit and Accounting Guides and auditing SOPs are listed in AU-C appendix D, *AICPA Audit and Accounting Guides and Statements of Position*."

[fn2] Footnote 3 of Paragraph .01 of AU-C section 9230 states:

> Paragraphs .11–.15 of this interpretation address situations in which the auditor is not required by law, regulation, or audit contract to provide a regulator access to the audit documentation.

[fn3] Footnote 4 of Paragraph .02(a) of AU-C section 9230 states:

> The auditor may wish (and in some cases may be required by law, regulation, or audit contract) to confirm in writing with the client that the auditor may be required to provide a regulator access to the audit documentation. Sample language that may be used follows:

b. Make appropriate arrangements with the regulator for the review.

c. Maintain control over the audit documentation, and

d. Consider submitting the letter described in paragraph .05 of this interpretation to the regulator.

.03 Making appropriate arrangements with the regulator may include establishing the specific details such as the date, time, and location of the review. The audit documentation may be made available to a regulator at the offices of the client, the auditor, or a mutually agreed-upon location. However, maintaining control of audit documentation is necessary in order for the auditor to maintain the integrity of the audit documentation and the confidentiality of client information. For example, the auditor (or the auditor's representative) may be present when the audit documentation is reviewed by the regulator.

.04 Ordinarily, the auditor may not agree to transfer ownership of the audit documentation to a regulator. Furthermore, the auditor may not agree, without client authorization, that the information contained therein about the client may be communicated to or made available to any other party. In this regard, the action of an auditor providing access to, or copies of, the audit documentation shall not constitute transfer of ownership or authorization to make them available to any other party.

.05 An audit performed in accordance with generally accepted auditing standards is not intended to, and does not, satisfy a regulator's oversight responsibilities. To avoid any misunderstanding, prior to allowing a regulator access to the audit documentation, the auditor may submit a letter to the regulator that

a. sets forth the auditor's understanding of the purpose for which access is being requested;

b. describes the audit process and the limitations inherent in a financial statement audit;

The audit documentation for this engagement is the property of [*name of auditor*] and constitutes confidential information. However, we may be requested to make certain audit documentation available to [*name of regulator*] pursuant to authority given to it by law or regulation. If requested, access to such audit documentation will be provided under the supervision of [name of auditor] personnel. Furthermore, upon request, we may provide copies of selected audit documentation to [*name of regulator*]. The [*name of regulator*] may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

4

c. explains the purpose for which the audit documentation was prepared, and that any individual conclusions must be read in the context of the auditor's report on the financial statements;

d. states, except when not applicable, that the audit was not planned or conducted in contemplation of the purpose for which access is being granted or to assess the entity's compliance with laws and regulations;

e. states that the audit and the audit documentation should not supplant other inquiries and procedures that should be undertaken by the regulator for its purposes;

f. requests confidential treatment under the Freedom of Information Act or similar laws and regulations, [fn4] when a request for the audit documentation is made, and that written notice be given to the auditor before transmitting any information contained in the audit documentation to others, including other governmental agencies, except when such transfer is required by law or regulation; and

g. states that if any copies are to be provided, they will be identified as "Confidential Treatment Requested by [*name of auditor, address, telephone number*]."

The auditor may obtain a signed acknowledgment copy of the letter as evidence of the regulator's receipt of the letter.

Considerations

The regulatory standards in Section 13 of the MAR outlined above indicate that "Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion." Some regulators have experienced issues gaining access to certain workpapers due to proprietary information or client privilege. As a reminder, in accordance with Section 13 of the MAR as outlined above, every insurer "shall require the accountant to make available for review by insurance department examiners, all workpapers prepared in the conduct of the accountant's audit."

Although Section 13 of the MAR requires that external auditors provide "photocopies" of their workpapers, in response to requests from insurance regulators, some external auditors have at times satisfied this regulatory requirement by providing audit workpapers in non-

[fn4] Footnote 5 of Paragraph .05(f) of AU-C section 9230 states:

> The auditor may need to consult the regulations of individual agencies and, if necessary, consult with legal counsel regarding the specific procedures and requirements necessary to gain confidential treatment.

photocopy formats, including electronic copies of workpapers in a Portable Document Format ("PDF") (i.e., the native files have been converted to PDF). Notwithstanding the limit of the regulatory requirement to provide photocopies of audit workpapers, regulators have expressed a view that the provision of some workpapers (e.g., Excel spreadsheets) as a photocopy or in an electronic format such as a fully secured PDF is not sufficient for their purposes due to an inability to view certain information, such as:

1. Information included in hidden columns or rows that can only be reviewed in native format.
2. Information embedded in formulas or comment boxes that can only be reviewed in native format.
3. Information that is difficult to use due to formatting issues associated with generation of PDF documents (e.g. illegible font sizes, large spreadsheets breaking over many pages, etc.).

Because of the inability to access and use information contained in electronic workpapers when presented in PDF form, regulators have asked the AICPA NAIC Task Force to suggest potential accommodations for regulator access to audit documentation. Refer to the Best Practices section below for information.

Although paragraph .05 of Interpretation No. 1 of AU-C section 9230, referenced above, recommends submitting a letter to the regulator that communicates expectations of the regulator's use of audit documentation before allowing access to audit workpapers, there may be situations in which the regulator is unable to acknowledge or sign the letter, particularly if the language included in the letter differs from that provided above. In situations in which the regulator does not acknowledge or sign the letter, the external auditor would need to consider other options for communicating expectations and requests to the regulator when providing access to the workpapers, such as documenting that the letter was submitted to or discussed with the regulator.

Best Practices

The following list of best practices to be considered by both the external auditor and insurance regulators attempts to balance regulators' needs, efficiency of the regulatory examination (examination), the ability of auditors and companies to prevent access to auditors' workpapers by unauthorized persons, and the requirement for external auditors to maintain control over audit documentation as required by generally accepted auditing standards. These best practices are not meant to and do not change the scope of the actual regulatory requirements incumbent on audit firms, which are contained in each state's laws or regulations.

External Auditors:

The following are suggested actions for the external auditor to consider when regulators request access to audit documentation:

- **Workpaper Access** – At the outset of the examination, provide the insurance regulators with timely, secure, remote access to the audit workpapers and make appropriate staff available to address questions.
    - Continue to make access to workpapers available to regulators throughout the examination, upon request.
- **Workpaper Format** – To the extent that the workpapers are requested by the insurance regulators in a common native format (i.e., the original file format associated with widely available commercial word processing or spreadsheet software, such as Microsoft Word or Excel) as opposed to, or in addition to, converting to PDF, determine whether additional security measures are appropriate such as password protection to access the secure site that contains the workpaper copies.
    - Insurance regulators strongly discourage password protection directly on individual workpapers to avoid usability and efficiency issues.
- **Disclosure** – When providing regulators with workpapers, include a disclosure letter as outlined above stating that original workpapers are maintained/owned by the external auditor, and that the external auditor expressly disclaims any responsibility for any alteration of files, reports which may be created from such files such as additional test items added to an insurer's or auditor's Excel spreadsheet, and any reliance which may be placed on such alterations to the workpaper files.

Insurance Regulators:

The following are suggested actions for the insurance regulator to consider when requesting access to audit documentation:

- **Notification** – Encourage the insurer under examination to notify the external auditor of the upcoming examination to provide sufficient time in advance of the start of field work of the examination, so that the firm can prepare its audit workpapers for sharing.
    - Keep the audit timeline in mind when requesting access to workpapers, as the external auditor may not release workpapers until the audited financial statements and related workpapers have been finalized.
- **Meeting** – Hold a planning meeting with relevant engagement team members of the external auditor to facilitate the workpaper access and review process, including gaining an understanding of:
    - The audit approach and organization of electronic workpapers
    - Key risk areas
    - Expected reliance on controls

  - Timing of external audit tests of controls and
  - Access to and availability of workpapers throughout the exam
- **Scope** – Consider the scope of what workpapers are necessary for the examination by reviewing the audit workpapers before requesting copies (photocopies, PDF and/or native formats) of any workpapers. In particular, consider whether a request for all workpapers without reviewing the audit files is necessary and efficient. To the extent electronic copies of audit workpapers in native format (e.g., Excel spreadsheets) might be preferable, recognize that such request goes beyond the regulatory requirements imposed by the law. However, the original workpaper must be legible in photocopy or PDF form.
- **Communication** – Communicate with the external auditor and local engagement team members on matters related to workpaper access and copies, before involving the national firm representative (if relevant) and the insurer[fn5].
- **Coordination** – For coordinated examinations involving more than one regulatory entity, coordinate amongst the various regulators to review all applicable legal entities' workpapers at the same time.
  - When using contract resources to represent the insurance department, consider providing appropriate notification to the CPA firm of the contractor's authorization to act on the department's behalf. See Attachment B of the "AICPA Four-Step Process for Use by Regulators" publication on the NAIC website for a template that can be used for this purpose.

***

As stated in Section 13 of the MAR, the review by insurance department examiners of workpapers prepared by the independent certified public accountant in the conduct of the audit and any communications related to the audit between the independent certified public accountant and the insurer shall be considered investigations and all workpapers and communications obtained from the CPA firm during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the department.

[fn5] In 2003 the AICPA/ NAIC Working Group (with assistance from the AICPA NAIC Task Force) developed and adopted a process, for external auditors and financial examiners related to access to audit documentation, that also included a list of individuals that the financial examiner should contact in the event of any issues. This information was included in the AICPA Audit Risk Alert – Insurance Industry Developments 2007/08 and has also been integrated into the NAIC's Financial Examiners Handbook. That information is attached in Appendix A.

Appendix A

The AICPA/ NAIC Working Group (with assistance from the AICPA NAIC Task Force) has developed and adopted a process (below) for external auditors and financial examiners related to access to audit documentation that included a list of individuals that the financial examiner should contact in the event of any issues.

This information has been integrated into the NAIC's Financial Examiners Handbook. It was emphasized that this process is informal, non-authoritative, and non-binding. The AICPA NAIC Task Force envisions this process to be additive to the remedies available to insurance regulators. The benefits of this additive process would (1) help enhance communication between regulators and independent certified public accountants, (2) improve the effectiveness of obtaining access to audit workpapers on a timely basis, and (3) assist in strengthening the quality of statutory audits.

Reminder—Access to CPA Audit Documentation

An external auditor is required by Section 13 of the NAIC Model Audit Rule to provide timely access to or copies of audit documentation when requested by regulators.

Interpretation No. 1of AU-C section 9230 addresses the responsibilities of an auditor when a regulator requests access to audit documentation.

The AICPA's task force on NAIC matters has worked actively with subgroups consisting of designated regulators and NAIC representatives to pursue ways to increase the examiners' reliance upon the statutory audit and use of underlying audit documentation.

The AICPA NAIC Task Force helped to establish the four-step process to provide a protocol for financial regulators who are having difficulty pursuing a resolution of (1) questions with respect to a firm's individual engagement to perform a statutory audit, (2) difficulties in gaining access to working papers, or (3) the regulator concerns about the work performed by the CPA. The financial regulator should initially work through the insurance company to obtain access to the work papers of the company's external auditor. If a financial regulator determines that an additional response is required, after informing appropriate management, it is suggested that the financial regulator contact the following individuals in this suggested order while keeping the company informed of ongoing developments, as needed:

1. The engagement partner
2. The designated national firm representative (see Attachment A of the "AICPA Four Step Process for Use by Regulators" document posted on the NAIC website)
3. Chair of the insurer's audit committee
4. State board of accountancy, ethics (or quality review) committee, or other regulatory bodies as deemed appropriate

Firms or individual practitioners performing statutory audits of regulated insurance entities that wish to designate a national firm representative and have not already done so should contact NAIC representatives at financialexams@naic.org.

Draft: 12/17/25

Restructuring Mechanisms (E) Working Group
Virtual Meeting
December 1, 2025

The Restructuring Mechanisms (E) Working Group of the Financial Condition (E) Committee met Dec. 1, 2025. The following Working Group members participated: Glen Mulready, Co-Chair, and Andy Schallhorn (OK); Elizabeth Kelleher Dwyer, Co-Chair, and Matthew Gendron (RI); Mel Anderson (AR); Rolf Kaumann (CO); Jack Broccoli and Jared Kosky (CT); John Street (IL); Robert Wake (ME); Steve Mayhew (MI); Fred Andersen (MN); John Rehagen (MO); Tadd Wegner (NE); David Wolf (NJ); Dale Bruggeman (OH); Diana Sherman (PA); Amy Garcia (TX); Dan Bumpus, Greg Chew, and Doug Stolte (VA); Steve Drutz (WA); and Amy Malm (WI).

1. Discussed Comments Received on Exposures

Commissioner Mulready directed the Working Group to the comments received on the *Restructuring Mechanisms* white paper (White Paper) and *Best Practices Procedures for IBT/Corporate Divisions* (Best Practices) document, which were organized by page number. Robin Marcotte (NAIC) noted that the Working Group received five comment letters (Attachment Five-A).

A. Reviewed Comments Regarding the White Paper

Marcotte stated that revisions recommended to the White Paper, based on a preliminary review with some Working Group members, have been incorporated as tracked revisions for the full Working Group to review.

Marcotte stated that the Association of Insurance and Reinsurance Run Off Companies (AIRROC) and the American Council of Life Insurers (ACLI) both made comments regarding the listing of state laws. Marcotte stated that, as there were multiple lists in the document, some variations were noted, and the revisions have been incorporated to ensure the lists are complete and consistent.

Marcotte stated that AIRROC also recommended two footnotes, which have been incorporated, noting that insurance business transfers (IBTs) and corporate divisions are not limited to run-off business. She stated that there was a minor edit to one of the footnotes regarding the reference to the United Kingdom (UK) law.

Commissioner Mulready asked if there were any questions about the recommendations. Wake stated that he had comments regarding the use of the term “run-off.” He noted that unless one of the companies is in run-off, a corporate division almost always involves ongoing business with at least one of the entities. He noted that all entities in a corporate division having ongoing business would be uncommon. Similarly, Wake asked about UK Part VII transfers and how often they involve ongoing business. Commissioner Mulready asked if the proposed clarification was that both run-off and ongoing business could occur if the frequency of either situation was a factor. Wake replied that it was useful information to understand if UK Part VII transfers involve truly ongoing business. Wake stated that he generally views UK Part VII schemes of arrangement as dealing with some sort of closed block. Wake noted it would be interesting to see how a UK Part VII transfer works on a truly ongoing book of business.

Gendron suggested displaying the draft White Paper revision so that the Working Group could see the proposed clarification in context. Wake noted that it is true that a corporate division statute can be used to split a company into two or more parts, and there are certainly some scenarios where both parts are ongoing. Gendron asked if

Wake would like to add a clarification at the end of the proposed footnote stating that corporate divisions can also be used to have two ongoing entities or to create two entities, one or more of which may be actively writing. After discussion, the Working Group agreed to incorporate modified footnote language based on Gendron and Wake's recommendation.

Marcotte stated RiverStone commented regarding Section 2A—Other International Jurisdictions of the White Paper. RiverStone suggested adding a paragraph noting that mechanisms for IBTs have existed in many other jurisdictions for a number of years. The NAIC staff recommendation was to incorporate the paragraph from RiverStone, which notes Australia, the European Union (EU), Singapore, Switzerland, and the UK, without the word "whilst." No objections from the Working Group were noted regarding the recommendations discussed.

Marcotte stated that the next comment was from the ACLI was mentioned earlier, regarding the listings of laws on IBT and corporate divisions, to ensure the lists on different pages are accurate, and add more recent actions. She noted that the revisions were recommended to be incorporated.

Marcotte stated that AIRROC provided a recommendation to include two IBT transactions that occurred in Oklahoma in the White Paper. She stated that Oklahoma had previously reviewed the recommendation, and was supportive of incorporating the example transactions. Therefore, the revisions were tracked in the materials.

Marcotte stated that AIRROC provided a recommendation regarding the discussion of the Virginia law regarding policyholder affirmative consent requirements. She stated that AIRROC suggested additional language regarding the Virginia corporate commission case. AIRROC also provided excerpts of that case's legal filing in the combined comment letters. She stated that comments were shared with the Working Group's members from Virginia for review. She stated that Bumpus provided comments that Virginia did not recommend incorporating most of AIRROC's suggested revisions. The Virginians' new revisions to the existing text were fairly minor, such as referencing "the code of Virginia" instead of "Virginia code."

Bumpus stated that Virginia thinks that the edits that Virginia proposed provide more clarity and seek to represent the subtlety of the Virginia law with a bit more accuracy. He indicated appreciation for the Working Group's willingness to consider those edits, and he was happy to answer any questions.

Commissioner Mulready asked if Robert Romano (AIRROC) wished to provide any additional comments. Romano stated that AIRROC has some differences of opinion, but Virginia is the ultimate authority on the subject, and AIRROC defers.

Marcotte stated that the National Council of Insurance Guaranty Funds (NCIGF) provided a description of the updates to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) and recommended a footnote to reference that the Receivership and Insolvency (E) Task Force is tracking state adoptions of Model #540 updates. She stated that the NCIGF wording has been incorporated for review in the White Paper. The revisions to Model #540 were to ensure the continuation of guaranty association coverage. The model changes have not been incorporated in all states.

Wake stated that the section needs to be further updated to write the section in more of a present tense because it currently focuses on an issue that has been addressed by updating Model #540. He stated that noting where the NAIC posts the most current chart of state adoptions would be helpful. Commissioner Mulready stated that the suggested footnote included a link to the state chart on the NAIC website. Wake and Gendron discussed ideas to update the section to note that issues were identified and addressed, and others will be referred out. Gendron and Wake were directed to draft updates to the section to provide a current description.

Gendron and Commissioner Mulready noted appreciation for the specific and constructive recommendations provided by the commenters.

B. Reviewed Comments Regarding the Best Practices

Marcotte stated that revisions recommended to the *Best Practices Procedures for IBT/Corporate Divisions* document (Best Practices) based on preliminary review with some Working Group members, have been incorporated as tracked revisions for the full Working Group to review.

Marcotte stated that RiverStone commented that IBT transactions are not generally designed for troubled companies and may not be appropriate for troubled companies unless detailed analysis is undertaken and suitable mechanisms for policyholder protections are put in place. She stated that the recommendation has been incorporated.

Marcotte stated that AIRROC provided a recommendation to add a factor on appropriate liquidity to the list of things to consider so that capital and liquidity projections are listed. She noted that because liquidity was an important factor, it was recommended to be added.

Marcotte stated that AIRROC provided a recommendation to move an item on the management assessment and corporate governance assessment from a section on assessment of risk capital to Section III—Robust Regulatory Review, with a note that the step can be undertaken by an independent expert if preferred.

Marcotte stated that although AIRROC recommended deleting Section 4d.b.i,, on stressed reserves, the Working Group decided to maintain Section 4d.b.i. regarding stressed reserves under reasonable deterministic criteria/scenarios provided by the domiciliary regulator.

Marcotte stated that the ACLI provided a comment recommending the restoration of previously deleted language, which suggested that the regulator consider requiring cut-through provisions for policyholders of the weaker entity. The ACLI asked that the sentence not be deleted, as removing it could result in those originating IBT and corporate division transactions being less thorough in ensuring the weaker company has sufficient capital and opportunity to survive. Marcotte stated that the recommendation was to restore the prior language because it does not require cut-throughs; it simply allows for their consideration as another regulatory tool. No Working Group members made comments.

Marcotte stated that AIRROC continued to recommend moving the run-off procedures to somewhere other than the Best Practices document. She stated AIRROC also suggested revising the introductory text to make clear that proper analysis of runoff would depend on many varying characteristics of the portfolio. She stated that the recommendation was not incorporated. She stated that when the Best Practices are forwarded to the Financial Analysis Solvency Tools (E) Working Group for incorporation into the *Financial Analysis Handbook*, that Working Group may choose to put the run-off procedures in a different section. She indicated that the Working Group may wish to discuss the revisions.

Commissioner Mulready called on Romano, who noted that runoff applies in many different circumstances and portfolios to companies, to different types of business. Romano stated that the topic of runoff merits much more discussion than can be provided in this single section, which deals with IBTs and corporate divisions. Romano said AIRROC thought that it probably merits a whole separate discussion and suggested that it be eliminated or at least

qualified by language that clear that this, in effect, is not supposed to be an encyclopedic discussion of the subject. That was the reasoning behind AIRROC's wanting to limit, eliminate, or move the section.

Marcotte stated there was an editorial comment that, after prior deletions, a sentence in the run-off section does not make sense. She said the sentence has been corrected. She noted that the overall changes to the Best Practices document only affect a few pages.

2. Adopted the White Paper and Best Practices Document and Discussion of Next Steps

Marcotte stated that the comment letter from AIRROC and the joint letter from New York Life, Insurance Company, the Western & Southern Financial Group, and The Northwestern Mutual Life Insurance Company specifically commented on the Working Group's next steps. Both letters provided comments on the implementation of the Best Practices. Both letters agreed on a proposed referral to the Financial Analysis Solvency Tools (E) Working Group to consider incorporating the Best Practices into the *Financial Analysis Handbook*. However, the letters differ on whether the Best Practices should be required. She stated that the joint letter suggests that the Best Practices be required, whereas AIRROC suggests that they be optional.

Marcotte stated the two letters also differ on whether there is a need to develop a national standard, since AIRROC would like this to be an optional tool. She stated that the joint letter notes the need for a national standard as part of a robust accreditation system.

Marcotte stated that the materials include an excerpt of this Working Group's charge to consider whether there is a need to request approval from the Executive (EX) Committee on developing changes to specific models or developing a model as a result of findings from the White Paper. The Working Group also has the charge to develop Best Practices, to be used considering approval of proposed transactions.

Marcotte noted that if the White Paper is adopted, it would presumably be sent to the Financial Condition (E) Committee. If the Best Practices document is adopted, it could either be sent to the Financial Condition (E) Committee, or it could be sent as a referral to the Financial Analysis Solvency Tools (E) Working Group to incorporate the guidance into the *Financial Analysis Handbook.* After incorporation, there could later be a multi-step decision regarding whether it should become an accreditation standard.

Commissioner Mulready indicated that, as he had previously noted, he would be opposed at this stage to making the Best Practices an accreditation standard. He noted that in the future, it could be addressed as the Best Practices document becomes more commonly accepted and is applied in the different states.

Director Dwyer called on Broccoli to provide some comments on the process that something must go through to be considered for accreditation. Broccoli stated that the Best Practices would have to go to the Financial Condition (E) Committee or to the various working groups. He stated that once the Best Practices are included in the *Financial Analysis Handbook* and are being used, the Financial Regulation Standards and Accreditation (F) Committee could consider it. He stated that it is premature at this time to have an accreditation discussion. He also noted the need to road test some of the Best Practices procedures by using them to review real transactions, allowing for fine-tuning.

Dan Daveline (NAIC) indicated agreement with the sequence of actions that Broccoli described. He noted that the Best Practices would not be considered for accreditation until after incorporation into the *Financial Analysis Handbook* and after it was sent to either the parent committee or when it was identified to the Financial

Regulation Standards and Accreditation (F) Committee as a material change. He noted that the discussion would be at a future date.

Dwyer affirmed that the referral of the Best Practices to the Financial Analysis Solvency Tools (E) Working Group does not make it an accreditation standard.

Malm stated that one thing the Working Group may want to consider in the future regarding whether it should be an accreditation standard is meeting bright-line indicators prior to requiring the Best Practices. She noted the possibility of using the number of states that are applying the procedures, etc., could be used to ensure consistency across the U.S. for solvency monitoring of IBTs and corporate divisions.

Commissioner Mulready confirmed that the Working Group members were comfortable allowing Gendron and Wake to collaborate to redraft the guaranty section of White Paper to be in the present tense.

Kaumann made a motion, seconded by Wake, to adopt the White Paper with the revisions discussed during the meeting, including the present tense revisions to be drafted by Wake and Gendron and Wake's footnote revision (Attachment Ten); and to adopt the Best Practices with the revisions discussed during the meeting (Attachment Five-B). The motion passed unanimously.

The Working Group directed Marcotte to prepare a memorandum to the Financial Analysis Solvency Tools (E) Working Group recommending that the Best Practices be considered for incorporation into the *Financial Analysis Handbook.*

Daveline noted that the White Paper would be presented to the Financial Condition (E) Committee at the Fall National Meeting.

Commissioner Mulready informed the Working Group that the National Conference of Insurance Legislators (NCOIL) recently reviewed and readopted its Insurance Business Transfer Model Act at its Atlanta meeting.

Commissioner Mulready thanked everyone for the ongoing feedback.

Having no further business, the Restructuring Mechanisms (E) Working Group adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/RMWG/2025/12-1-25 Call/Minutes/12-1-25 RMWG minutes after tpr .docx

Restructuring Mechanisms (E) Working Group
December 1, 2025
Comment Letters Received

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ACLI
Financial Security for Life

November 14, 2025

Restructuring Mechanisms Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1000
Kansas City, MO 64106

RE: ***Restructuring Mechanisms White Paper***
Best Practices Procedures for IBTs/Corporate Divisions

Members of the Restructuring Mechanisms Working Group:

The American Council of Life Insurers (ACLI)[1] would like to submit the following comments on the Working Group's draft White Paper and Best Practices Procedures document:

- Page 8 of the draft White Paper should be updated to better reflect legislation that has been enacted in the states. For IBTs, bills were enacted in Arizona in 1997, Illinois in 2023 and Georgia in 2024. For corporate divisions, bills were enacted in Georgia in 2019 and Colorado in 2021, and Illinois amended its law in 2019 and 2023.

- On Page 17 of the draft Best Practices Procedures document, the following sentence was deleted in Section VI: "*Consider whether to require that "cut through" provisions be put in place for policyholders of the weaker entity*". We ask that this sentence not be deleted since removing it could result in those who are originating IBT and corporate division transactions to be less thorough in ensuring that the weaker company has sufficient capital and opportunity to survive.

Thanks for this opportunity to provide comments. If you have any questions, please feel free to contact me.

Respectfully submitted,

Wayne A. Mehlman

Wayne Mehlman
Senior Counsel, Insurance Regulation
waynemehlman@acli.com

1 The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 275 member companies represent 93 percent of industry assets in the United States.

Leveraging Legacy Liabilities

Kathryn E. Reynolds
Executive Director
(603) 491-7249
E-Mail: katie@airroc.org
Web: www.airroc.org

November 18, 2025

Re: Comments on the October 2025 Exposure Drafts of the Restructuring Mechanisms White Paper and Best Practices Procedures for IBT/Corporate Divisions

To Director Elizabeth Kelleher Dwyer (RI) and Commissioner Glen Mulready (OK), Co-Chairs of the Restructuring Mechanisms (E) Working Group:

AIRROC (the Association of Insurance and Reinsurance Run Off Companies) is pleased to offer comments in response to the NAIC Restructuring Mechanisms (E) Working Group exposure of its drafts of the Restructuring Mechanisms White Paper and Best Practices Procedures for IBT/Corporate Divisions. As a non-profit association AIRROC and its Board do not advocate for any specific position but provide resources and information.

As mentioned in our prior submissions, AIRROC is the only US-based non-profit association focusing on the legacy sector of the insurance and reinsurance industries. Membership is on a corporate level and given the impact and importance of legacy business to the entire industry, AIRROC has attracted many talented and experienced participants that have legacy or run-off business in their portfolios. The members include major US and international insurance and reinsurance companies, legacy acquirers, well-known rehabilitations, receiverships and liquidations, brokers, run-off managers and state insurance departments. AIRROC also benefits from its associate members, comprised of law firms and legacy service providers, such as the Big 4 accountancy firms, which support the organization with invaluable knowledge and expertise.

AIRROC and its members appreciate the opportunity to submit comments to these drafts and does so with the understanding that we are at the end of a long process with considerable time and effort spent by many regulators and industry participants. Our comments are offered to assist the Working Group to finalize this process. We trust that the drafts when finalized will be a useful resource for those who will be presented with run-off issues in the future including potential Insurance Business Transfers (IBT's) and/or Corporate Division (CD) transactions.

Our comments are as follows[1]:

[1] All page numbers refer to those in the marked versions of drafts exposed for comment.

1. White Paper (pp. 1-2 -- 1.A. Introduction & B. Purposes)

We suggest that the White Paper (the carry-over paragraph at the top of page 2) include Georgia, which recently adopted an IBT law in May of 2024, in its list of states that have adopted IBT legislation.

Additionally, to avoid implying that restructuring mechanism legislation is limited to run-off, we suggest that the White Paper clarify that insurance business transfers (IBTs) and corporate divisions (CDs) can also be applied to on-going business by adding the following footnote at the end of that same paragraph:

> Although these statutes are generally available to restructure both run-off and on-going operations, to date IBTs have been used only for run-off transfers. The Rhode Island law limits IBTs, by statute, to defined types of run-off.

For the same reason, we suggest adding the following footnote to the end of the last paragraph on page 2 of the White Paper:

> As mentioned above, IBTs and CDs need not be limited to run-off transfers. UK transfers and CDs in the US have been used for on-going business. See Section 2.A. regarding UK Part VII transfers, including in respect of life and annuity business where policies continue to be active, and Section 3.B. regarding CDs used in Pennsylvania and Illinois, both of which affected on-going business.

2. White Paper (p. 12 -- 3.A.B. Transactions Completed to Date).

The last complete paragraph on page 12 of the White Paper omits two more IBT transactions. To complete this discussion we suggest the following text be added to the end of that paragraph:

> Subsequently, two more IBT transactions have been effected: Fletcher Reinsurance Company (a Missouri domestic company) transferred its reinsurance business to Yosemite in 2023, and The Hanover Insurance Company (a New Hampshire company) transferred its Excess and Casualty Reinsurance Association (ECRA) reinsurance liabilities to Yosemite in 2025. Both transfers were effected under Oklahoma law.

3. White Paper (pp. 16-17 - Virginia Law Requiring Affirmative Consent Requirements).

We have reviewed the relevant docket in the case described in this section (Virginia State Corporation Commission Case No. INS-2021-00055, copy attached) and would like to correct some inaccuracies. Below is our suggested revision that we believe corrects some inaccuracies but is faithful to the original intent:

> The Virginia State Corporation Commission, of which the Bureau of ~~I~~Insurance is part, also acts as a court of record. It applied Virginia's anti-novation statute to

the previously mentioned PWIC/Yosemite IBT. In that particular case, the transferred business, included a number of Virginia workers' compensation policies. As such, the Bureau informed PWIC and Yosemite that the IBT—as to the Virginia policies—required policyholder consent under § 38.2-136 (B) of the Code because it involved the cessation or assumption of policy obligations on risks located in Virginia. In response, PWIC and Yosemite, without conceding that a Commission order was required, requested that the Commission waive the policyholder consent requirement by finding that the transfer of the Virginia policies was in the best interests of the policyholders pursuant to § 38.2-136 (C)(iii) of the Code. The Commission found that the transfer of Virginia policies was subject to the requirements of § 38.2-136 (B) of the Code (i.e. policyholder consent and proper licensure), but approved the transfer pursuant to § 38.2-136 (C)(iii) of the Code (i.e. best interests of the policyholders).

Based on this precedent, it is the position of the Bureau~~Therefore, it should be clear to all states,~~ that ~~when considering~~ an IBT (and, by extension a CD) may not be imposed upon~~ or CD involving~~ Virginia policyholders, absent policyholder consent, unless the~~The Virginia~~ Commission ~~must~~ finds the transfer of the Virginia policies to be "in the best interests of the [Virginia] policyholders" in accordance with § 38.2-136 (C)(iii) of the Virginia Code. . .~~If this is not found, the transfer will not apply to Virginia policyholders.~~

In addition to the suggestion noted above regarding Virginia's statute, we suggest that the section entitled Virginia Law Requiring Affirmative Consent Requirements should be moved to a Footnote. There is already general language in the White Paper above this section that discusses potential issues regarding the Assumption Reinsurance Model Act that could apply in a number of states, but to over-emphasize the issue with respect to one state seems more appropriate in a footnote.

4. Best Practices Procedures (pp. 9 & 11- II.4.a. Financial Support & III.2.a. High Level of Confidence).

We note that there is no explicit mention of liquidity as a factor for consideration in restructuring transactions. We expect that regulators will consider this to be an important factor and therefore suggest that this factor be included as follows:

- P. 9 (II.4.a), add a new factor iv., "Appropriate liquidity."
- P. 11 (III.2.a.), add between the words "capital projections", the words "and liquidity".

5. Best Practices Procedures (p. 9-13 - 4. Assessment of Risk Capital).

The order and numeration of this section appears to be confusing. We suggest that this section be revised for clarity. For example Item 4.e ("Management Assessment and

Corporate Governance Assessment") would be better listed as a separate item (e.g., a new section 5) rather than an item under section 4 which is entitled "Assessment of Risk Capital".

But, of particular practical relevance is Item b.ii which appears to require a "stressed reserves" comparison as part of an actuarial report in regular course, even though the prior item (Item b.i) calls for such an assessment when dealing primarily with "volatile liabilities". We urge the Working Group to discourage excessively proscriptive requirements and to allow regulators and the independent expert to evaluate the transaction at hand and the appropriate standard for actuarial review under the circumstances. Accordingly, we suggest that Item b.ii be deleted.

6. Best Practices Procedures (p. 20-21 - Section IX – Run-Off Procedures).

As the White Paper and the Working Group mandate has been to study restructuring mechanisms, it appears to us that the discussion of run-off procedures and operations in this document in the absence of a restructuring may be misplaced. This subject merits substantial further study, including how to identify run-offs and how to address the many management approaches and environments where run-offs may appear. We urge the Working Group to eliminate this section in favor of further study.

Should the Working Group prefer to retain this Section, we would suggest a revision to the introductory text (following the text box) to make clear that the proper analysis of a run-off will depend greatly on many varying characteristics of the portfolio which go beyond the scope of the factors described in this Section. Accordingly, we would suggest the substitution of the following text for the penultimate sentence:

> As the importance to an insurer of its run-off portfolio and the portfolio's characteristics and size can vary greatly, regulators need to analyze run-off portfolios on a case-by-case basis. If regulators consider it appropriate, they may wish to include some of the following factors in their analysis.

7. Future of Restructuring Mechanisms Working Group Activities.

With the finalization of the White Paper and Best Practices Procedures Guidance, the Working Group faces the question of how to assure that its work product is implemented and that there is follow-up.

> **Best Practices Procedures Referral**. Among the referrals being made to other NAIC bodies, it appears that at present the Working Group intends on referring the Best Practices Procedures to the Financial Standards and Accreditation (F) Committee.
>
> We suggest that, as an interim step prior to accreditation, the Working Group consider a referral to the Financial Analysis Solvency Tool Working Group to

determine whether this guidance should be made available to financial analysts through the Financial Analysis Handbook (as an optional tool).

Continuing Mandate of the Working Group. We urge the Working Group to consider a number of steps to assure that its work remains useful to other regulators and the market, including continuing the Working Group's mandate and its involvement in restructuring issues. As an established body within the NAIC, the Working Group can act as a clearing house for regulatory issues arising from restructurings requiring NAIC attention. Although the Working Group is making referrals to other NAIC bodies for continuing study of numerous issues arising from restructuring mechanisms, those studies will lack the unifying guidance that comes from the Working Group. Also, it would be useful for the Working Group to be available to address questions regarding the White Paper and Best Practices and to be available to receive referrals/recommendations going forward.

Thank you for allowing AIRROC to participate in the Working Group's deliberations. As always, we stand ready to answer questions and to serve as a resource.

Respectfully submitted,

Kathryn E. Reynolds
Executive Director, AIRROC

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JUNE 17, 2021

APPLICATION OF

YOSEMITE INSURANCE COMPANY
AND PROVIDENCE WASHINGTON
INSURANCE COMPANY

CASE NO. INS-2021-00055

For approval of the transfer of certain
insurance policies pursuant to
§ 38.2-136 (C)(iii) of the Code of Virginia

ORDER APPROVING APPLICATION

By Application filed with the State Corporation Commission ("Commission") of the Commonwealth of Virginia ("Virginia") dated April 14, 2021, Yosemite Insurance Company, an Oklahoma-domiciled insurer ("Yosemite"), and Providence Washington Insurance Company, a Rhode Island-domiciled insurer ("PWIC" together with Yosemite, "Applicants"), requested approval of the transfer of 251 Virginia workers' compensation policies from PWIC to Yosemite ("Virginia Transfer") pursuant to § 38.2-136 (C)(iii) of the Code of Virginia ("Code").[1] Yosemite and PWIC are affiliates within the Enstar Group ("Enstar") and both are licensed to transact the business of insurance in Virginia and are in good standing.

The transfer of these Virginia workers' compensation policies is part of an Insurance Business Transfer ("IBT") that PWIC filed with the Oklahoma Insurance Department on November 13, 2019 pursuant to Oklahoma's Insurance Business Transfer Act. On November 26, 2019, the Commissioner of the Oklahoma Insurance Department approved the IBT after

[1] PWIC previously obtained the Virginia policies in question from Reciprocal of America, in receivership, pursuant to a Loss Portfolio Transfer Agreement approved by an order of the Commission on June 16, 2014. *See Final Order*, Case No. INS-2013-00190 at 9 (June 16, 2014) (adopting Hearing Examiner's recommendations and finding that the "Deputy Receiver has met all the requirements of § 38.2-136 (C) of the Code.").

concluding it would not have a material adverse impact on the interests of the policyholders. On October 15, 2020, the District Court of Oklahoma County approved the IBT following an approval hearing.

The Commission's Bureau of Insurance ("Bureau") informed Yosemite and PWIC that the IBT required policyholder consent under § 38.2-136 (B) of the Code to the extent that it involved the cessation or assumption of policy obligations on risks located in Virginia whereby the assuming insurer assumes the policy obligations of the ceding insurer as direct obligations.

Pursuant to § 38.2-136 (C)(iii) of the Code, the Applicants have requested that the Commission waive § 38.2-136 (B) of the Code's policyholder consent requirement for the Virginia Transfer by finding that the transfer of these policies is in the best interests of the policyholders.[2] The Applicants have waived the right to a hearing under § 38.2-136 (C)(iii) of the Code in their application.

In support of the Application, Yosemite and PWIC state, *inter alia*, that during the Oklahoma IBT proceedings notice of the Virginia Transfer was mailed to the Virginia policyholders and that no policyholder objected prior to or during the approval hearing held before the District Court of Oklahoma County.

Following submission of the Application, Yosemite and PWIC informed the Bureau on May 14, 2021 that Enstar is in the process of selling PWIC and had entered into a stock purchase agreement with Everspan Insurance Company ("Everspan"). As a result, if the Virginia Transfer were not to occur, the Virginia workers' compensation policies in question would leave Enstar and go to Everspan with PWIC.

[2] While requesting an order pursuant to § 38.2-136 (C)(iii) of the Code, the Applicants do not concede that such an order is necessary for the Virginia Transfer. *See* Application at 4.

The Bureau, based upon the Application, the record in the Oklahoma IBT proceedings and the information available in this matter, has recommended that the Virginia Transfer is in the best interests of the Virginia policyholders. Based upon the Bureau's review of the Application and the Applicants' representations, the Virginia policyholders will not lose any rights or claims afforded under their original contracts pursuant to Chapter 16 of Title 38.2 of the Code.

NOW THE COMMISSION, having considered the Application, the recommendation of the Bureau that the Virginia Transfer is in the best interests of the Virginia policyholders, and the law applicable hereto, is of the opinion that the Virginia Transfer is subject to the requirements of § 38.2-136 (B) of the Code, and that the Application should be approved.

Accordingly, IT IS ORDERED THAT the Application of Yosemite Insurance Company and Providence Washington Insurance Company for the approval of the transfer of 251 Virginia workers' compensation policies from PWIC to Yosemite pursuant to § 38.2-136 (C)(iii) of the Code be, and it is hereby, APPROVED.

A COPY hereof shall be sent by the Clerk of the Commission by electronic mail to: Scott J. Sorkin, Esquire, Bland & Sorkin, P.C., at ssorkin@blandsorkin.com, 5398 Twin Hickory Road, Glen Allen, Virginia 23059; Robert Redpath, Senior Vice President and U.S. Legal Director, Enstar (US) Inc., at robert.redpath@enstargroup.com, 475 Kilvert Street, Suite 330, Warwick, Rhode Island 02886; and a copy shall be delivered to the Commission's Office of General Counsel in care of Attorney, Thomas J. Sanford and the Bureau of Insurance in care of Deputy Commissioner Douglas C. Stolte.

National Conference of Insurance Guaranty Funds

NCIGF COMMENT LETTER
ON NAIC'S RESTRUCTURING MECHANISMS WORKING GROUP'S
RESTRUCTURING MECHANISMS WHITE PAPER DRAFT
November 18, 2025

Director Dwyer and Commissioner Mulready:

The National Conference of Insurance Guaranty Funds ("NCIGF") writes to comment on the Restructuring Mechanisms Working Group's (the "Working Group") October 2025 Discussion Draft of its Restructuring Mechanisms White Paper (the "White Paper").

NCIGF appreciates the Working Group, Receivership and Insolvency Task Force (RITF), and NAIC staff's continued efforts to incorporate changes related to guaranty association coverage. Guaranty associations are a foundational part of the national state-based system's consumer protection and resilience. As recognized by the Working Group, an Insurance Business Transfer (IBT) or Corporate Division (CD) must not change the coverage guaranteed to a consumer.

In Section 6B, addressing Guaranty Association Issues (page 22), the third paragraph addresses the necessity of a statutory change to ensure property and casualty guaranty coverage is not disrupted by an IBT or CD. We recommend the Working Group update that paragraph to reflect that the RITF and NAIC have completed the referenced workstream, adopting a model change; additional states have adopted the statutory solution; and state adoption is ongoing. The following change would reflect that update:

"On the property and casualty side, amendments to the guaranty fund statutes likely will be necessary. As described above, the NAIC has adopted statutory changes to the Property and Casualty Insurance Guaranty Association Model Act to address continued coverage. A number of states ~~— California, Illinois, and Oklahoma —~~ have enacted statutory solutions ~~to the property and casualty guaranty association issues~~ similar to the NAIC model change ~~NCIGF has suggested to the working group.~~[FN] ~~In addition, NCIGF has provided proposed statutory language for other states to consider. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership and Insolvency Task Force for consideration. Specifically, the Working Group recommends that the language proposed by NCIGF be included in the NAIC Property and Casualty Insurance Guaranty Association Model Act.~~ Regulators, guaranty funds and other appropriate industry stakeholders should continue to work cooperatively to implement this statutory remedy with all deliberate speed."

Suggested footnote: The Receivership and Insolvency Task Force tracks those states that have adopted changes to their guaranty fund laws to address Restructuring Mechanisms issues. See https://content.naic.org/sites/default/files/inline-files/540%20Restructuring%20Adoption%20Map%20-%20July%202025.pdf.

Thank you for considering these suggestions, and for your ongoing partnership in protecting guaranty association coverage for consumers.

National Conference of Insurance Guaranty Funds
300 North Meridian, Suite 1020
Indianapolis, IN 46204
Phone: 317.464.8176

Roger H. Schmelzer
President & CEO
E-Mail: rschmelzer@ncigf.org

BY E-MAIL

November 18, 2025

Director Elizabeth Kelleher Dwyer
Commissioner Glen Mulready
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group (the "Working Group")

Attention: Robin Marcotte (rmarcotte@naic.org)

Re: Comments on Working Group's Re-Exposure of Best Practices

Dear Director Dwyer and Commissioner Mulready:

The undersigned companies appreciate the opportunity to comment on the revised *Best Practices Procedures for IBT/Corporate Divisions* document (the "Best Practices") and *Restructuring Methods: An NAIC White Paper* (the "White Paper") that was re-exposed by the Working Group. We recognize the Working Group's efforts in refining the exposure and believe both documents provide a solid foundation for ensuring solvency and consumer protections in Insurance Business Transfer ("IBT") and Corporate Division ("CD)" (collectively, "IBT/CD") transactions.

Our comment letter focuses solely on one issue – the need to develop and implement national accreditation standards for IBT/CD transactions. We urge the Working Group to take the appropriate steps so that the Best Practices are recognized not simply as recommended but rather as *required* minimum review standards for accreditation. We have consistently advocated for this in prior comment letters throughout the development of the Best Practices and White Paper. Now that the White Paper and the Best Practices are nearing their final form, we strongly reaffirm this critical need.

A robust accreditation system is essential for consistent and strong solvency regulation. Establishing Best Practices as an accreditation standard protects against significant risks from transactions that deviate from these practices. It also protects insurers and customers from avoidable failures and related costs, and precludes forum-shopping by those seeking to engage in regulatory arbitrage. We believe creating an accreditation standard will provide uniformity, consistency, and greater confidence for consumers and the industry, ensuring consistent state adoption and preventing companies from exploiting weaker regulations.

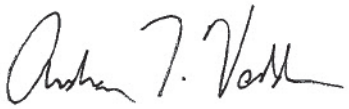
*****

We appreciate the Working Group's efforts since the last drafts and value the opportunity to provide additional thoughts on this particularly critical issue. Thank you for your consideration.

Sincerely,

Kristen DiCarmine
Vice President, Head of State Governmental Affairs
New York Life Insurance Company

Kevin L. Howard
Vice President, Deputy General Counsel & Head of Government Affairs
Western & Southern Financial Group



Andrew T. Vedder
Vice President – Enterprise Risk Management
The Northwestern Mutual Life Insurance Company

RiverStone International

17h November 2025

To Director Elizabeth Kelleher Dwyer (RI) and Commissioner Glen Mulready (OK), Co-Chairs of the Restructuring Mechanisms (E) Working Group:

Re: Comments on the October 2025 Exposure Drafts of the Restructuring Mechanisms White Paper and Best Practices Procedures for IBT/Corporate Divisions

RiverStone International ("RiverStone") is pleased to offer the following comments in response to the NAIC Restructuring Mechanisms (E) Working Group exposure of its drafts of the Restructuring Mechanisms White Paper (the "White Paper") and Best Practices Procedures (the "Procedures") for IBT/Corporate Divisions.

RiverStone's perspective on the exposures is informed by its proven track record in providing legacy business solutions, as a recognised and highly reputable specialist legacy insurer. RiverStone is regulated by the Massachusetts Division of Insurance, the Bermuda Monetary Authority, the UK's Prudential Regulation Authority ("PRA") as group supervisor, Lloyd's of London, the Central Bank of Ireland and the Malta Financial Services Authority. We have completed 47 economic / legal transfers since 2010, assuming gross liabilities of over $17.7 billion. As of 30 September 2025, the RiverStone group has $1.7 billion of shareholder equity, with $6.0 billion of total liabilities.

RiverStone wishes to express its thanks and support to the working group for its overall endeavors to develop the White Paper and the Procedures. We believe that the legacy insurance market plays an important role in supporting insurers to manage their liabilities whilst ensuring the effective run off of policyholder liabilities in accordance with their terms. Effective implementation of the proposals set out in the White Paper and Procedures would, we believe, represent a significant step forward in enhancing the US legacy market, whilst ensuring that effective regulatory oversight remains in place at all times. We look forward to working with the working group and all regulators in this regard.

RiverStone is also a member of AIRROC (the Association of Insurance and Reinsurance Run Off Companies) and supports and endorses the comments provided by AIRROC on the White Paper and the Procedures.

In addition to the comments from AIRROC, RiverStone submits the following additional suggestions.

1. COMMENT ON THE WHITE PAPER

Whilst the White Paper focuses heavily on the UK regime as a comparable to the US system, it is important to note that mechanisms for insurance business transfers have existed in many other jurisdictions for a number of years.

Accordingly, we would propose that the first paragraph of Section 2A of the White Paper is amended to reflect this as follows:

RiverStone International

Whilst r~~R~~estructuring laws and regulations are relatively new in the US, ~~but the~~ legal mechanisms for the transfer of insurance business have been implemented and operational in ~~the UK for over twenty years~~ a number of major insurance jurisdictions for many years, including the UK (since 1982), Australia (since 1973 for general insurance and 1995 for life insurance), the EU and Switzerland (since 2008) and Singapore (since 2000). The current UK regime is based on Part VII of the Financial Services and Markets Act of 2000 ("Part VII" and "FSMA), which replaced an earlier regime set out in the Insurance Companies Act 1982 . The Part VII mechanism enables insurers…

2. COMMENT ON THE PROCEDURES

Page 1 of the Procedures notes that "*IBT and CD transactions are not generally designed for troubled companies*". Whilst we recognise the importance of ensuring effective oversight over troubled companies and any restructuring or liability transfer of such companies, we believe that IBT and CDs can play an important role in supporting regulators as they address the issues raised by troubled companies and achieving a resolution that protects policyholders.

Accordingly, we would propose that the third paragraph of the first page of the Procedures is amended as follows:

> IBT and CD transactions ~~are not generally designed~~ may not be appropriate for troubled companies, unless detailed analysis is undertaken and suitable mechanisms for policyholder protections are put in place.

3. CONTACT INFORMATION

If you have any questions, queries or concerns regarding the content of this letter, please do not hesitate to contact David Rocke, Jamie Saunders or Mike Cain, whose contact details are as follows:

David Rocke Group Head of M&A RiverStone International Dorchester house, 7 Church Street, Hamilton, HM11 Bermuda +1 441 504 4201 *David.Rocke@riverstone.international*	Jamie Saunders Chief Underwriting Officer RiverStone International Dorchester house, 7 Church Street, Hamilton, HM11 Bermuda +1 441 504 4202 *Jamie.Saunders@riverstone.international*	Mike Cain Group General Counsel RiverStone International No. 2 Minster Court Mincing Lane, London EC3R 7BB United Kingdom +44 20 4621 2908 *mike.cain@rsml.co.uk*

Yours sincerely,

David Rocke
Group Head of M&A
RiverStone International

Best Practices Procedures for IBT/Corporate Divisions

As Adopted by the Restructuring Mechanisms (E) Working Group on 12-1-25

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Best Practices Procedures for IBT/Corporate Divisions

As Adopted by the Restructuring Mechanisms (E) Working Group on 12-1-25

Best Practices Procedures for IBT/Corporate Divisions

Insurance Business Transfer (IBT) Transactions / Corporate Divisions Transactions

Background

An **insurance business transfer** (IBT) represents a transaction designed to transfer existing insurance obligations of one insurer (transferring insurer) to a second insurer (assuming insurer) without policyholder consent, subject to approval regulatory approval and court approval. While policyholder consent is not required, notice to policyholders, key stakeholders and the general public is required, and concerns regarding the transaction will be considered in the regulatory and/or court approval process. Following an IBT, the assuming insurer becomes directly liable to policyholders and the transferring insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the transferring insurer.

A corporate division (CD) is a division of one dividing insurer into two or more resulting insurers. The dividing insurer'sassets and liabilities are allocated between or among the resulting insurers without requiring affirmative policyholder consent. Following a CD, the resulting insurer(s) becomes directly liable to policyholders and the dividing insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the dividing insurer.

IBT and CD transactions may not be appropriate for troubled companies unless detailed analysis is undertaken and suitable mechanisms for policyholder protections are put in place.

The procedures in this section are best practices for state insurance regulators to use in reviewing IBT and CD transactions. While acknowledging that such transactions may differ, this guidance is intended to recommend minimum review standards, where applicable and does not prohibit a regulator from requesting and reviewing additional information.

The term insurer in this document refers to licensed insurance risk bearing entities. Although some jurisdictions do not consider certain health entities insurers, this term is used generically to include such entities.

Unless otherwise noted, the following guidance is intended to pertain to both IBT and CD transactions.

Section I – Insurer Information

The applicant requesting the transaction must provide the following minimum documentation for review by the regulatory authorities:

1. **Entity Contact Information**

    a. Below information for 1) applicant; 2) CD – Dividing and Resulting insurer(s); 3) IBT – transferring and assuming insurer(s)

    b. Insurer names

    c. DBA/AKA (if applicable)

    d. NAIC company code

    e. NAIC group code prior to transaction (if applicable)

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f. State or jurisdiction of domicile of all insurers in the transaction

g. List of states/jurisdictions where each insurer is currently licensed and list of states/jurisdictions where each insurer was ever licensed

h. Comments (regarding surplus lines, etc.)

i. Contact person

j. Address

k. Phone number

l. Email address

2. **Affiliates of the Involved Insurers**

a. Organizational chart pre-transaction

b. Ultimate controlling person pre-transaction

c. Organizational chart post-transaction

d. Ultimate controlling person post-transaction

e. For each new insurer that will be created by the proposed CD, a copy of its:

i. Proposed articles of incorporation

ii. Proposed bylaws and

iii. The kinds of insurance business that the new insurer(s) would be authorized to conduct

f. Respective controlling parties of dividing or transferring and resulting or assuming insurers

3. **Management of Applicants**

a. Officer and director information for involved insurer(s)

b. Individual's first and last name

c. Position title

d. Known regulatory actions

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Section II – Transactional Design

The applicant requesting the transaction must provide the following minimum documentation for review by the regulatory authorities:

The following procedure is intended to mitigate the risk of approving a proposed IBT/CD transaction that may not be well designed based upon the effects of the transaction.

1. **Insurance Business Transfer – Narrative of the proposed IBT, including:**

    a. Identification of the policies subject to the IBT.

    b. Reasons for undertaking the IBT.

    c. All steps necessary to accomplish the IBT, including legal and regulatory requirements and the timetable for completing such requirements.

    d. The effect of the IBT on the transferring insurer's and assuming insurer's financial condition.

    e. The effect of the IBT on the transferring insurer's and assuming insurer's policyholders (including with respect to guaranty association coverage) claimants and other stakeholders.

    f. Summary of the IBT plan, including any agreements.

    g. Identification and description of the business to be transferred (including the lines of business, liabilities by state/jurisdiction, and guaranty associations that could be affected should the assuming or resulting insurer be liquidated).

    h. Most recent audited financial statements, along with quarterly and annual reports of the transferring insurer and the assuming insurer filed with its domiciliary regulator.

    i. The most recent actuarial report and opinion that quantifies the liabilities in the business to be transferred to the assuming insurer(s) under the policies or reinsurance agreements.

    j. Three years of pro-forma financial statements demonstrating the projected solvency of the assuming insurer(s) and explanation of assumptions used and certification that all financial regulatory requirements will be met after the transaction. The reviewing regulator has the discretion to request more than three years of financial projections if deemed appropriate. For example, more years of financial projections would likely be requested if the subject business is expected to take more than three years to run-off.

    k. Officers' certificates of the transferring insurer(s) and the assuming insurer(s) attesting that each has obtained all required internal approvals and authorizations regarding the IBT plan and completed all necessary and appropriate actions relating thereto.

    l. Description of any reinsurance arrangements that will transfer to the assuming insurer or from the assuming insurer that would cover the subject business under the IBT.

    m. Description of any guarantees or additional reinsurance that will cover the transferred business.

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n. A statement describing the assuming insurer's proposed investment policies and any contemplated third-party claims management and administration arrangements.

o. An exhibit similar to Schedule P Part 2 showing how management's reserve estimates have changed over time for the business to be transferred/divided, on both a gross and net of reinsurance basis.

p. An exhibit showing how the Appointed Actuary's (or other internal/third party actuary who has reviewed the subject business) estimates have changed over time for the business to be transferred/divided, on both a gross and net of reinsurance basis.

q. List of states/jurisdictions where the assuming insurer(s) is licensed.

r. Full description and analysis and any other information relevant to whether the transaction will reduce, eliminate, or otherwise change guaranty association coverage, including:

   i. For IBT transactions involving the transfer of life, annuity or health insurance the applicant's representation that the assuming insurer(s) is licensed with respect to the transferred business in the same U.S. jurisdictions where the transferring insurer(s) is licensed or had ever been licensed with respect to the transferred business.

   ii. For IBT transactions involving property and casualty insurance, the applicant's representation that the laws of each U.S. jurisdiction where any such policies issued by the transferring insurer are transferred such that rights to guaranty fund coverage are not reduced, eliminated, or otherwise changed as a result of the transaction.

s. A full description and analysis of all plans regarding run-off operations of any of the insurer(s) relating to the business being transferred.

t. Update to the Own Risk and Solvency Assessment reports ("ORSA") demonstrating how the proposed transaction would impact the ORSA analysis for the transferring insurer(s) as well as for any insurer that will be assuming policy liabilities if the proposed transaction is approved.

u. Documentation of how the administration of policies, including claims handling by the transferring insurer(s) following the transaction will provide a continuing level and quality of service.

v. Form of notice to be provided under the IBT to any policyholder whose policy is part of the transfer, including a full description as to how such notice shall be provided.

2. **Corporate Division – Narrative of the Proposed CD, including:**

   a. Identification of the policies subject to the CD

   b. The manner of allocating between or among the resulting insurer(s) including:

      i. Any assets of the dividing insurer that will not be owned by all of the resulting companies as tenants in common.

      ii. The liabilities of the dividing insurer, including policy liabilities, to which not all of the resulting insurer(s) will become jointly and severally liable.

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c. The manner of distributing shares in the new insurer(s) to the dividing insurer(s) or its shareholders.

d. A reasonable description of the liabilities, including policy liabilities, and items of capital, surplus,or other assets, in each case, that the dividing insurer(s) proposes to allocate to each resulting insurer(s), including specifying the reinsurance contract, reinsurance coverage obligations, and related claims that are applicable to those policies.

e. All terms and conditions required by the laws of the jurisdiction or the articles of incorporation and bylaws of the dividing or resulting insurer(s).

f. Evidence demonstrating that the interest of all classes of policyholders (including with respect to guaranty association coverage), claimants and other stakeholders of the dividing and resulting insurer(s) will be properly protected, and all other terms and conditions of the division.

g. Nothing in this shall expand or reduce the allocation and assignment of reinsurance as stated in the reinsurance contract.

h. If the dividing insurer(s) survives the division, the plan of division shall include any proposed amendments to such insurer(s) bylaws and information as to whether any interests in such insurer(s) will be canceled or converted including:

    i. All proposed amendments to the dividing insurer's articles of incorporation and bylaws, if any;

    ii. If the dividing insurer(s) desires to cancel some, but less than all, shares in the dividing insurer(s), the manner in which it will cancel such shares; and

    iii. If the dividing insurer(s) desires to convert some, but less than all, shares in the dividing insurer(s) into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination thereof, a statement disclosing the manner in which it will convert the shares.

i. If the dividing insurer(s) does not survive the proposed division, the plan of division shall contain the manner in which the dividing insurer(s) will cancel or convert shares in the dividing insurer(s) into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination thereof.

j. An exhibit similar to Schedule P Part 2 showing how management's reserve estimates have changed over time for the business to be transferred/divided, on both a gross and net of reinsurance basis.

k. An exhibit showing how the Appointed Actuary's (or other internal/third party actuary who has reviewed the subject business) estimates have changed over time for the business to be transferred/divided, on both a gross and net of reinsurance basis.

l. Business plan.

m. Ongoing operations of the resulting insurer(s).

    i. A listing of the insurer's major markets/products.

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ii. A description of the insurer's strategy covering major markets/products and customers and the critical success factors for achieving these strategies.

iii. A description of the insurer's competitive positioning for each of its major markets/products and a discussion of growth potential, profit potential and trends for each.

iv. Identification and a discussion of the significant trends in the insurer's major markets/products, e.g., demographic changes, alternative markets, distribution methods, etc.

v. Identification of the largest risk exposures of the insurer, e.g., financial market volatility, environmental exposures, geographic distribution, etc.

vi. A description of the major business risks of the insurer, e.g., sales practices, data integrity, service delivery, technology, customer satisfaction, etc.

vii. List of states/jurisdictions where the resulting insurer(s) is/are licensed.

n. Information relevant to whether the transaction will reduce, eliminate, or otherwise change guaranty association coverage, including:

i. For corporate division transactions involving life, annuity or health insurance, the applicant's representation that each resulting insurer is licensed in the same U.S. jurisdictions where the dividing insurer is licensed or had ever been licensed with respect to the life, annuity or health policies being allocated to the resulting insurer.

ii. For corporate divisions involving property and casualty insurance, the applicant's representation that the laws of each U.S. jurisdiction where any such policies issued by the dividing insurer are allocated such that rights to guaranty association coverage are not reduced, eliminated, or otherwise changed as a result of the transaction.

o. Run-off operations.

i. A description of all plans regarding any run-off operations.

p. Documentation of how the administration of policies including claims handling by the dividing insurer following the transaction will provide a continuing level and quality of service.

3. **Financial Information for IBT and CD**

a. Historical financial statements, including the most recently filed annual and quarterly statutory statements.

b. Financial statements (in a spreadsheet format) detailing the accounting of the proposed IBT or CD including:

i. Schedules detailing assets and liabilities to be reallocated as part of the IBT or CD.

ii. An accounting of any special charges, re-evaluations, or write-downs to be made as part of the IBT or CD.

c. Pro forma financial statements of the insurer(s) as if the IBT or CD were approved including an explanation of the underlying assumptions.

d. Financial projections for three years (assuming the IBT or CD is approved) for the transferring/dividing and assuming/resulting insurer(s) and an explanation of the assumptions upon which the projections are based. The reviewing regulator has the discretion to request more than three years of financial projections if deemed appropriate. For example, more years of financial projections would likely be requested if the subject business is expected to take more than three years to run-off.

e. A description of any tax consequences of the IBT or CD.

4. **Financial Support**

a. While every IBT or CT plan should stand on its own when determining the appropriate capital requirements, there may be situations where the parent may be offering continued financial support or management services that may be considered by the domiciliary regulator. In those instances, the provision for financial and managerial support by the parent entity to any insurer(s), needs to be legally enforceable before such support is given consideration in review of the transaction. If the plan provides for a commitment of parental and other legally enforceable plans for financial support such support might be needed to run off operations in the event of:

i. Inadequacy of reserves.

ii. Asset deterioration.

iii. Deterioration in the collectibility of reinsurance recoverables.

iv. Appropriate liquidity

5. **Organizational Impact**

a. The plan should affirm that all resulting insurer(s) shall be in compliance with licensure requirements in all applicable jurisdictions. If the restructuring transaction involves the transfer of reinsurance business from one reinsurer to another, approval of the transaction should consider the impact on the direct writer to continue to receive credit for reinsurance if it existed prior to the transaction.

b. Analysis of the change in organizational structure resulting from the transaction. Areas of emphasis include the following:

i. Ownership of the resulting corporate structures

ii. Relationship between management of the resulting insurer(s)

iii. Substantial reinsurance arrangements between resulting insurer(s)

iv. Other ongoing business ties between the resulting insurer(s)

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Section III – Robust Regulatory Review

1. **Initial Review of the Transaction**

The domestic regulator should conduct an initial review of the proposal prepared by the applicant insurer to determine if all information required by Section I and Section II has been provided and the transaction has been properly designed. Some domestic regulators may choose to call a limited scope financial examination as part of conducting their review. The domestic regulator should ensure:

a. The documented reasons for the proposed transaction are reasonable and appropriate based upon the domestic regulator's existing knowledge of the insurer/group.

b. The steps necessary to accomplish the plan, including legal and regulatory expectations and a timeline, are reasonable and appropriate.

c. The projected impact of the transaction (proforma financial statements and RBC before and after) on the financial condition of all involved insurer(s) will not render any insurer(s) in a troubled company state.

d. The proforma business plan for all insurer(s) including major business risks, products, etc., of the insurer (e.g., sales practices, data integrity, service delivery, technology, customer satisfaction, etc.) as described in Section II is reasonable and appropriate.

2. **High Level of Confidence**

Reviewing authorities should undertake efforts to establish, at a high level of confidence, that policyholders and other key stakeholders will experience no material adverse impacts.

a. The regulatory review must be robust, including evaluations of financial projections, actuarial analysis and capital and liquidity projections. In addition, the review should also include a confirmation that the insurer(s) have performed a due diligence of the legal implications in other jurisdictions, specifically those that have anti-novation laws. Correspondingly, all affected regulators should conduct a review of their own laws to ensure there is no legal bar to the transaction.

b. The review should be conducted by the domestic regulator assisted by qualified independent experts (or in-house department of insurance expertise for CD) and should identify key risks to the transaction. The independent expert should not be a department of insurance employee and should be able to assert independence from the reporting entities under discussion. The expert review should, at a minimum, include the following:

   i. A prospective solvency assessment.

   ii. A finding that the assets to be transferred to insurers involved in the transaction are adequate to cover the insurers' liabilities being transferred.

   iii. A conclusion that the transaction does not have any material adverse impacts on policyholders, including services, benefits from reinsurers, guaranty associations or other secondary market mechanisms.

iv. A consideration of the plans of any insurer(s) involved in the transaction to liquidate another involved insurer, sell or dividend assets, consolidate, merge, or make other changes, and the resulting impact on capital, policyholders, reinsurers, and guaranty associations.

v. An analysis of any relevant contracts, including claims management and reinsurance, and recordkeeping.

vi. Management assessment and corporate governance assessment. (Note this can be undertaken by the independent expert if preferred).

c. The domestic regulator should consider whether any insurer(s) will lose the benefits of policy line diversification following the transaction. In making this determination, the domestic regulator should determine whether following the transaction the insurers are operating in a single industry segment is offering differentiated types of insurance products or is otherwise exposed to increased risk because of its insurable risk profile.

3. **Require Strong Financial Standards and Stress Testing**

a. Prescribed conservative assumptions should be included in capital calculations to avoid the manipulation of capital thresholds. (See additional information in the section on assessment of capital risk.)

b. Actuarial reserve and capital calculations should be performed by an expert that is independent of the insurance companies involved. Resulting projected RBC ratios and projected capital ratings should be reviewed. Policyholders and other key stakeholders should have the same economic protections which existed prior to the IBT or CD, including but not limited to guaranty association protection.

c. The final decision should outline the purpose of the transaction and impact to policyholders and other key stakeholders, and the opinion of the independent expert(s) and reviewing regulators, including other impacted regulators, and the input from policyholders.

d. Use uniform NAIC valuation and accounting standards.

i. When evaluating the solvency impact of a proposed transaction, the accounting utilized should be in conformance with the NAIC's uniform statutory accounting principles valuation and accounting rules in the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual). Regulators are discouraged from allowing any permitted practices. If permitted practices are utilized, the impact of the deviations from the AP&P Manual at the time of the transaction, and in any subsequent projections, should be thoroughly analyzed and quantified and should be disclosed as part of the information shared with other affected regulators. In addition, statutory filings shall continue to provide disclosures of the impact of prescribed and permitted practices in accordance with the AP&P Manual.

e. The domiciliary regulatory should consider the financial strength ratings issued by rating agencies along with other financial strength benchmarks, for all insurer(s) involved in the transaction.

4. **Assessment of Risk Capital**

a. In IBT transactions where the liabilities of the assuming insurer(s) are intended to be segregated from the other liabilities not associated with such a transfer and are expected to be both self-sustaining (e.g., no more funds may be transferred to fund such liabilities under the terms of the transfer) and self-containing

(e.g., funds cannot be used to cover liabilities not associated with the transfer), the domiciliary regulator must ensure that there are appropriate statutes and/or regulations in place that provide a legal framework to protect the assets of the segregated accounts in the event of an insolvency of the segregated account. In addition, RBC should be calculated for each segregated account and for the company as a whole. The regulator should also consider requesting and reviewing other capital metrics (e.g., Best's Capital Adequacy Ratio (BCAR)or the company's own measure of economic capital for the business to be transferred/divided)

b. An actuarial report of the adequacy of reserves (gross and net) being transferred should include an analysis of:

   i. A comparison of the existing reserves to a Value at Risk (VaR) of 99.5% for a one-year period (non-life business), 97% for a five-year period (non-life business) or conditional tail expectation (CTE) of 90 or other higher level that are necessary to mitigate the risks being transferred. Some liabilities (such as asbestos, environmental, and other latent liabilities) are highly volatile and may not lend themselves to traditional methods of estimating percentiles for reserve stress testing. The standards presented may not be practicable in all situations. Regulators could consider focusing on stressing the reserves in a deterministic manner rather than attempting to quantify the 99.5% Value at Risk (VaR) for a one-year period, the 97% VaR for a five-year period, or the Conditional Tail Expectation of 90 or higher where these metrics may be difficult to estimate and/or potentially misleading.

   ii. A comparison to stressed reserves under reasonable deterministic criteria/scenarios provided by the domiciliary regulator.

   iii. A comparison of the proposed claim staff expertise and levels compared to estimate of previous claims staff expertise and levels.

c. If the reviewing authority requires additional capital which is higher than the required reserve, the additional amount should be reported in special surplus.

d. If the proposed transaction includes on-going operations for non-life business, the review should include an understanding of the basis for the projected liabilities associated with the ongoing business. This review should include pricing assumptions such as rate change history, loss trends, and on-going expenses. The independent expert should assess the potential need for a premium deficiency reserve as well as the adequacy of pricing for ongoing business.

e. Capital reviews of the transaction should consider the following (if relevant) to the transaction:

   i. Capital and/or reinsurance limits assessments should include quantitative analysis.

   ii. Risk exposure modeling.

   iii. Horizon and confidence levels to address short-term (1 year); mid-term (5 to 10 years); long-term (relatively consistent with liability horizon).

   iv. Stress scenarios and their relationship to capital adequacy.

   v. Discuss impact on capital needs attributable to: any diversification in liabilities (different types of exposures); asset mix; amount and quality of "outside" existing inuring reinsurance (applies to

portfolio before any reinsurance acquired subsequent to the transaction) and internal hedging.

f. Upon request, the domiciliary regulator should provide access to information to other licensed U.S. jurisdictions including the established amount of assets to be transferred to compensate for the uncertainty associated with the business and that the remaining assets need to be self-sustaining for the obligations transferred to it.

5. **State-Imposed Restrictions**

a. If necessary, consider issuing U.S. jurisdiction-imposed restrictions to apply to the insurer(s) after the transaction, such as:

i. Dividend restrictions.

ii. Notice to impacted U.S. jurisdictions of major changes.

iii. Planned targeted examinations.

iv. Special surplus restricted capital.

Section IV – Review of the Transaction by an Independent Expert

1. **Use of an Independent Expert**

a. The ability of a commissioner to hire independent experts for specialized transaction review and financial testing, to be paid for by the applicant, is essential.

b. The regulatory review process for IBT or CD will utilize an independent expert to advise and assist the ultimate reviewing authority (regulator and or the court) in reviewing proposed transactions (including advising on any material adverse impact on policyholders, reinsurers, or guaranty associations) and to provide any other assistance or advice the regulator may require.

c. For CD, an independent expert is preferred but not required. If the domiciliary jurisdiction reviewing the transaction decides not to use an independent expert, the reviewing domiciliary jurisdiction shall document its conclusion that it has the expertise and provide notice to other jurisdictions with policyholders affected by the transaction on their conclusions regarding the use of state/jurisdiction department of insurance expertise.

d. The independent expert (or in-house department of insurance expertise for CDs) evaluation should be undertaken by an expert to establish with a high level of confidence that policyholders and other key stakeholders experience no material adverse impacts, including but not limited to the availability of guaranty association coverage. The independent expert must provide a detailed report regarding the prospective solvency of the resulting insurer(s) or the assuming insurer(s) in the event of an IBT or CD that utilizes an outside independent expert.

e. Other independent experts will also provide reports to be reviewed by the regulator and the ultimate approving authority. This will include an independent actuarial review of the reserves and capital (e.g., RBC and financial strength) before and after the transaction. The review is to ensure that all of the policyholders and other key stakeholders are not materially adversely impacted after the proposed

transaction. Note that the actuarial review is one of several experts that will likely be included and taken into consideration. While the independent expert (or in-house department of insurance expertise for CDs) can provide comments and evaluation of the reports of the other experts, the overall expert cannot change the reports of the other employed experts. For example, the reviewing expert cannot change the consulting actuarial opinion.

f. The experts (or in-house department of insurance expertise for CDs) should be independent of any influence from the companies involved and subject to the approval of the domestic regulators.

2. **Determine Scope of Each Expert Report**

The domiciliary regulator should determine:

a. How the expert report will be issued to the ultimate approving authority.

b. What parts of the report will be public.

c. Verify that the expert is independent.

d. Who appointed the expert and how the requesting entity will pay the costs.

e. What are the expert's qualifications and experience.

f. Does the expert have any conflicts of interest.

g. Are the procedures to be performed by the expert documented in a manner that is understandable.

h. Opinion of the expert on the likely effects of the plan.

i. Opinion of the expert on whether there were alternatives.

j. Opinion of the expert on whether different groups of policyholders, claimants and other stakeholders are likely to be impacted differently by the plan.

k. Opinion of the expert on the likely effects of the transaction on any reinsurer of the transferor or dividing parties.

l. If the independent expert has expertise in state guaranty association law, consideration of factors relevant to whether the transaction will reduce, eliminate, or otherwise change guaranty association coverage in accordance with sections II(1)(n) and (2)(k)(vii).

Section V – Reserves and Capital

Proposed CD and IBT transactions require that the independent experts and reviewing regulators certify that the reserves and the capital position (e.g., RBC) that will apply to all insurers before and after the transaction will create no material adverse impacts on the policyholders and other key stakeholders. The following procedures are intended to assist in evaluating this risk.

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1. **Retain Qualified Independent Actuarial Experts**

    a. The actuarial expert should perform a "ground up" actuarial review of case and incurred but not reported reserves with particular focus on any long-tail claims. The actuarial expert should also opine on:

        i. Methodologies used by the insurer to estimate reserves.

        ii. The adequacy of reserves on a gross and net of reinsurance basis.

        iii. The insurer's economic approach to funding the run-off liabilities, including cash flow model stress tests.

        iv. If reserve discounting is permitted, funding of the discount and the adequacy of reserves net of discount.

    b. The adequacy of the expertise of the insurer's claims unit.

    c. Ascertain that the initial plan allows sufficient capacity for material adverse reserve development.

2. **Determine Impact Based on an Independent Actuarial and Capital Review**

    a. Based on review of the reserves and capital (e.g., RBC) before and after the transaction, the regulator should determine if the policyholders, claimants, and other stakeholders are not materially adversely impacted by the proposed transaction.

3. **Analysis of Reinsurance - Independent Reinsurance Experts**

    a. An analysis of reinsurance recoverables by a qualified expert including:

        i. A review of the process used to monitor, collect and settle outstanding reinsurance recoverables.

        ii. An analysis of existing and projected reinsurance balances including the expected timing of cash flows.

        iii. An analysis of the quality and financial condition of the reinsurers and prospects for recovery.

        iv. A detailed description of write-offs or required reserves based on the independent analysis taken as a whole.

        v. Disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes.

        vi. A discussion of the impact of the IBT or CD on the collectibility of reinsurance balances.

    b. A legal analysis of the effect that a rehabilitation or liquidation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and on the legal rights of the reinsurers to claim setoffs against such recoveries.

    c. If reinsurance is an integral part of the transaction, a copy of such agreement(s) and a written opinion from

a qualified expert as to:

i. The adequacy of coverage.

ii. The ability of the treaty to perform as anticipated and be unaffected by delinquency proceedings.

iii. The practical operation of the treaty.

iv. The timing and method of payment of reinsurance premium.

v. The financial condition of reinsurers.

vi. The sufficiency of coverage and other resources.

d. A discussion of existing or proposed reinsurance programs, whether with affiliates or other reinsurers, to assist the regulatory authority in determining that provisions are consistent with other information provided and that adequate coverage exists for both ongoing and run-off operations.

e. Any proposed amended, cancelled, or new pooling agreements, including explanations of significant differences before and after the restructuring or transfer, flowcharts to demonstrate the proposed movement of business, and the anticipated financial impact upon the affected companies.

4. **Analysis of Liabilities Other than Reserves**

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

a. Identification of any key concerns about potential legal decisions and/or pending verdicts that would substantially increase the expected aggregate liabilities.

b. Potential political or currency risks.

c. Potential "Black Swan" events (unusual and or infrequent).

i. Potential sources of "hidden" or unknown liabilities – for example, unintended latent liability coverage, unintended extra-contractual obligations, unidentified or reinstated policies, quality of policy record keeping.

ii. Risks related to the use of, or changes to the use of, outsourcing for claims management, asset management, or other administrative functions.

iii. Reliance on legal advice concerning claim liabilities.

5. **Analysis of Assets**

The regulator or its independent experts should conduct an analysis of assets to determine if existing assets and

future cash flows are sufficient to fund liabilities. This analysis should include:

a. Disclosure of assumptions regarding the assets of the insurer(s) involved in the IBT or CD, especially those assets with high volatility, liquidity uncertainties, material valuation issues, or representing a material percentage of the invested asset portfolio. Assets analysis should include an understanding of the asset allocation strategy and reinvestment strategy, including descriptions of how those strategies will change over time.

b. Current appraisals of any material real estate or mortgage holdings, independent valuation of limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other assets of concern.

c. A list of assumptions used by the insurer(s) as to investment yield, and disclosure of the effect that the reallocation of assets will have on historical investment yields.

d. If the asset analysis performed of the insurer indicates a potential asset/liability matching problem, documentation that the insurer plans to act, such as:

   i. Reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk.

   ii. Securing a parental guarantee of investment yield.

   iii. Securing a parental guarantee of asset valuation or a parental agreement to substitute the insurer's assets.

   iv. Disposing of assets and replacement of better-quality assets or cash prior to approval of the IBT or CD.

Section VI – Analysis of Issues Affecting Policyholders, Claimants and Other Stakeholders

1. **Legal Clauses**

   a. Consider whether to require that "cut through" provisions be put in place for policyholders of the weaker entity.

2. **Consideration of Rights of Policyholders and Other Key Stakeholders in Other Jurisdictions**

   a. Consider whether to require that a mechanism be put in place to obtain policyholder consent regarding any novations.

   b. Preserve rights of policyholders and other key stakeholders regarding secondary market mechanisms protections.

Section VII – Due Process Communication of Transaction

Robust due process must be afforded to stakeholders (policyholders, claimants, reinsurers, guaranty associations, other regulators, etc.) impacted by a transaction which includes access to information concerning the transaction.

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The following procedures are intended to address the risk of inadequate communication with various stakeholders.

1. **Review Proposed Communication Plan**

   The regulator will review the proposed communication plan to ensure that the transaction is described in enough detail and provides enough time for a person to determine if they will be adversely impacted.

2. **Communication to Policyholders, Claimants and Other Stakeholders**

   The domiciliary jurisdiction of the dividing or transferring insurer(s) must approve a plan that appropriately notifies impacted stakeholders regarding all aspects of the proposed transaction and stakeholders' ability to comment or object. Policyholders, claimants and other affected stakeholders should always be given notice, access to all information needed to meaningfully review a proposed transaction, and an opportunity to be heard in court (IBT) or at the public hearing (CD).

   a. Notice to stakeholders in a form to be approved by the regulator and shall include, at a minimum, notice to**:**

      i. Policyholders.

      ii. Claimants and their counsel of record.

      iii. Reinsurers.

      iv. NOLHGA/NCIGF/all affected state or U.S. jurisdiction insurance guaranty associations.

      v. Other stakeholders.

   b. The notice shall provide:

      i. Adequate time to allow stakeholders to assess the impact as determined by the domestic regulator, but no less than 30 days.

      ii. Opportunity to submit written comments and or attend public hearings.

      iii. Notice of the date, time and place of the public hearing.

3. **Due Diligence Requiring**

   Depending upon the nature of the transaction, the domiciliary regulator may require the transferring insurer(s) to provide reasonable notification to stakeholders and policyholders of the transaction, which may include, but are not limited to, the following:

   a. Mailing the notice to the stakeholder by first-class mail, postage prepaid to their last-known address as indicated by the records of the transferring insurer or to the address to which premium notices or other policy documents are sent;

   b. Sending the notice by internationally recognized delivery service (if needed);

c. By electronic means to any stakeholder who provided consent to receiving service by electronic mail and provides instructions for making the electronic notice or service. "Electronic means" shall include communications by facsimile or electronic mail;

d. By publication in a newspaper of general circulation in the state in which the transferring insurer has its principal place of business and in such other applicable publications; or

e. By retaining the services of a professional or entity that specializes in locating current addresses for businesses and persons.

4. **Notify/Coordinate with Affected Regulators**

The domiciliary regulator should communicate with other affected regulators regarding the transaction. The process should allow adequate opportunity to object or provide a letter of non-objection of all affected U.S. jurisdictions and the assuming and resulting entities should be licensed in all U.S. jurisdictions needed so as not to impair policyholders' access to their state guaranty associations. Stakeholders should be provided, at a minimum:

a. Adequate time to assess the impact.

b. Opportunity to submit written comments and or attend public hearings.

Section VIII – Guaranty Association and Other Secondary Market Considerations

1. **Guaranty Association Coverage**

Prior to approving a proposed restructuring transaction, a commissioner should make a factual determination regarding guaranty association coverage issues based on the criteria outlined below.

a. For IBT or CD transactions involving life, annuity or health insurance, the assuming or resulting insurer(s) should be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to the IBT or CD transaction. This means that the assuming insurer or resulting insurer(s) must be licensed in all U.S. jurisdictions where the transferring or dividing insurer was licensed or had ever been licensed with respect to the policies being transferred or allocated in the transaction.

b. For IBT or CD transactions involving property and casualty insurance, the guaranty association laws in relevant U.S. jurisdictions should address IBT or CD transactions such that rights to guaranty association coverage are not reduced, eliminated, or otherwise changed as a result of the transaction. This is a jurisdiction-by-jurisdiction inquiry and may depend on whether the guaranty association law has been amended to address IBT or CD transactions.

c. Guaranty association representatives, National Conference of Insurance Guaranty Funds (NCIGF) and National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) are useful resources for any guaranty association coverage issues that arise in evaluating these transactions**.**

2. **Secondary Market Mechanisms**

a. Where there was secondary market or similar mechanisms which benefited the policyholders orotherwise

accrued to the claims of policies before the CD or IBT, state regulators should ensure that the benefits remain after the CD or IBT. A CD or IBT should not reduce, eliminate or in any way impact coverage benefits.

b. Other organizations such as the National Workers Compensation Reinsurance Association should be contacted when relevant.

Section IX – Run-Off Procedures

Drafting Note:
Section IX is on procedures for those entities that are in run-off. It is not presumed that all IBT or all corporate divisions will result in run-off entities. Many of these procedures would likely be conducted post transaction approval. Therefore, the final location of the run-off procedures may be different than the other pre-transaction best practices sections.

To the extent the amount of run-off business (business that was written in prior years which is no longer being sold) is material for an insurer, the domiciliary regulator should consider separate procedures on such business. Such procedures may apply to all operations or just certain aspects of the insurer's operations. Run-off can also occur as a result of an IBT which transfers part of the business of one insurer (transferring insurer) to another insurer (assuming insurer) or a CD transaction where one insurer divides into two or more resulting insurers. In all these situations, the run-off business should be subject to the following regulatory guidance as a baseline of guidance. The regulator can perform additional procedures beyond those listed.

1. **Review the Required Documented Run-Off Plan**

   a. Review the monthly financial reporting of the run-off (claims development on a direct, ceded and net basis), actual vs projected results and the following related information:

      i. Assumptions or material changes in assumptions regarding the assets included in the plan including specifically those that are subject to greater volatility, liquidity uncertainty, valuation issues, appraisals on material real estate and mortgage holdings.

      ii. Material disputes with reinsurers or other third parties.

   b. Material reinsurance agreements and written opinion from qualified expert as to:

      i. Adequacy of the coverages.

      ii. Ability of the plan to perform as anticipated.

      iii. Practical operation of the plan.

      iv. Timing and method of payment of the reinsurance premiums.

      v. Financial condition of the reinsurers.

2. **Require the Following as Part of the Approval of the Run-Off Plan**

Best Practices Procedures for IBT/Corporate Divisions

a. Pre-approval of any new reinsurance agreements or change in existing reinsurance agreements.

b. Pre-approval of any change in the daily operations of the insurer's existing practices including claims paying, investments practices and collections (e.g., reinsurance processes).

c. Pre-approval of any affiliated transactions.

d. Pre-approval of any commutation of liabilities (inward or outward).

3. **For Run-Off Plans, Consider Subjecting to Pre-Approval all the Following Other Items:**

a. Dividends (including ordinary);

b. Disposal or encumbrances of assets;

c. Withdrawal of bank accounts;

d. Lending of any funds;

e. Transfer of property;

f. Incurring any debt, obligation or liability;

g. Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate or contract; and/or

h. Reserves to be held lower than Value at Risk (VaR) of 99.5% for a one-year period (non-life business), 97% for a five-year period (non-life business) or conditional tail expectation (CTE) of 90 or other higher level that are necessary to mitigate the risks being transferred. Some liabilities (such as asbestos, environmental, and other latent liabilities) are highly volatile and may not lend themselves to traditional methods of estimating percentiles for reserve stress testing. The standards presented may not be practicable in all situations. Regulators could consider focusing on stressing the reserves in a deterministic manner rather than attempting to quantify the 99.5% Value at Risk (VaR) for a one-year period, the 97% VaR for a five-year period, or the Conditional Tail Expectation of 90 or higher where these metrics may be difficult to estimate and/or potentially misleading.

i. Material reinsurance agreements and written opinion from qualified expert as to:

i. Adequacy of the coverages.

ii. Ability of the plan to perform as anticipated.

iii. Practical operation of the plan.

iv. Timing and method of payment of the reinsurance premiums.

v. Financial condition of the reinsurers.

Best Practices Procedures for IBT/Corporate Divisions

GLOSSARY OF TERMS

(Related to the Form A System)

Term	Description
Affiliate	An "affiliate" of, or person "affiliated" with, a specific person is a person who directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.
Applicant (Information)	The applicant is the insurer wishing to enter into a CD or IBT and making a filing with the domiciliary regulator. When entering applicant information, one or the other may be entered but not both a company name and individual name.
Application Status	The application status may be any one of the following: Approved, Approved with Stipulation, Transaction Closed, Transaction Not Closed, Denied or Withdrawn. Submitted, Under Review, and Withdrawn.
CoCode	CoCode is the company code number assigned to the insurer by the NAIC.
Comments	Comments are a list of statements regarding the filing.
Company	A company is an applicant or entity that is other than an individual.
Contact Name	The contact's name is the initial contact person at the state or jurisdiction of domicile. The state contact person is the department staff, usually an analyst, serving as the primary liaison between the applicant, and the domestic insurer.
Directors	Directors are the individuals who sit on the board of directors governing the applicant (company).
Domestic Insurer	The domestic insurer is the company being acquired or merged. The term insurer shall have the same meaning as set for within each U.S. jurisdiction's insurance code. Domestic insurer means an insurer domiciled in the respective state (e.g., a TX domestic insurer is licensed and domiciled in the state of Texas).
Domicile State Information	Domicile state or jurisdiction information is information regarding the initial contact person at the state or jurisdiction of domicile.
Entity	An entity is any person, company or organization related to the filing or having an interest in the filing. Entity types are as follows: applicant, affiliate, company, director, key party, officer, and shareholder.
Filing Number	The filing number is a tracking number assigned to a Form A filing only after the filing is saved by the Form A system.
Group Code	The group code is a unique three to five-digit number assigned by the NAIC to identify those companies that are part of a larger group of insurance.
"Independent Expert"	An impartial person who has no financial interest in either the assuming company or transferring company, has not been employed by or acted as a consultant or other independent contractor for either the assuming company or transferring company within the past twenty-four (24) months and is receiving no compensation in connection with the transaction governed by this regulation other than a fee premised on a fixed or hourly basis.

Draft: 10/1/2025

Risk-Focused Surveillance (E) Working Group
Virtual Meeting
October 1, 2025

The Risk-Focused Surveillance (E) Working Group of the Financial Condition (E) Committee met Oct. 1, 2025. The following Working Group members participated: Amy Malm, Chair (WI); Johanna Nickelson, Vice Chair (SD); Blase Abreo (AL); Kim Hudson (CA); Jack Broccoli (CT); Carolyn Morgan (FL); Daniel Mathis (IA); Casey Shaw (IL); Tom Travis (LA); Dmitriy Valekha (MD); Patrick Tess (MI); Shannon Schmoeger (MO); Monique D. Smith (NC); Jennifer Rose (NE); Paul Lupo (NJ); Mark McLeod (NY); Tracy Snow (OH); Eli Snowbarger (OK); Diana Sherman (PA); John Tudino (RI); Amy Garcia (TX); Jake Garn (UT); Greg Chew (VA); Karen Ducharme (VT); and Tarik Subbagh (WA).

1. Adopted Updated Salary Guidance for NAIC Handbooks

Malm stated that the primary agenda item for the call is to discuss the results of a salary analysis, which was conducted by NAIC staff to gather information needed to update recommended salary ranges published in NAIC handbooks. A survey of all state insurance departments was conducted earlier this year to generate the *Insurance Department Resources Report* published by the NAIC. This survey requested data on salaries paid to financial analysts and examiners.

NAIC staff were asked to aggregate and analyze the information received, which included adjusting the salary data for localized cost of living rates and then aggregating it to calculate national averages for the various positions studied. NAIC staff also gathered external market data for comparison against industry salaries, including banking regulators, public accounting, and corporate positions.

Once the survey results were aggregated and industry comparisons identified, NAIC staff met with Working Group leadership to develop proposed adjustments to the salary ranges. The goal in proposing adjustments was to both adjust the ranges for recent market movements and to align more closely with comparable industry and banking regulation positions. The existing pay rates were kept in mind so that the proposed ranges aren't unrealistic or out of reach for states.

Malm stated that in addition to the proposed adjustments to salary ranges, there is also a need to update the legacy, daily examination rates that are included in the NAIC's *Financial Condition Examiners Handbook,* as they are still utilized in certain states for compensation or exam billing purposes. Historically, the daily rates have been adjusted based on changes in the Consumer Price Index (CPI), year over year.

Travis Lenz (NAIC) provided an overview of the proposed salary range adjustments, noting that as the last adjustments were approved in 2023, the proposed adjustments represent two years' worth of adjustment. Lenz also stated that the staff recommendation for adjustments to the legacy daily rates was for an across-the-board 2.70% adjustment based on the annual change in the CPI.

Snowbarger made a motion, seconded by Valekha, to adopt the proposed salary range and daily rate adjustments for inclusion in NAIC handbooks (Attachment Six-A). The motion passed unanimously.

2. Received an Update on the Reciprocal Exchange Project

Malm stated that earlier this year the Working Group formed a Reciprocal Drafting Group to develop NAIC handbook guidance related to the solvency monitoring of reciprocal exchanges. During its initial meeting, the

Drafting Group identified some overarching legal issues related to the applicability of regulatory requirements to reciprocal exchange transactions. At issue is whether the Attorney-in-Fact (AIF) of a reciprocal exchange qualifies as an affiliate, which would require regulatory review and approval of service agreements and transactions to assess compliance with fairness and reasonableness standards.

This issue was referred to the Financial Condition (E) Committee to be addressed as it extends beyond the scope of this Working Group. At the 2025 Summer National Meeting, the Financial Condition (E) Committee voted to establish a new Reciprocal Exchange (E) Working Group to develop revisions to the NAIC's *Insurance Holding Company System Regulatory Act* (Model #440) ensuring that transactions between reciprocal exchanges and their AIFs are subject to fairness and reasonableness standards.

As the project includes a model law development proposal, it must first be approved by the NAIC Executive (EX) Committee before work commences. This is expected to occur at the 2025 Fall National Meeting. Once the project is approved and then ultimately completed, the Drafting Group is expected to reconvene to develop supporting handbook guidance and address other related issues.

Having no further business, the Risk-Focused Surveillance (E) Working Group adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/2025_1Spring/RFSWG/Surveillance WG 2-26-25 Minutes.docx

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

To: Risk-Focused Surveillance (E) Working Group

From: NAIC Staff

Date: September 10, 2025

RE: Recommended Increases to Financial Analyst and Examiner Salary Range Guidelines and Financial Examiner Per Diem Rates

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The Risk-Focused Surveillance (E) Working Group is charged with maintaining and updating salary range guidelines for financial analysts and financial examiners published in the *Financial Analysis Handbook* and *Financial Condition Examiners Handbook*, respectively. The Working Group expects to consider updates to the salary ranges every two years, with a salary survey conducted during 2025, and resulting recommendations to be considered for inclusion in the 2026 Handbooks. Additionally, as several states currently base examiner compensation on the salary and per diem guidelines contained in Section 1-II(D) of the *Financial Examiners Handbook,* the Working Group expects to update per diem rates annually. Suggested increases to the salary ranges and per-diem rates are included in this memo.

Salary Range Guidelines

In 2019 the Working Group adopted salary range guidelines that were developed in recognition of the importance of compensation, particularly as it relates to the ability of an Insurance Department to attract and retain well-qualified employees. These guidelines, which were first published in the 2020 editions of the Financial Analysis Handbook and Financial Condition Examiners Handbook, were based on an in-depth salary survey that collected and analyzed salary data for state insurance regulators, banking regulators, and other related positions in the financial services sector (e.g., internal and external auditors, etc.). The salary ranges recommended in this memo are based in part on the salary-only results of the 2025 Insurance Department Resources Report (IDRR) survey for financial regulatory positions.

Current compensation data were collected from 50 localities in a broad survey of Departments' compensation associated with the IDRR. Cost of living at or near each location was determined from the Council for Community and Economic Research (C2ER) Cost of Living Index for purposes of standardizing and aggregating the data for analysis. In 11 instances where data was unavailable for the department's location, data from nearby locales were used. When several nearby locales were available, their values were averaged. All salary data were then adjusted using these cost-of-living values to a national average. Locality-adjusted salary data were weighted by the number of reported positions at each Department.

To facilitate a comprehensive comparison when establishing recommended compensation ranges, data from multiple industry sources were gathered. Salary information for corporate internal audit and financial analyst positions was obtained from Robert Half for the same locations represented in the survey responses. Compensation figures for public accounting audit and assurance roles were also sourced from Robert Half, although equivalent data was not available for the Examiner-In-Charge (EIC)/Supervisor/Assistant Chief Examiner level. In addition, comparable salary data was obtained from two federal banking regulator organizations: The Office of the Comptroller of the Currency (OCC) and

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

the Federal Deposit Insurance Corporation (FDIC). Unfortunately, state banking data was insufficiently available for reliable comparison.

These data were then compared to determine the suggested new compensation range guidance in the Handbooks. Initial suggested values for the ranges were considered based on the weighted average and the weighted standard deviation from the survey data, then adjusted based on reported compensation for the comparable positions as many of the ranges lag behind their comparable industry and banking regulator values. These increases are calibrated by position to mitigate salary compression and address salary gaps in the more senior positions. Steps were taken to limit the number of departments positioned outside these updated ranges following the adjustment.

As noted in Handbook guidance, these values are intended to represent national, salary-only compensation ranges broadly applicable across all jurisdictions and based on a national average cost of living. Individual jurisdictions may need to adjust these ranges to their location's cost of living before comparison to their pay structure. In addition, the complexity of insurers in a specific state and/or the specialized knowledge and skills required to regulate them could impact the appropriateness of the range to a particular jurisdiction or position.

Please note that as the ranges were last adjusted in 2023 for publication in the 2024 NAIC Handbooks, the recommended increases to the ranges reflect a two-year adjustment period.

	Current Range		Proposed Range		Recommended Increase	
Positions	***Low***	***High***	***Low***	***High***	***Low***	***High***
Financial Analyst / Examiner	$ 52,000	$ 85,000	$ 58,000	$ 95,000	11.5%	11.8%
Sr Financial Analyst / Examiner	$ 64,500	$ 105,000	$ 77,000	$ 123,000	19.4%	17.1%
EIC / Supervisor / Asst Chief	$ 87,000	$ 150,000	$ 95,000	$ 165,000	9.2%	10.0%
Chief Analyst / Examiner	$ 100,000	$ 170,000	$ 115,000	$ 210,000	15.0%	23.5%

Daily Rate Guidelines

Adjustments to the per diem guidelines are largely based upon changes in the Consumer Price Index (CPI). The CPI, as defined by the U.S. Bureau of Labor Statistics (BLS), is a measure of the average change in prices of goods and services purchased by households over time. The CPI is based on prices of food, clothing, shelter, fuels, transportation fares, charges for doctors' and dentists' services, drugs, and other goods and services purchased for day-to-day living. In 2008, regulators determined that because the CPI takes into consideration most costs incurred by the average household, it is reasonable that an increase in salary should be within the same parameters as the increase in the cost of living.

The following data table shows the average annual salary increases adopted in the previous four years as compared to the CPI, as well as the proposed increase for the following year. The information "as published by BLS" compares the CPI as of July of each year, consistent with the analysis performed in

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

past years. As shown below, the rates suggested by the NAIC have been consistently comparable to those published by the BLS, regardless of method used.

	2021	2022	2023	2024	2025
As Published in the next *Financial Condition Examiners Handbook*	4.50%	8.50%	3.20%	2.90%	2.70%*
As Published by BLS	5.37%	8.52%	3.18%	2.89%	2.70%
Difference	-0.87%	-0.02%	0.02%	0.01%	0.00%

**Suggested Change*

Based upon the July 2025 CPI data, the estimated annual change in CPI is approximately 2.7%. As such, if the Committee intends to base salary increase on changes in the CPI, we recommend a 2.7% increase in all position classifications as shown below.

Classification	**2025 Daily Rates**	**Suggested Increase**	**2026 Daily Rates**
Insurance Company Examiner, AFE*	$407	2.70%	$418
Automated Examination Specialist, AFE (no AES**)	$500	2.70%	$514
Senior Insurance Examiner, CFE***	$500	2.70%	$514
Automated Examination Specialist, AES	$562	2.70%	$577
Automated Examination Specialist, CFE (no AES)	$562	2.70%	$577
Insurance Examiner In-Charge, CFE	$602	2.70%	$618
Supervising or Administrative Examiner	$638	2.70%	$655

*Accredited Financial Examiner

**Automated Examination Specialist

*** Certified Financial Examiner

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

TO: Robert Wake (ME), Chair, Mutual Recognition of Jurisdictions (E) Working Group
Monica Macaluso (CA), Vice Chair Mutual Recognition of Jurisdictions (E) Working Group

FROM: Jake Stultz, Manager II – Accounting Policy
Daniel Schelp, Chief Counsel, Regulatory Affairs

RE: 2025 Due Diligence Review of Qualified Jurisdictions & Reciprocal Jurisdictions

DATE: October 21, 2025

Executive Summary & Recommendation

The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. The Working Group will also perform a yearly review with respect to non-Covered Agreement Reciprocal Jurisdictions. In this regard, NAIC legal and financial regulatory services staff has performed a due diligence review of these jurisdictions, and has the following recommendations for the Working Group's consideration:

1. The following Qualified Jurisdictions should retain their status on the *NAIC List of Qualified Jurisdictions*:

   - Bermuda, Bermuda Monetary Authority (BMA)
   - France, Autorité de Contrôle Prudentiel et de Résolution (ACPR)
   - Germany, Federal Financial Supervisory Authority (BaFin)
   - Ireland, Central Bank of Ireland (Central Bank)
   - Japan, Financial Services Agency (FSA)
   - Switzerland, Financial Market Supervisory Authority (FINMA)
   - United Kingdom, Prudential Regulation Authority of the Bank of England (PRA)

2. The following non-Covered Agreement Reciprocal Jurisdictions should retain their status on the *NAIC List of Reciprocal Jurisdictions*:

   - Bermuda, Bermuda Monetary Authority (BMA)
   - Japan, Financial Services Agency (FSA)
   - Switzerland, Financial Market Supervisory Authority (FINMA)

Process for Periodic Evaluation after Initial Approval

The *Process for Evaluating Qualified and Reciprocal Jurisdictions* ("Process") provides a process for evaluating both Qualified and Reciprocal Jurisdictions after their initial approval. Pursuant to NAIC policy and procedure, the Working Group, with the assistance of NAIC staff, will perform a yearly review of Qualified Jurisdictions to assess whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions, and that this yearly review shall follow such abbreviated process as may be determined by the Working Group to be appropriate.

For this review, NAIC legal and financial regulatory services (NAIC staff) staff searched for any publicly available information that would potentially impact the jurisdictions' status as a Qualified Jurisdiction or as a Reciprocal Jurisdiction, including any changes to existing insurance and reinsurance laws and regulations in the jurisdictions. Next, NAIC staff researched whether a new Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), or any other externally produced documentation was available, including the Technical Note on Insurance Sector Supervision, and any other information regarding the laws, regulations, practices, and procedures applicable to the jurisdiction's reinsurance supervisory system. This research also included any public reports from ratings agencies and any other public information that was deemed to be relevant.

Except as otherwise noted in this memorandum, NAIC staff did not engage directly with the Qualified Jurisdictions or Reciprocal Jurisdictions and relied solely on publicly available information. Additionally, NAIC staff considered any information received (if any had been received) directly from state insurance regulators, interested parties or affected U.S. insurance companies that could potentially impact the status of the Qualified Jurisdictions or Reciprocal Jurisdictions.

Life Reinsurance Placed in Qualified or Reciprocal Jurisdictions

There have been several regulator-only discussions regarding the regulatory practices of insurance supervisors and systems from jurisdictions outside of the U.S. focusing on private equity owned life insurers' offshore reinsurance over the past several years. There have been ongoing discussions at the Macroprudential (E) Working Group, as well as other NAIC groups regarding the use of offshore reinsurance. NAIC staff does not believe that these activities rise to a level that would impact the status of any Qualified or Reciprocal Jurisdictions, but that it is appropriate that this issue be included in this discussion. NAIC staff will continue to closely monitor this issue and will provide any added information to the Working Group, as appropriate.

Additionally, the following projects have been completed or are in progress right now to further address these issues:

- Actuarial Guideline 55 (AG 55) introduced new considerations for managing asset-intensive reinsurance arrangements, requiring asset adequacy testing and reporting to ensure reserves remain sufficient under stress.
- AG 53 aims to enhance transparency and ensure the solvency and stability of insurers by increasing the understanding of risk, structures, and underlying economics of privately structured investments. It requires increased disclosures and sensitivity tests for High Net Yield (PHNY) assets, focusing on complex risks that are more difficult to model and quantify.

- Statutory Accounting Principles (E) Working Group has adopted several agenda items that intend to clarify the reporting of assets associated with modified coinsurance and funds withheld arrangements, which are common for offshore reinsurance.
- During the Summer of 2025, the Reinsurance (E) Task Force held two regulator-only educational sessions designed to enhance regulatory awareness regarding offshore reinsurance practices.

Jurisdictions with Ongoing Regulatory Changes

Bermuda

In early 2024, the Bermuda Monetary Authority implemented several enhancements to their regulatory regime. The changes have three main areas of focus: 1) updates to the calculation of the Bermuda Solvency Capital Requirement (BSCR), 2) the calculation of technical provisions (risk margin and scenario-based approach), and 3) updates to their supervisory regime (transaction approvals, liquidity risk management, supervision, reporting and disclosure). The reasons that the enhancements were implemented were to:

1. Respond to the shifts and trends observed in the long-term sector e.g., entry of private equity firms and alternative asset managers.
2. Enhance resilience of Bermuda (re)insurers e.g., through increased emphasis on stress testing considering the increasingly fluid operating and interest rate environment.
3. Tailor supervisory intensity to align with evolving risk profiles of long-term insurers e.g., increased appetite for non-traditional assets.
4. Enhance transparency through increased disclosures and cross-border bi-lateral engagements between the BMA and cedant regulators
5. Ensure the level of policyholder protection in Bermuda continues to be comparable with that in other competent jurisdictions e.g., the US and Europe.

NAIC staff are continuing to monitor the implementation of these changes. Feedback so far from the BMA has been positive, but NAIC staff has requested data on the impact of these revisions, and we plan to provide that to the members of the Working Group once we have it. In addition, Fitch Ratings noted that the reforms have strengthened capital requirements, supervision, and risk assessment, supporting market stability and transparency. The changes have led to increased pricing, fees, and higher required capital, which may influence some insurers' preferences for regulatory regimes. However, the majority are expected to remain in Bermuda due to its robust regulatory framework and continued Solvency II equivalence and NAIC Reciprocal Jurisdiction status.

United Kingdom

In November 2022, the UK announced that they are moving away from Solvency II to a similar framework to be called Solvency UK. During 2023, there were two consultation papers issued by the Bank of England, each of which further details the upcoming changes. The expected changes are wide ranging and include matching adjustment reform (MA is a mechanism that allows insurers to recognize, upfront as capital resources, a proportion of the investment return, in excess of the risk-free rate, that they project to earn over the future lifetime on the assets matching their MA liabilities), changes to the way stress testing is performed, and a number of other minor changes that are intended to promote economic growth. The UK is subject to a covered agreement, so there is no

action that needs to be taken at this time, but NAIC staff will monitor the changes and implementation of these reforms over the next year.

Japan

In June 2022, the Japan Financial Services Agency (FSA) announced its intention to reform its solvency regulation framework, effective April 1, 2025. The overall intent of these reforms is to make Japan's regulatory regime more similar to the Insurance Capital Standards of the International Association of Insurance Supervisors (IAIS) and Solvency II. The primary change will be to the methodology for calculating the solvency margin ratio for Japanese insurers, moving from a factor-based approach to one that assesses assets and liabilities on an economic value basis. NAIC staff will monitor the changes and implementation of these reforms over the next year.

NAIC Staff Overall Findings

Upon review of all publicly available information, NAIC staff has reached the conclusion that the reinsurance supervisory systems of the seven Qualified Jurisdictions listed above continue to achieve a level of effectiveness in financial solvency and reinsurance regulation for purposes of reinsurance collateral reduction, that their demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with their respective reinsurance supervisory systems, and that their laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Model Law and Regulation. NAIC staff have reached similar conclusions with respect to the three Reciprocal Jurisdictions listed above that are not subject to an in-force Covered Agreement.

Therefore, it is the recommendation of NAIC staff that the above listed jurisdictions continue to qualify for inclusion on the *NAIC List of Qualified Jurisdictions* and the *NAIC List of Reciprocal Jurisdictions*.

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

TO: Robert Wake (ME), Chair, Mutual Recognition of Jurisdictions (E) Working Group
Monica Macaluso (CA), Vice Chair Mutual Recognition of Jurisdictions (E) Working Group

FROM: Jake Stultz, Manager II – Accounting Policy
Daniel Schelp, Chief Counsel, Regulatory Affairs

RE: 2025 Due Diligence Review of GCC Recognize and Accept Jurisdictions

DATE: October 21, 2025

Executive Summary & Recommendation

The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation* ("GCC") to determine whether there have been any significant changes over the prior year that might affect inclusion on the List. In this regard, NAIC legal and financial regulatory services staff have performed a due diligence review of these jurisdictions, and have the following recommendations for the Working Group's consideration:

1. Effective December 18, 2024, the NAIC determined that the Canadian Office of the Superintendent of Financial Institutions (OSFI) (i.e., all Canadian Provinces except for Quebec) met the criteria set forth for inclusion on the List under the NAIC *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation*. The OSFI joined those Reciprocal Jurisdictions on the List as identified under Section 4L(2)(c) of the NAIC *Insurance Holding Company System Regulatory Act* (#440); i.e., European Union member states, United Kingdom, Bermuda, Japan, and Switzerland.

2. For this due diligence review, NAIC legal and financial regulatory services staff searched for any publicly available information that would potentially impact the jurisdictions' status as a GCC Recognize and Accept Jurisdiction, including any changes to existing insurance laws and regulations in the jurisdictions. Additionally, NAIC staff considered any information received (if any had been received) directly from state insurance regulators, interested parties or affected U.S. insurance companies that could potentially impact the status of GCC Recognize and Accept Jurisdictions.

3. Upon review of all available information, NAIC staff has reached the conclusion that the above listed jurisdictions continue to meet the criteria to be included on the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation,* and further recommend that they retain their status on this List.

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Kansas City 1100 Walnut Street, Suite 1000, Kansas City, MO 64106-2197 p | 816 842 3600
New York One New York Plaza, Suite 4210, New York, NY 10004 p | 212 398 9000
www.naic.org

Structural Proposal – Life RBC Only

Late 2025/Early 2026
Identification of comparable attributes completed.

Feb/Mar 2026
Structural proposal should be exposed by WG by Spring National Meeting.

April 2026
Comments received. Proposal adopted by WG no later than April 30.

May 2026
Adoption of the proposal by CADTF no later than May 15.

2026 Summer National Meeting
Consider adoption by E Committee.

Factor Proposal – Life RBC Only

Late 2025/ Early 2026
Identification of comparable attributes completed.

Q1 2026
Academy to work on Model modifications as requested by regulators, if any.

April 2026
Propose factors to be exposed by WG no later than April 30.

May/June 2026
Comments received. Adoption of proposal by WG no later than June 15.

June 2026
Adoption by CADTF no later than June 30.*

June/July 2026
Expose SSG CLO Model.[i]

2026 Summer National Meeting
Consider adoption by E Committee.

* Only the Task Force may extend the June 30th adoption deadline for previously considered proposals upon a two-thirds consent of the TF members present where such extension can be no later than July 30th of the current year.

[i] Will be considered if LRBC Methodology is delayed.

Non-Life RBC Consideration

1. **Early/Mid-2026 (Once Life RBC has a set path)**
   - Referral by RBCIREWG to respective WGs (PCRBCWG & HRBCWG).
   - WGs to discuss whether changes to respective non-life RBC framework is warranted.
   - Engage PC and Health Academy.

2. If changes are warranted, follow Life RBC timeline but different adoption year. (see #4 below. Can consider early adopt structural changes to facilitate impact analysis)

3. Separate discussions and proposals for Health and P/C.

4. P/C and Health RBCWG traditionally expose referrals received. Exposure of a referral for at least 30 days puts P/C and Health in a position that a 2026 adoption is not attainable, especially in view of the need to involve P/C and Health Academy for additional analysis. A 2027 effective year is more realistic.

Restructuring Mechanisms

An NAIC White Paper

December 11, 2025

Created by the

Restructuring Mechanisms (E) Working Group

of the

Financial Condition (E) Committee

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Table of Contents

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

A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period resulting in obligations for insurers that need to be reserved for to ensure payment of claims when they come due. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer's business model and left to pay its claims as they come due over time. For some insurance companies, run-off business remains embedded with the core business without the ability to segregate the run-off business. There are even run-off specialists that have developed within the insurance industry that specialize in handling these old blocks of business. It should be noted that the term 'run-off' can be defined in different ways. For example, it is sometimes used to refer to policies with 'tail' liabilities but no further premium collections, but in some lines of business, such as long-term care, companies will continue to collect renewal premium on run-off books of business. However, a formal definition that can be strictly applied for legal or accounting purposes is not necessary for purposes of this white paper.

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

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

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality including but not limited to run-off. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD"). Several states, including Arizona, Arkansas,

Georgia, Illinois, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes[1] while other states such as Arizona, Arkansas, Colorado, Connecticut, Georgia, Illinois, Iowa, Michigan, and Pennsylvania, have enacted CD statutes. The stated intent of these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will begin with some historical background from the United Kingdom ("UK") to provide historical context and explain some of the inspiration for the US laws. Then this white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the UK are seen as a model that can be used in as a starting point for states developing their own IBT frameworks, the U.K. procedures are discussed in Section 2 of this white paper.

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

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

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group's ("Working Group") discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to run-off insurance risks to improve the efficient allocation of capital and management resources to run-off and on-going insurance operations. Company efficiencies that are obtained through restructuring transactions include the segregation and transfer of run-off books of business with the intent to free up capital, although it should be noted that if not done properly, it can reduce policyholder protection, at least from the perspective of some regulators. Restructuring transactions also create other company efficiencies, such as better allocation of specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalization and facilitate the run-off of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of run-off books of business reduces volatility and improves capital efficiency with benefits for reinsurers and policyholders of both run-off and on-going books of business. Furthermore, run-off experts bring focused expertise to managing run-offs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Run-off business can be both a distraction to management's focus as well as redirect regulatory focus away from the insurer's ongoing business. The isolation of such business from on-going business

[1] Although these statutes are generally available to restructure both run-off and on-going operations, to date IBTs have been used only for run-off transfers. The Rhode Island law limits IBTs, by statute, to defined types of run-off.

enhances the visibility of those run-off operations as well as the supervision of run-off operations, by both regulators and the insurer[2].

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

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

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

[2] As mentioned above, IBTs and CDs need not be limited to run-off transfers. Part VII transfers in the UK and CDs in the US have been used for on-going business. CD's can be used as the functional equivalent of a transfer by creating two (or more) new companies, one of which (corresponding to the transferor) retains the dividing company's active business, while the other (corresponding to the transferee) retains a closed block and goes into runoff or remains ongoing. Section 3.B discusses CDs of this type in Pennsylvania and Illinois. However, CDs can also be used for other purposes, to separate two or more ongoing business units which can then go their separate ways.

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

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

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

the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulatory Concerns with Restructuring Plans

While restructuring may provide value to the insurer, some regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that could provide less capital than is needed to satisfy the insurer's obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to approve the restructuring plan. Regulators have utilized procedures to ensure the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

Section 2: History of Restructuring in the United Kingdom

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

Restructuring laws and regulations are relatively new in the US, legal mechanisms for the transfer of insurance business has been implemented and operational a number of major insurance jurisdictions for many years, including the UK (since 1982), Australia (since 1973 for general insurance and 1995 for life insurance), the EU and Switzerland (since 2008) and Singapore (since 2000). The current UK regime is based on Part VII of the Financial Services and Markets Act of 2000 ("Part VII" and "FSMA), which replaced an earlier regime set out in the Insurance Companies Act 1982. The Part VII of the Financial Services and Markets Act of 2000[6] ("Part VII" and "FSMA") enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 300[7] successful Part VII transfers have taken place in the UK without any unplanned insolvencies, guidance is provided to American insurers on how this process could continue to unfold in the US. (See further discussion of a planned solvent run-off/ insolvency in the section on Impact of UK Part VII Transactions in the US.)

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

In accordance with the FSMA, the Prudential Regulatory Authority ("PRA") and the Financial Conduct Authority ("FCA") maintain a Memorandum of Understanding which describes each regulator's role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. In general, the PRA is focused on solvency regulation while the FCA is focused on market conduct regulation. Under

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[6] Financial Services and Markets Act of 2000, 48 Eliz. 2, part VII (Eng.). Financial Services and Markets Act of 2000, part VII (Eng.), https://www.legislation.gov.uk/ukpga/2000/8/contents .

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

the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

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

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

Part VII transfers require a "scheme report." A similar report is required under US IBT laws, but states do not use the word "scheme" because it has negative connotations in U.S. English. Under section 109(2) of FSMA, the scheme report may only be made by an independent expert who:

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

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

(a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and

(b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

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

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

During the Working Group's discussion of the Part VII transfers, consumer representatives raised the UK court's decision in *In re Prudential and Rothesay*[8], which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA

[8] As noted by Birny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. The decision denying the Part VII Transfer is available online here: https://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Ch/2019/2245.html. Note this decision was overturned by The Prudential Assurance Company Limited v. Rothesay Life PLC [2020] EWCA Civ 1626.

appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as objections. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeal[9] found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeal stated:

(1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.

(2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries' capital.

(3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.[10]

Ultimately, the UK High Court of Justice approved the Part VII transfer between Prudential and Rothesay in a judgment dated November 24, 2021,[11] Despite this series of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement (or commutation plans) are another method of to resolve insurer liabilities within the UK, other Commonwealth countries and Rhode Island[12]. Solvent schemes are distinct from a Part VII transfer. These solvent schemes are primarily designed as a procedure to allow an insurer

[9] *Prudential Assurance Company Ltd and Rothesay Life Plc, Re*, England and Wales Court of Appeal (Civil Division)(Dec. 2, 2020). That appeal court decision is available online here: https://www.judiciary.uk/wp-content/uploads/2020/12/Prudential-Judgment.pdf.

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

[11] [2021] EWHC 3152 (Ch). Available online at https://www.bailii.org/ew/cases/EWHC/Ch/2021/3152.html

[12] Rhode Island adopted a law in 2002 that allowed the department and then the RI Superior Court to approve a commutation plan. R.I. Gen. Laws Chapter 27-14.5. There has been one transaction where a commutation plan was proposed and approved by the RI Superior court in 2010. *See*, In re GTE Reinsurance Co., No. PB 10-3777, 2011 WL 7144917 (R.I. Super. Ct. Apr. 25, 2011). That decision denied a constitutional challenge to the state statute authorizing the commutation plan.

to settle all liabilities through a court supervised mandatory commutation. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of being transferred. While such an arrangement may provide some of the same features as a Part VII transfer, solvent schemes do not continue the coverage with a new insurer the way a Part VII transfer does. Instead, the coverage is typically terminated in exchange for a sum of money being paid by the insurer to the insured. Other differences exist in law but this is the most significant for purposes of this white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. One type of restructuring law generally follows the UK structure, Rhode Island was the first state to take this approach adopting a statute in 2002 titled Voluntary Restructuring of Solvent Insurers[11] patterned after Solvent Schemes of Arrangements ("Solvent Schemes"). Rhode Island refers to this process as a "Commutation Plan." Another type of restructuring modeled after UK law is an Insurance Business Transfer or IBT, which is modeled after a Part VII transfer in the UK. A third type of restructuring we will discuss is called a Corporate Division ("CD") generally follows longstanding corporate law and is akin to a reverse merger.

Commutation Plans under Rhode Island law differ from Solvent Schemes in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.[13]

Although Commutation Plans continue to be available in Rhode Island. In 2015 Rhode Island became the first state to provide for Insurance Business Transfer Plans.[13] Similar to the Part VII transfers, but , in contrast to the UK, the Rhode Island regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments received continues to believe that it meets the statutory requirement, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

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

In 2018, Oklahoma adopted the Insurance Business Transfer Act[15]modeled after UK's Part VII regulation with a few significant differences. The differences include no restriction on the type of insurance

[13] In re GTE Reinsurance Co., No. PB 10-3777, 2011 WL 7144917, at *5–6 (R.I. Super. Ct. Apr. 25, 2011) [13] 230 RICR 20-45-6.

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

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

nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed three IBTs in October 2020, September 2021, and September 2023 involving a Rhode Island, Wisconsin, and Missouri insurer respectively which are described below. None of the plans was challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act[16] which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is made for an extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report.

One of the earlier CD statutes was adopted in Pennsylvania.[17] That statute is not within the Pennsylvania insurance statutory title, but rather is part of their general corporate law title. That law creates a CD and allows that the CD be transacted with or without the approval of all "interest holders." And as discussed later, having a mechanism not requiring all "interest holders" approving is important from a commercial point of view.

In 2017, Connecticut adopted a statute titled "An Act Authorizing Domestic Insurers to Divide,"[18] that authorized the Connecticut Division of Insurance to approve CD plans. This statute creates a lane for insurers to file CD plans with the Connecticut DOI to divide itself into two or more companies, with the resulting insurers segregating the assets and liabilities, including insurance policies, of the initial insurer as detailed in their plan of division. While the Connecticut CD law may allow interested parties to offer their opinion of the transaction as part of a public hearing, the Commissioner of Insurance makes the ultimate decision on the plan.

In 2018, Illinois adopted a statute titled "the Domestic Stock Company Division Law (SB1737)"[19] that allowed the Director of the Illinois Department of Insurance to approve a CD for Illinois domestic insurers once specific requirements are satisfied this was amended in 2023 (SB 762).

The National Council of Insurance Legislators (NCOIL) has promulgated a model IBT law[20] modeled after the Oklahoma IBT statutes, as well as a model CD law[21]. A number of states have adopted CD statutes, whether specific to insurance or based on the state's general power over corporations. Those states include Arizona, Colorado, Connecticut, Georgia, Illinois, Iowa, Michigan, Arkansas, and

[16] As announced by the Arkansas Department of Insurance July 8, 2021, ACA §§ 23-69-501, *et seq*. (See Arkansas statute at https://www.arkleg.state.ar.us/Bills/Detail?id=SB203&ddBienniumSession=2021%2F2021R
[17] 15 PA. CONS. STAT. §§ 361–368 (2017).
[18] Connecticut Public Act No. 17-2, available at: https://www.cga.ct.gov/2017/act/pa/2017PA-00002-R00HB-07025-PA.htm [cga.ct.gov].
[19] Illinois Public Act 100-1118. Available at https://www.ilga.gov/legislation/publicacts/100/100-1118.htm.
[20] Insurance Business Transfer Model Act (Nat'l Council of Ins. Legislators 2020). Since the adoption of the NCOIL Model some states have used aspects of that model in their legislation.
[21] Insurer Division Model Act (Nat'l Council of Ins. Legislators 2021).

Pennsylvania[22]. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

A. Similarities and Differences between Statutes

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

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

The Illinois' Domestic Stock Company Division Law[23] requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless at least one of the following disqualifying factors is found:

(1) policyholder/shareholder interest are not protected;

(2) the resulting insurer would not be eligible to receive a license in the same state as the dividing insurer;

(3) division violates the Uniform Fraudulent Transfer Act;

(4) division is made for the purpose of hindering, delaying, or defrauding other creditors;

(5) any of the companies is insolvent after the division is complete.

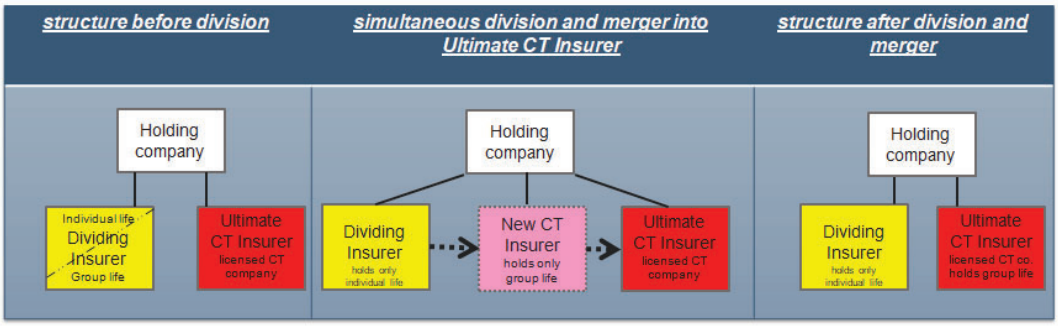
The Connecticut CD statute[24] creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the dividing insurer; (2) the names of the resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the

[22] See A.R.S. §§ 29-2601, *et seq*.; C.G.S.A §§ 38a-146, *et seq*.; 215 ILCS 5/35B-1 *et seq*.; M.C.L.A. §§ 500.5500 *et seq*; A.C.A. §§ 23-69-501, *et seq*.; 15 Pa.C.S. §§ 361 *et seq*.
[23] 215 ILL. COMP. STAT. 5 as found at https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1249&ChapterID=22.
[24] C.G.S.A §§ 38a-146, *et seq*., Public Act No. 17-2.

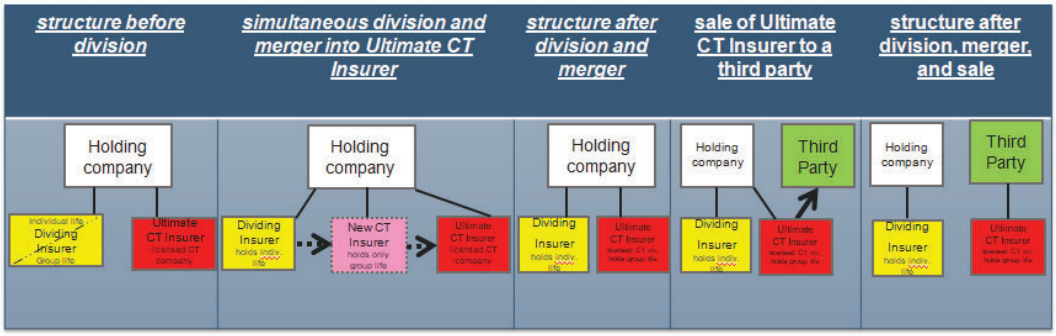
manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department, which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if it is in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing. The Connecticut Division's Law only applies to Connecticut domestics (i.e., both the dividing insurer(s) and ultimate resulting insurers must be Connecticut domestics). In addition, all insurance lines, whether active or closed block, may submit a plan of division under the statute.

Compliant with Connecticut's insurance division law, there are three ways by which a Connecticut domestic insurer may effectuate a corporate division. Please see the descriptions below which include illustrations of a hypothetical dividing insurer writing both individual and group life insurance. In this hypothetical, insurer intends to divide the group life business:

- **Division and Simultaneous Merger into an affiliated CT insurer.** In a division, one company is divided into two or more resulting companies and assets and liabilities are allocated to the resulting company as a corporate law successor to the dividing company. The division itself does not allow the resulting companies to leave the ownership group. The resulting company stays within the same insurance group but in a separate legal entity. It may potentially be used to set up a company for future sale.



- **Division and Simultaneous Merger into an affiliated CT insurer followed by a 3rd party's acquisition of the CT insurer.** This would be a two-step process. A division with a simultaneous merger are effectuated following the process outlined in the prior example. However, in this example the division and simultaneous merger are followed by a subsequent sale of the resulting insurer and Change in Control Application (Form A). This sale of the resulting company may occur soon after the division or at some eventual future date.



- **Division and Simultaneous Merger into an Unaffiliated CT insurer.** This structure is similar to the prior example in that the resulting insurer ends up with an unaffiliated insurer. However, in this structure the transactions are all part of the same filing and proceeding. The insurer is divided into two or more resulting companies and a simultaneous merger of the resulting company into a company owned by the third party, the unaffiliated CT domestic insurer.

The Pennsylvania CD statute[25] was enacted in 1990 and is discussed in the NAIC 1997 white paper on Liability-Based Restructuring, attached to this paper as an appendix. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the state's equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

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

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because with the exception of Colorado and Iowa, the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal expertise. The processes set forth in the CD laws are not modeled after UK Part VII Transfers, but are instead modeled after existing US laws dealing with corporate restructuring and insurance laws dealing with change of control, mergers, and demutualizations.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in 1995, when the Pennsylvania Insurance Department approved a division of the Cigna Corporation, which is commonly referred to as the "Brandywine transaction," after the name of one of the resulting insurers.

[25] 15 PA. CONS. STAT. §§ 361 *et seq*.

This transaction is discussed in more detail within Appendix 1 of the 1997 Liability-Based Restructuring White Paper, but having been approved, ultimately resulted in the proposed business within the transaction to be transferred to another insurance group.

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

In 2011, GTE Re[26] completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision[27] on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company's ("PWIC") IBT plan.[28] The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company ("Sentry"), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for approval.[29] This IBT transferred a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2021. The dividing companies were eight Illinois-domiciled insurance subsidiaries of a corporation that transacted, among other business, automobile insurance in Michigan. The dividing companies allocated certain portions of the automobile insurance business written by the dividing companies in Michigan – namely their inactive policies with outstanding claim reserve – to eight new insurance companies created in the divisions. The eight new insurance companies were then simultaneously merged into three previously established Illinois-domiciled insurance companies that became the surviving companies of the mergers. The surviving companies of the mergers are Illinois-domiciled insurance companies licensed to conduct business in Illinois and Michigan.

[26] C.A. No. PB 10-3777 (R.I. Super. Apr. 25, 2011).
[27] State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777 available at https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/decisions/10-3777.pdf.
[28] Judgment & Order of Approval & Implementation of the IBT Plan, In re Transfer and Novation of Insurance Policies from Province Wash. Ins. Co., et al., CJ-2019-6689 (D.Ct. Okla. Cnty Oct. 15, 2020), available at https://www.oscn.net/dockets/GetCaseInformation.aspx?db=oklahoma&number=CJ-2019-6689&cmid=3831864.
[29] Approval Order in Case No. 20-0582-IBT from Oklahoma Insurance Commissioner, filed on November 23, 2020, at https://www.oid.ok.gov/wp-content/uploads/2020/11/20-0582-IBT-SAW-Order-11-23-20.pdf.

The Illinois Department utilized a website to make their process transparent, [30] and it includes a report from their Hearing Officer, [31] as well as an Order approving the CD in March 2021.[32]

Section 4: Impact of IBTs and CDs on Claimants

A. Guaranty Association Issues

In order to prevent restructuring from materially adversely affecting consumers, it is essential to ensure that guaranty association coverage is not reduced or eliminated or otherwise changed by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine guaranty association coverage. It is possible that a corporate restructuring could result in the reduction, elimination or change in guaranty association coverage provided in the event of the restructured insurer's insolvency if steps are not taken to prevent that result. The potential coverage issues are different for life and health guaranty association coverage and property and casualty guaranty association coverage. We address them separately below:

Transactions Involving Life or Health Insurance

The Working Group received input from the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA") about the concerns for insurance consumers with life and health insurance coverage.

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

(1) The consumer seeking protection must be an eligible person under the guaranty association statute; typically, this is achieved by being a resident of the guaranty association's state at the time of the insurer's liquidation;

(2) The product must be a covered policy; and

(3) The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state or have been licensed in the state to write the lines of business covered by the guaranty association.

In most states, coverage can also be provided for an "orphan" policyholder of the insurer by the guaranty association in the insolvent insurer's domestic state. Orphan policyholders are policyholders who are residents of states where the guaranty association cannot provide coverage because the insolvent insurer

[30] https://idoi.illinois.gov/consumers/company-divisions.html.
[31] The Hearing Officer's report is available online at: https://idoi.illinois.gov/content/dam/soi/en/web/insurance/consumers/documents/allstate-division-doiho-report-only3-29-21.pdf.
[32] For more on the Illinois transaction, FORC has published an article on the topic, available at: https://www.forc.org/Public/Journals/2021/Articles/Summer/Vol32Ed2Article5.aspx.

is not a member insurer due to not being licensed at the time required by the guaranty association act. The orphan policyholder situation can arise when a policyholder purchases a policy in a state where the issuing company is licensed (i.e., is a member of the guaranty association) but subsequently moves to a state where the issuing insurance company was never licensed (i.e., is not a member of the guaranty association). The provision in the NAIC Life and Health Insurance Guaranty Association Model Act, and the laws of most states, that provides that orphan policies are covered by the guaranty association in the insolvent insurer's domestic state is designed to plug the gap in these rare situations.

A key factor when considering a life or health IBT or CD transaction is whether the resulting insurer is or will be a member insurer of the same guaranty associations where the transferring insurer was a member insurer. If the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer, guaranty association coverage will be preserved and not changed for all policyholders. (Of course, specific guaranty association coverage will be determined if/when the resulting insurer is placed under an order of liquidation with a finding of insolvency.) If the resulting insurer is not a member insurer of the same guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or be covered as orphans by the guaranty association in the insurer's domestic state. Orphan coverage was not designed to plug the gap in this situation. Shifting the coverage obligation to the domestic state guaranty association could result in guaranty association coverage being concentrated in that state.

To address these concerns with respect to IBT and CD transactions involving life or health insurance, NOLHGA advises that restructuring statutes (or regulators reviewing proposed restructuring transactions) clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

Transactions Involving Property and Casualty Insurance

The Working Group received input from the National Conference of Insurance Guaranty Funds ("NCIGF") about the concerns arising out of property and casualty insurance restructurings.

The NAIC Property and Casualty Insurance Guaranty Association Model Act (Model # 540)[33] does not have any specific provisions addressing orphan policies.[34] Consequently, a concern was raised that guaranty association coverage might not be provided if policies are transferred to a nonmember insurer. The existence of coverage could hinge on how a particular state's law was worded and how the courts interpreted that language. The comments noted that many property and casualty guaranty association statutes required that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred.

NCIGF's position was that where there was guaranty association coverage before the IBT or CD, state regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not impact guaranty association coverage in any way, neither by reducing or eliminating in nor by creating or expanding it (for example, when an IBT involved surplus lines business). It was also noted that the same membership and timing issues that are raised by IBTs could also be raised in the case of any other policy novation, including the assumption reinsurance transactions discussed below. In response to these concerns,

[33] Available at https://content.naic.org/sites/default/files/model-law-540.pdf

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

the NAIC amended Model #540 in 2023, expanding the definition of "Covered Claim." However, as with any other model law, these changes will not have any effect until they are adopted by the respective state legislatures.

B. Assumption Reinsurance Model Act and Other Affirmative Consent Requirements

Assumption Reinsurance Model Act

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholder with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, in situations where the solvency of the insurer might be at risk. There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.[35] Under the Model Act, individual policyholders are notified of a proposed transfer of their policy and "have the right to reject the transfer and novation of their contracts of insurance."

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes[36], individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be effectuated. When a new agreement replaces an existing agreement, a novation occurs. There is no judicial involvement under the Assumption Reinsurance Model Act.

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

This is not an issue that can be resolved in this white paper, and may ultimately be decided by a court after an IBT or CD is approved over a state or policyholder's objection. But the issue has not yet been addressed by any court nor raised in the proceedings on restructurings.

Virginia Law Requiring Affirmative Consent Requirements

A state may also require such consent through independent anti-novation statutes or the application of common law principles. For example, in one state, the principle of policyholder consent is codified in the insurance code.[37] This state's code prohibits the assumption of policy obligations on risks located in

[35] Available at https://content.naic.org/sites/default/files/inline-files/MDL-803.pdf.
[36] There is an open question about whether assumption reinsurance statutues may provide an exclusive mechanism to transfer blocks of business. Policyholders in an assumption reinsurance transaction, must give at least implied consent, but what happens when the laws of different states are in conflict is an open question.

[37] See Virginia Code at § 38.2-136.

the state as direct obligations unless (1) the policyholder consents and (2) the assuming insurer is properly licensed in the state. Absent policyholder consent, such a transaction requires an order from the Virginia State Corporation Commission (hereafter referred to as the Commission) approving the transaction. The Commission may enter such an order whenever (i) the Commission finds a licensed insurer to be impaired or in hazardous financial condition, (ii) a delinquency proceeding has been instituted against the licensed insurer for the purpose of conserving, rehabilitating, or liquidating the insurer, or (iii) the Commission finds, after giving the insurer notice and an opportunity to be heard, that the transfer of the contracts is in the best interests of the policyholders. Additionally, if granting an approval order, the Commission is required to ensure that policyholders do not lose any rights or claims afforded under their original policies by the state Property and Casualty Insurance Guaranty Association or the state Life, Accident and Sickness Insurance Guaranty Association.

The Virginia State Corporation Commission, of which the Bureau of Insurance is part, acts as a court of record. It applied Virginia's anti-novation statute to the previously mentioned PWIC/Yosemite IBT. In that particular case, the transferred business, included a number of Virginia workers' compensation policies. As such, the Bureau informed PWIC and Yosemite that the IBT—as to the Virginia policies—required policyholder consent under § 38.2-136 (B) of the Code of Virginia because it involved the cessation or assumption of policy obligations on risks located in Virginia. In response, PWIC and Yosemite requested that the Commission waive the policyholder consent requirement by finding that the transfer of the Virginia policies was in the best interests of the policyholders pursuant to § 38.2-136 (C)(iii) of the Code of Virginia. The Commission entered an Order Approving Application finding that the transfer of Virginia policies was subject to the requirements of § 38.2-136 (B) of the Code of Virginia (i.e. policyholder consent and proper licensure), but approved the transfer pursuant to § 38.2-136 (C)(iii) of the Code of Virginia finding the transfer to be in the best interests of the policyholders.

Therefore, it should be clear to all states, that when considering an IBT or CD involving Virginia policyholders, absent policyholder consent, the Commission must find the transfer of Virginia policies to be "in the best interests of the policyholders" in accordance with § 38.2-136 (C)(iii) of the Code of Virginia. If this is not found, the transfer will not apply to Virginia policyholders.

C. Separate Issues in Long-Term Care

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

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

That being said, there should be increased scrutiny for any block transfers, not just those relating to long-term care insurance, that are currently in a projected deficit situation.

It is important to note that all of these concerns exist whenever there is an entity involved in the restructuring plan that has potentially troubled policies, including (but not limited to) long-term care insurance. It does not matter whether the potentially troubled policies are to be transferred to a new entity or are to remain in the current entity that will no longer contain the transferred policies (and corresponding assets that may have provided additional financial protection to the troubled block). Creating monoline LTC entities through restructuring mechanisms may result in significant long term solvency risk.

Section 5: Legal Impacts of IBT and CD Laws

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

As previously discussed by others,[38] a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. Article IV of the US Constitution included both the Full Faith and Credit Clause and the Privileges and Immunities Clause, and separately courts have been known to honor decisions from other courts through a doctrine of Comity. These represent three methods that insurers might rely on to extend the legal and practical effect of a restructuring mechanism beyond the state that issued the initial decision or judgment, and can make the restructuring transaction effective in all other states in which the insurer does business.

As the highest court in the land, the US Supreme Court has addressed the Full Faith and Credit clause in the US Constitution. The Court wrote "a final judgment in one State, if rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, qualifies for recognition throughout the land. For claim and issue preclusion (res judicata) purposes, in other words, the judgment of the rendering State gains nationwide force."[39] However, that mandate is not absolute, as the Court also has written that "[t]he Full Faith and Credit Clause does not compel "a state to substitute the statutes of other states for its own statutes dealing with a subject matter concerning which it is competent to legislate."[40] The determination of whether a court will provide full faith and credit will likely rely upon the issues raised and considered by the Court or the regulator issuing a decision approving a restructuring plan. If a policyholder wishes to challenge a restructuring plan based on the full faith and credit clause, they must first identify the property or right of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to a new insurer in a restructuring plan without alleging additional harm may have difficulty identifying the property interest of which they have been deprived.

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

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

[39] Baker by Thomas v. Gen. Motors Corp., 522 U.S. 222, 232–33 (1998)

[40] Id. at 232-3

more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

While full faith and credit is used to apply the judgment of one state's action in another state, the Privileges and Immunities Clause guarantees "that in any State every citizen of any other State is to have the same privileges and immunities which the citizens of that State enjoy."[41] This means that the Clause imposes a direct restraint on state action in the interests of interstate harmony.[42] This protection provides that citizens of one state should not be discriminated against by another state, such as through the approval of a restructuring plan. However, in applying those protections, the US Supreme Court has first applied a threshold test of whether the out-of-state application of the Privileges and Immunities Clause to a particular instance of discrimination against out-of-state residents entails a two-step inquiry. As an initial matter, the court must decide whether the ordinance burdens one of those privileges and immunities protected by the Clause. Baldwin v. Montana Fish and Game Comm'n, 436 U.S. 371, 383, 98 S.Ct. 1852, 1860, 56 L.Ed.2d 354 (1978). Not all forms of discrimination against citizens of other States are constitutionally suspect. United Bldg. & Const. Trades Council of Camden Cty. & Vicinity v. Mayor & Council of City of Camden, 465 U.S. 208, 218, 104 S. Ct. 1020, 1027, 79 L. Ed. 2d 249 (1984)

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

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers and insureds have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK.[43] This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis,[44] while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. *Narragansett Electric Co. v. American Home Assurance Co.* is one such case.[45] In *Narragansett Electric Co.*, the court reviewed claims by a London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier. Equitas had assumed a block of business from Lloyd's of London in a Part VII transfer, but argued that it had not assumed the obligations at issue. As the court summarized, "Equitas's motion to dismiss raises the question whether this transfer

[41] Baldwin v. Fish & Game Comm'n of Mont., 436 U.S. 371, 382 (1978)
[42] United Bldg. & Const. Trades Council of Camden Cty. & Vicinity v. Mayor & Council of City of Camden, 465 U.S. 208, 220 (1984).
[43] *See* SIDLEY AUSTIN LLP, PART VII TRANSFERS EFFECTUATED PURSUANT TO THE UK FINANCIAL SERVICES AND MARKETS ACT 2000 (2017), https://www.sidley.com/-/media/publications/part-vii-transfers.pdf.
[44] *See* Jennifer D. Morton, Note, *Recognition of Cross-Border Insolvency Proceedings: An Evaluation of Solvent Schemes of Arrangement and Part VII Transfers under U.S. Chapter 15*, 29 FORDHAM INT'L L.J. 1312, 1314–15 (2006).
[45] *See* Narragansett Elec. Co. v. Am. Home Assur. Co., No. 11 Civ. 8299(PKC), 2012 WL 4075171 (S.D.N.Y. Sept. 12, 2012). There, a claim originated in Pawtucket, Rhode Island, but involved waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co*., 57 N.E.3d 18, 24 (Mass. App. Ct. 2016).

of insurance obligations from Lloyd's to Equitas is effective and enforceable under U.S. law." First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent to US policyholders raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a UK's independent expert's report.[46] Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. *Allianz* is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. *Allianz* also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

Allianz involved a dispute over liabilities incurred by General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into run-off and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared the ultimate parent company—Berkshire Hathaway. At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America ("Howden"), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos-related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in *Allianz* seemed to be that the transferee insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden's potential asbestos claim. Part VII transfers can be used as part of a finality mechanism as part of a solvent wind-down of a business. Aetna International LLC transferred liabilities to Allianz Partners as part of its exit strategy for non-core international operations, leading to the deauthorization of the UK entity ahead of a full solvent liquidation.

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied

[46]There, a claim originating in Pawtucket, Rhode Island, but with waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co*., 57 N.E.3d 18, 24 (Mass. App. Ct. 2016). *See* Steven E. Sigalow & Richard E. Stewart, *How Lloyd's Saved Itself*, 37 THE INS. FORUM (2010), *reprinted in* JONES DAY, http://www.jonesday.com/files/Publication/dae28676-d6c8-4de6-9cbb-c05aee419d4b/Presentation/PublicationAttachment/533860ba-d4f1-4056-85d9-78b84dc71af5/How%20Lloyd's%20Saved%20Itself.pdf (last visited June 9, 2021). *Air & Liquid Sys. Corp. v. Allianz Ins. Co*., No. 2:11-CV-00247-JFC, 2012 U.S. Dist. LEXIS 121553 (W.D.P.A. 2012).
Id. at *12. This interrelated nature is not unusual and is referred to as an intra-company transaction.

Bermuda law, rather than the requested Minnesota law.[47] The court determined that, given the location of the petitioner's assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action.30[48] The court in *Hopewell* also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.

The Working Group is also aware that a number of UK Part VII transfers which have affected US surplus lines policyholders and US cedents in respect of collateral security held to their benefit have been reviewed and recognized as effective by US regulators in all 50 states and the International Insurers Department of the NAIC.

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

As reflected in this white paper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The insurance regulators of virtually all states have recognized the effectiveness in the US of Part VII transfers for insurance regulatory purposes on numerous occasions[49]. Additionally, there are insurers on the NAICs International Insurers Department quarterly listing for surplus lines carriers after having completed a Part VII transfer. The Working Group believes there should be a standard set of financial principles and guidelines under which to review these transactions. Accordingly, the Working Group created a subgroup to specifically address these financial issues.

The Restructuring Mechanism Subgroup ("Subgroup") has been charged with the following initial work related to this White Paper (Note that the Subgroup was changed to a Working Group):

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long- term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial

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

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

[49] As cited by Gregory Overton FIA, Price Waterhouse Coopers, http://www.project-river-transfers.com/ProjectRiver-IESupplementalReport.PDF [project-river-transfers.com] "In respect of Unionamerica's US Reinsurance Trust Fund, 30 US State regulators are needed to approve River Thames as an accredited reinsurer in place of Unionamerica. I understand that approval has been received from 11 US state regulators to date, with a further 18 awaiting the approval of the New York Department of Financial Services ("NY DFS") to complete its review. Enstar has confirmed to me that all additional information requests and pre-conditions in connection with the application of all 30 US States have been addressed save that the NY DFS have stipulated that the new trust fund must be established by River Thames and funded to the minimum required level prior to the transfer of the protected policyholders. Enstar are in the process of meeting this final condition. Once it is met US regulatory counsel remain confident that the remaining approvals will be received shortly thereafter."

Regulation Standards and Accreditation (F) Committee for its consideration as a basis for accreditation standards.[50]

Members of the Subgroup have studied the UK Part VII procedures, and have concluded that they set forth robust processes and that similar guidelines should be established for IBTs and CDs. Those best practices will be appended to this paper as an Appendix.

B. Guaranty Association Issues

As discussed above, the application of these restructuring mechanisms could raise serious issues over the continuation of guaranty association coverage if an insurer subsequently becomes insolvent after the restructuring. These issues can, and should, be addressed both in the restructuring process itself and in guaranty association legislation. In some states, such as Colorado and Illinois, and to a certain degree, Arkansas, the restructuring laws require an assuming or resulting insurer to be licensed in the same state(s) as the transferring or dividing insurer. In addition, as previously noted, other states might assert jurisdiction over transactions that affect their residents. One state has higher standards for those transactions in cases where policyholder consent has not been provided. In that state, policyholders cannot lose any rights or claims under the original policies by the state guaranty associations. Unless and until guaranty association coverage can be ensured, transactions involving policies in states with anti-novation statutes and similar may be more complicated.

On the life and health side, as noted above, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for life and health guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

On the property and casualty side, one key development took place when the NAIC Property & Casualty Insurance Guaranty Association Model Act (Model 540) was updated in 2023 to address continued coverage. A number of states have now enacted these amendments or similar statutory solutions. Inclusion in the model, of course, only provides a roadmap for a state. While Model #540 has been updated, until a state adopts that language it will not have any effect[51]. Regulators, guaranty associations and other appropriate industry stakeholders should therefore continue to work cooperatively to implement this statutory remedy in all states, whether or not those states have restructuring laws, because restructurings in other states can have nationwide, or even worldwide impact.

For all these reasons, the Working Group suggests that regulators should very carefully consider how plans presented address guaranty association coverage issues to assure that consumers are not harmed by the transaction.

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

[51] The Receivership and Insolvency Task Force tracks those states that have adopted changes to their guaranty fund laws to address Restructuring Mechanisms issues. See https://content.naic.org/sites/default/files/inline-files/540%20Restructuring%20Adoption%20Map%20-%20July%202025.pdf

C. Proposals for Minimum Requirements

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

(1) Requirement of court approval for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.

(2) Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.

(3) Requirement of a notice to stakeholders, a public hearing, a robust public and transparent regulatory process, and an opportunity to submit written comments are necessary for all stakeholders, including policyholders, reinsurers, and guaranty associations.

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

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

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of run-off liabilities. However, these newly formed companies may have difficulty getting licensed in the various states either because of "seasoning" issues or because a state may be hesitant to grant a license to a company that is not writing ongoing business. The state reviewing the transaction does not have the power to require other states to license the resulting insurer(s). Making it a mandatory condition of approval may have the unintended consequences of giving other states a veto power over any IBT or CD transaction with respect to business in that state. In a CD, the state regulator would have the authority to require the merger of the divided line(s) of business, whether into an affiliated company of the dividing insurer or unaffiliated company, be made into an entity that is so adequately licensed. This can either be done under an adopted specific standard of approval (see Colorado and Illinois) or the general standard of policyholder protection.

There are two possible outcomes, neither of them desirable. Either the restructuring fails to go forward, even though it is in the public interest, or the resulting or transferee company operates without a license, creating gaps in guaranty association coverage and a lack of regulatory control over the company's ongoing operations, which can open the door to actions that harm consumers. The Working Group, therefore, recommends that the appropriate working group (National Treatment and Coordination (E) Working Group) consider whether any changes should be made to the licensure process for companies resulting from restructuring transactions of run-off blocks. A streamlined process that still ensures appropriate regulatory oversight (and any licensure necessary to preserve guaranty association coverage) may be appropriate in limited circumstances. However, care needs to be taken to ensure that the licensing process is robust and rigorous enough for new entities emerging from a restructuring transaction so that the policyholders of the new entities retain a comparable level of regulatory and solvency protection as under the original entities.

E. Impact on Other NAIC Models & Other NAIC Groups

The Working Group has tentatively decided to pursue the development of changes to the NAIC Protected Cell Model Act (#290). Before doing so, it may be appropriate for the Statutory Accounting Principles (E) Working Group to first determine the appropriate accounting for an IBT or CD that utilizes a protected cell. In recent years, regulators have generally concluded that while protected cells or segregated accounts can provide a means of segregation from one policyholder or group of policyholders to another, the financial reporting and RBC should be calculated for each protected cell/segregated account, for the legal entity on a stand-alone basis, and for the legal entity on a consolidated basis. This should be confirmed and codified before the NAIC updates #290.

The Working Group received comments that the RBC formulas may not adequately reflect the risk profile of insurers in run-off or those with significant run- off portfolios. The Working Group made referrals regarding the definition of Run-off to the RBC Working Groups. Those Working Groups and responses noted the variety of situations that can occur, but in the end, there was not sufficient regulatory support for adjusting the formulas to address the variety of run-off situations. The 1997 White Paper in Attachment One also details situations in which the RBC Models have narrow exclusions.

F. Extra Procedures for Long-Term Care Insurance IBT or CDs

As previously noted, increased scrutiny for any block transfers that are currently in projected deficit situations should occur, in particular long-term care insurance. However, to be more clear, the Working Group strongly discourages states from entertaining the use of an IBT or CD involving long-term care insurance, but if a state does consider, they should bring such a proposed transaction to all of the licensed states first and generally such transactions should only be utilized to the extent the NAIC develops a national solution for such transactions, which could occur in the future if such a national solution was proposed to a particular NAIC group that could document and develop such a solution.

ATTACHMENT 1 – 1997 NAIC White Paper

Liability-Based Restructuring White Paper

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

Adopted by Liability-Based Restructuring Working Group & EX4 in June 1997 Adopted by Executive Committee in September 1997 Adopted by Plenary in December 1997

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I. SCOPE

In general, restructurings can be effected through various forms and occur for different reasons: a parent company may divest itself of insurance operations by walling off and trying to sell certain operations, or making material changes to pooling arrangements in a way that, in effect, results in a corporate restructuring. Similarly, an insurance organization may spin-off some of its operations, possibly taking a private company public, may separate commercial and personal lines operations, or may create an off-shore entity to which problematic liabilities and/or assets are transferred due to favorable regulatory and tax

environments. The most common specific examples of restructuring during the past several years have been liability-based restructurings (LBRs) of insurance operations into discontinued and on-going operations, primarily because of material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities. Policyholders, insurers, regulators and guaranty funds have expressed concerns about these transactions. Descriptions of some recent restructurings are summarized in Appendix 1.

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

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

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

II. BUSINESS REASONS

A. Rating Considerations

One of the major considerations in recent LBRs has been the insurer's desire to maintain or obtain favorable financial and other rating designations from the private rating agencies. Ratings play a major role in determining whether an insurer can remain competitive in its target market and may affect its ability to attract new capital. Insurers that have been subject to earnings drag due to the adverse development of APH or other liabilities may be faced with rating downgrades. By separating problem liabilities from on-going operations, the insurer may improve or maintain its rating. In turn, this may allow the insurer to more effectively take advantage of business opportunities, potentially achieve higher returns on its capital, and become more attractive to the financial markets.

B. Solvency Issues

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

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

C. Other

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

III. ADVANTAGES AND DISADVANTAGES

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

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

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

IV. FINANCIAL SOLVENCY ISSUES

A. General Solvency Considerations

Regardless of the nature of an LBR, a key responsibility of the regulatory authority in assessing whether to approve the transaction will be to analyze financial solvency issues. The regulatory

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

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

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

B. Reserve Adequacy

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

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

Third, the regulatory authority should consider requiring the development of a cash flow model stress test to evaluate the adequacy of assets, including reinsurance, to fund the liabilities. The

ultimate liabilities, payment patterns and cash flow assumptions should be included in the review. The stress test should consider varying loss payment patterns and investment yields.

C. Reinsurance

1. Collectibility of Reinsurance Balances

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

2. Reinsurance Coverage

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

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

D. Liquidity and Value of Assets

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

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

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

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

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

E. Capital and Surplus Adequacy

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

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

Other factors to consider in determining the adequacy of capital and surplus levels include volatility and uncertainty related to reserve estimates, the quality of assets, and the degree of parental and affiliated support.

F. Support From Parents and Other Affiliates

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

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

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

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

V. LEGAL AND PUBLIC POLICY ISSUES

A. Applicable Laws

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

1. General Corporation Statutes

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

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

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

a. Mergers and Consolidations

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

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

b. Divisions

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

2. Insurance Code Provisions

a. Insurance Holding Company Act[4]

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

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

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

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

Certain aspects of an LBR may be subject to the Holding Company Act even though the act does not explicitly address LBRs. An LBR may be subject to review by the regulatory authority under the Holding Company Act if the insurer is a member of an insurance holding company system. For example, if an LBR results in a change of control[52] of a domestic insurer, the transaction must be pre-approved by the regulatory authority in accordance with certain stated criteria.[53]

In addition, the Holding Company Act governs transactions between the domestic insurer and other members of the insurance holding company system even if there is no change in control.[54] Some of these transactions trigger advance notification to the regulatory authority depending upon the nature and extent of the transaction. All of these transactions must be on terms that are fair and reasonable. An LBR will probably be subject to these requirements of the Holding Company Act if intercompany agreements such as management agreements, reinsurance agreements or tax allocation agreements are affected.

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

b. Examination Law

All states have examination statutes that provide the authority and responsibility to conduct examinations of insurers to determine their financial condition and compliance with insurance laws and regulations. This authority includes targeted examinations triggered by a wide array of events such as deteriorating financial condition, risk-based capital results, financial analysis results, financial ratios and LBRs. Generally, a periodic examination of insurers is contemplated; however: the regulatory authority may also conduct an examination as often as deemed appropriate.[55] The regulatory authority has the discretion within statutory confines to determine the scheduling, nature and scope of an examination. The regulatory authority is also granted examination powers under the Holding Company Act.[56]

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

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

[54] The NAIC Insurance Holding Company System Regulatory Act at Section 5A. Similar authority as to insurers that are not a part of an insurance holding company system can be found in the Disclosure of Material Transactions Model Act adopted by the NAIC. [8] *Id.* at Section 5B.

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

[56] The NAIC Insurance Holding Company System Regulatory Act at

Section 6A. [11] The NAIC Model Law on Examination at Section 4D.

Generally, the regulatory authority may retain attorneys, appraisers, actuaries, certified public accountants, loss-reserve specialists, investment bankers or other professionals and specialists at the cost of the insurer being examined.[11] Given the extraordinary nature and complexity of LBRs, it is essential that the regulatory authority have the ability to contract for the services of all experts and specialists deemed necessary and to assess such costs to the insurer.

The examination statutes generally provide for the confidentiality of all workpapers, recorded information and documents obtained by, or disclosed to, the regulatory authority in the course of an examination and that these materials may not be made public, subject to some limited exceptions.[57] The examination authority under the Holding Company Act contains a similar provision regarding confidentiality of examination materials. These confidentiality provisions are necessary for the regulatory authority to conduct a thorough examination. The examination statutes provide the regulatory authority an important tool to evaluate LBRs, but the examination law prevents the regulatory authority from disclosing examination documents that might be of interest to policyholders. (See § 5(B)(4)).

c. Other Laws

Other insurance regulatory laws that may need to be considered regarding an LBR relate to the orderly withdrawal from insurance business in the state,[58] demutualization, or redomestication[59] of the insurer to another state. Issues regarding guaranty fund coverage and assumption reinsurance requirements deserve special consideration and are discussed in separate sections of this paper. Other insurance laws and regulations may need to be considered in connection with an LBR. Therefore, it is important to evaluate all the ramifications of an LBR and the component steps and transactions necessary to achieve the LBR. This may involve regulatory issues not identified in this paper.

B. Due Process

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

The regulatory authority should consider the persons whose interests are affected by a proposed LBR and who is entitled to notice and the opportunity to be heard. The regulatory authority should

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

[58] *See* N.J. Stat. Ann. § 17:33 8-30 (1994).

[59] The Redomestication Model Bill adopted by the NAIC is enacted in 37 states.

consider whether a public hearing concerning the LBR is required or should be held.[60] The regulatory authority should consider whether interested parties should be allowed to present evidence, call witnesses and cross-examine the witnesses of other parties. The regulatory authority should consider whether policyholder consent is necessary.

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

C. Assumption Reinsurance

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

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

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

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

transaction must be filed with and approved by the regulatory authority of the insurer's state of domicile.

D. Policyholder Consent

When a new agreement replaces an existing agreement, a novation has occurred.[61] Because the Assumption Reinsurance Model Act specifically states that it is intended to provide for the regulation of assumption reinsurance transactions as novations of contracts,[17] general rules of contract law apply to any disputes arising under the assumption reinsurance agreements.

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

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

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

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

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

E. Rights of Other Interested Parties

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

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

obligation for an existing one, between the same or different parties…. A novation substitutes a new party and discharges one of the original parties to a contract by agreement of all parties….” [17] NAIC Assumption Reinsurance Model Act § 1 (1993).

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

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

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

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

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

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

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

F. Disclosure of Information

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

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

G. Guaranty Fund Coverage

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

1. Overview of Guaranty Fund System

Each state has a guaranty fund, created by statute, to provide a safety net for policyholders and third party liability claimants in the event of the insolvency of an insurer writing property and liability lines of insurance. Although the majority of state guaranty fund statutes are based upon the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act, there are variations from state to state that should be taken into account by the regulatory authority when reviewing a proposed LBR. First, the lines of business covered may differ. Also, the amount of coverage provided per claim varies. Although the Model Act and many state statutes provide for payment of covered claims of up to $300,000, some state laws provide more or less coverage. Several states have enacted net worth provisions that exclude from coverage the claims of persons whose net worth exceeds a certain benchmark, the rationale being that such persons are sophisticated purchasers and can afford to absorb some loss.[62]

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

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

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

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

a. Whether an unlicensed insurer is involved in the LBR;

b. Whether the restructured insurer that could become insolvent is the insurer that issued the policy;

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

c. Whether the restructured insurer that could become insolvent was the insurer at the time the insured event occurred;

d. Whether the guaranty fund coverage in other states varies from the coverage available in the regulatory authority's jurisdiction.

3. Conclusion

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

VI. ON-GOING REGULATORY OVERSIGHT

A. General

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

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

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

B. Oversight

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

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

Where there is common management and/or ownership of on-going and run-off operations of a restructured insurer, the regulatory authority needs to be aware of any potential conflicts of interest between the two entities. This may lead to inappropriate influence by the on-going entity of the runoff entity's operations. For example, it might be in the interest of the on-going entity for the run-off entity to settle claims of current on-going entity customers on a preferential basis. This could have the effect of jeopardizing whether the run-off entity will have sufficient assets to settle other policyholders claims. A similar conflict exists if there is a block of policies whose obligations revert to the on-going entity upon the insolvency of the run-off entity. If such conflicts exist the regulatory authority should consider an examination of the claim settlement patterns of the run-off entity as part of its regular examination process.

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

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

VII. CONCLUSIONS AND RECOMMENDATIONS

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

- LBRs present both advantages and disadvantages, and therefore, LBRs should not be prohibited per se, but each should be evaluated on its own merits by the regulatory authority.

• LBRs are extraordinary transactions that vary widely in form, method and circumstances, and therefore, a "one size fits all" stand alone model law approach is not recommended at this time. Insurance regulatory authorities must have adequate statutory authority with sufficient flexibility and discretion to respond to the situation presented. The Working Group believes that existing regulatory authority is generally adequate, but recommends that the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, the Assumption Reinsurance Model Act, and the Insurance Holding Company System Regulatory Act be revisited to consider whether amendments may be appropriate in light of LBRs.[63]

• An LBR should be subject to approval or disapproval by the domestic regulatory authority(ies) on the basis of a comprehensive and thorough review. The regulatory authority should have the ability to engage all experts necessary to assist in the review at the expense of the LBR applicant.

• The LBR applicant has the burden of justifying the LBR to the regulatory authority. The regulatory authority should not approve a proposed LBR if the transaction is likely to jeopardize the financial stability of the insurers, prejudice the interests of policyholders or be unfair or unreasonable to policyholders. An LBR is not an acceptable alternative to appropriate regulatory action, such as the rehabilitation or

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

• If the effect of the LBR is intended to extinguish an insurer's obligation to its policyholders, consent of the policyholders should be required. Such transactions result in a novation or have the same effect on policyholders as a novation and therefore should satisfy the procedural and legal requirements of a novation. States should consider adopting the Assumption Reinsurance Model Act or other legislation that will safeguard the interests of policyholders.[64]

• Public confidence in insurance and the integrity of the regulatory process requires that regulatory authorities strive to respond to LBRs as consistently as possible. Consideration should be given to developing a standardized regulatory review process through filing requirements, guidelines, protocols and best practices. The Pre-approval Checklist, Appendix 2, and On-going Regulation Oversight, Appendix 3, are examples of such regulatory guidelines.

• Interstate cooperation and communication are especially important. LBRs are likely to trigger the regulatory jurisdiction of more than one state and will be of interest to all states where affected

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

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

policyholders reside. The domiciliary state of the parent or largest insurer involved in the LBR should coordinate activities among the states having jurisdiction over some aspect of the LBR, make basic information available to nondomiciliary states and respond to specific inquiries from non-domiciliary states as necessary.

- Policyholders should have an opportunity for direct participation in the LBR approval process. At a minimum, this should include notice to policyholders of the proposed LBR with an explanation of the LBR and its effect on policyholders, meaningful access to information about the LBR, and a public hearing that affords policyholders an opportunity to be heard. Meaningful access to information necessarily requires that policyholders be given access to information that may be sensitive and proprietary. The competing interests of the policyholders and the insurer in this regard should be balanced with appropriate measures such as protective orders or confidentiality agreements to allow policyholders access to such information while protecting the insurer's interests, in accordance with applicable public information laws.

- The review of all financial aspects of a proposed LBR culminate in a determination of the adequacy of capital and surplus. It should be demonstrated that each insurer in the group will have adequate capital and surplus to support its own liabilities and plan of operation. The capital facilities at the holding company level also should be reviewed for adequacy should a member of the group require additional capital infusions, guarantees or other support measures.

- A key regulatory consideration in evaluating an LBR is whether there will be an on-going parental or affiliate involvement with the restructured insurer after the completion of the LBR. This involvement may take many forms, including, but not limited to, overlapping management, capital and surplus guarantees, reinsurance agreements, cut-through provisions and investment yield guarantees. The form and extent of the involvement or support will depend on the structure of the LBR and the entities involved.

- Material exposures to asbestos, pollution and health hazard claims (APH) have been the motivating factor in recent noteworthy LBRs. The Working Group recommends that the NAIC request that the

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

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

APPENDIX 1
Case Studies

Cigna Corporation Property and Casualty Division

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

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

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

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

Restructuring of the Crum and Forster Group

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

Following a preliminary restructuring in 1990 which included exiting from the standard personal lines market and other market-related action to improve on-going operational results, Xerox announced plans to exit the financial services business. During the latter part of 1992, in preparation for the LBR, the group greatly strengthened loss reserves, after having suffered significant losses from Hurricanes Andrew and Iniki. Although the LBR was intended to enhance the salability of the insurance operations, an immediate goal was to realign the business into stand-alone company groups. Each group was to be dedicated to a particular purpose with greater management accountability and better focus.

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

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

ITT Corporation

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

The Home Insurance Group

Prior to mid-1995, the Home Insurance Company and five of its seven property/casualty insurance subsidiaries operated under a pooling agreement for the writing of commercial business. Following several years of losses, the Home's upstream parents, Home Holdings, Inc. and Trygg Hansa AB, entered into an

agreement in principle in December 1994 with the Zurich Insurance Group to sell the Home Companies. The agreement virtually put the Home and its subsidiaries into run-off. The issues surrounding the acquisition and related transactions involved adequacy and funding of reserves, including asbestos and environmental, reinsurance, mergers and redomestications, and placement of renewal business. In addition, Home Holdings, Inc. had outstanding public shareholders and public bondholders.

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

APPENDIX 2

Pre-Approval Checklist

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

1. Narrative

A general written summary of the proposed LBR, explaining:

a. Reasons for undertaking the LBR;

b. All steps necessary to accomplish the LBR, including legal and regulatory requirements and the timetable for completing such requirements;

c. The effect of the LBR on the insurer's financial condition;

d. The effect of the LBR on the insurer's policyholders;

e. The consequences if the LBR is not approved.

2. Business Plan

a. On-going Operations

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

b. Run-off Operations

i. A description of all plans regarding any run-off operations.

3. Financial Information

a. Historical financial statements, including the most recently filed annual and quarterly statutory statements.

b. Financial statements (in a spreadsheet format) detailing the accounting of the proposed LBR including:

i. Schedules detailing assets and liabilities to be reallocated as part of the LBR.
ii. An accounting of any special charges, reevaluations, or write-downs to be made as part of the LBR.

c. Pro-forma financial statements of the insurer(s) as if the LBR were approved including an explanation of the underlying assumptions.

d. Financial projections for three years (assuming the LBR is approved) for both the run-off and on-going entities and an explanation of the assumptions upon which the projections are based.

e. A description of any tax consequences of the LBR.

4. Analysis of Reserves

Retain qualified independent actuarial experts.

a. The actuarial expert should perform a "ground-up" actuarial review of case and incurred but not reported reserves for asbestos, pollution, health hazard and other long-tail claims.

b. The actuarial expert should also opine on:

i. Methodologies used by the insurer to estimate reserves.
ii. The adequacy of reserves on a gross and net of reinsurance basis. iii. The adequacy of the expertise of the insurer's claims unit.
iv. The insurer's economic approach to funding the run-off liabilities, including cash flow model stress tests.
v. If reserve discounting is permitted, funding of the discount and the adequacy of reserves net of discount.

5. Analysis of Reinsurance

a. An analysis of reinsurance recoverables by a qualified expert including:

i. A review of the process used to monitor, collect and settle outstanding reinsurance recoverables. ii. An analysis of existing and projected reinsurance balances including the expected timing of cash flows.
iii. An analysis of the quality and financial condition of the reinsurers and prospects for recovery.
iv. A detailed description of write-offs or required reserves based on the independent analysis taken as a whole.
v. Disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes.
vi. A discussion of the impact of the LBR on the collectibility of reinsurance balances.

b. A legal analysis of the effect that a rehabilitation or liquidation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and on the legal rights of the reinsurers to claim setoffs against such recoveries.

c. If reinsurance stop loss or excess of loss coverage is an integral part of the transaction, a copy of such agreement and a written opinion from a qualified expert as to:

i. The adequacy of coverage;
ii. The ability of the treaty to perform as anticipated and be unaffected by delinquency proceedings;
iii. The practical operation of the treaty;
iv. The timing and method of payment of reinsurance premium; v. The financial condition of reinsurers; vi. The sufficiency of coverage and other resources.

d. A discussion of existing or proposed reinsurance programs, whether with affiliates or other reinsurers, to assist the regulatory authority in determining that provisions are consistent with other information provided and that adequate coverage exists for both on-going and run-off operations.

e. Any proposed amended, cancelled, or new pooling agreements, including explanations of significant differences before and after the restructuring, flowcharts to demonstrate the proposed movement of business, and the anticipated financial impact upon the affected companies.

6. Analysis of Liabilities Other Than Reserves

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

7. Analysis of Assets

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

a. Disclosure of assumptions regarding the assets of the insurer(s) involved in the LBR, especially those assets with high volatility, liquidity uncertainties, material valuation issues, or representing a material percentage of the invested asset portfolio.

b. Current appraisals of any material real estate or mortgage holdings, independent valuation of limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other assets of concern.

c. A list of assumptions used by the insurer(s) as to investment yield, and disclosure of the effect that the reallocation of assets will have on historical investment yields.

d. If the asset analysis performed by the insurer indicates a potential asset/liability matching problem, documentation that the insurer plans to take action such as:

i. Reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk.
ii. Securing a parental guarantee of investment yield.
iii. Securing a parental guarantee of asset valuation or a parental agreement to substitute the insurer's assets.
iv. Disposing of assets prior to approval of the LBR.

8. Parental Support

a. The plan should provide for the provision of financial and managerial support by the parent company to all entities.

b. The plan should provide for a commitment of parental support to run-off operations in the event of:

i. Inadequacy of reserves; ii. Asset deterioration; iii. Deterioration in the collectibility of reinsurance recoverables.

9. Organizational Impact

a. The plan should affirm that the restructured entity was either licensed or an approved surplus lines carrier in all jurisdictions in which it wrote business, and will be licensed in all jurisdictions where it takes on business as a result of the restructuring.

b. Analysis of the change in organizational structure resulting from the transaction. Areas to emphasize include:

i. Ownership of the resulting corporate structures; ii. relation between management of the resulting entities; iii. Substantial reinsurance arrangements between resulting entities; iv. Other on-going business ties between the resulting entities.

10. Analysis of Issues Affecting Policyholders

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

Attachment One

APPENDIX 3 ON-GOING REGULATORY OVERSIGHT

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

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

- Require intercompany balances with the inactive operations be settled within 90 days of each quarter.

- Require prior approval of affiliated transactions between inactive and active operations.

- Require prior approval for inactive operations to establish security deposits with any

Attachment One

other jurisdictions except to the extent required by law.

- Communications

- Require notice to all known policyholders and claimants affected by the transaction.

- Require a written response to any inquiry regarding the LBR.

- General Monitoring

- Require on-site monitoring facilities.

- Require right to notice of and right to attend all Board of Directors meetings.

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ATTACHMENT 2 – 2010 NAIC White Paper

Alternative Mechanisms for Troubled Companies

An NAIC White Paper

February 2010

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

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

Attachment Two

TABLE OF CONTENTS

I. INTRODUCTION

A. BACKGROUND/PURPOSE

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

> Undertake a study of alternative mechanisms, such as solvent schemes of arrangement, solvent run-offs, and Part VII portfolio transfers (a transfer leaving no recourse to original contractual obligor/insurer) and any other similar mechanisms to gain an understanding of:
>
> i. How these mechanisms are utilized and implemented.
> ii. The potential effect on claims of domestic companies, including the consideration of preferential treatment within current laws.
> iii. How alien insurers (including off-shore reinsurers) who have utilized these mechanisms might affect the solvency of domestic companies.
> iv. Best practices for state insurance departments to consider if utilizing similar mechanisms in the United States and/or interacting with aliens who have implemented these mechanisms.

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

B. AUTHORITY & APPLICABILITY

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

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

C. Other Considerations

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

II. General Advantages and Disadvantages for Utilizing Alternative Mechanisms for Troubled Companies

A. Advantages

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

- Alternative mechanisms may allow greater flexibility to achieve commercially acceptable results, such as freeing up capital.

B. DISADVANTAGES

- The inherent risk for consumer and claimant issues increases, requiring stronger regulatory monitoring and controls for protection. For some alternative mechanisms, there is no guarantee that appropriate fairness will take place.
- Alternative mechanisms for troubled insurers might become a tool for solvent carriers to transfer value away from policyholders.
- As to reinsurance, restructuring might affect the value of the future reinsurance claim or offset rights, arbitration rights, and reinsurance collateral.
- The cost of efficiency or company enticements may come at the expense of policyholders or insureds.
- Difficult decisions arise with a troubled insurer that is not clearly solvent or insolvent, and significant ramifications could follow with certain choices.
- Companies may seek to continue run-off or restructuring activities even after it becomes clear that the company is hopelessly insolvent, resulting in preferential payments made at the expense of outstanding claims.
- Compensation incentives may restrict future claims-paying ability.
- Voluntary restructuring schemes may deny policyholders and consumers the substantive and procedural safeguards otherwise available for their protection in court-supervised receivership proceedings.
- Run-off and restructuring schemes may be used to circumvent state priority and preference rules in order to discount claims at the expense of policyholders and other claimants. They may also be used to circumvent other consumer protection laws, including state receivership and guaranty association laws as well as commutation and assumption transfer laws.
- May allow the company to terminate coverage and extinguish liabilities over the objections of policyholders and other creditors by majority cram-down vote.
- Run-offs and restructuring schemes may result in substantially reduced payments to policyholders. State receivership laws typically require a showing that a rehabilitation plan is fair and equitable, complies with priority rules, and provides no less favorable treatment of claims than would occur in liquidation. Run-offs and alternative mechanisms, such as those addressed herein, may have the ability to sidestep these equitable standards and permit broad discretion in discounting claim values. In fact, the success of a plan may be dependent on the ability to impose deep discounts on claims, and there may be no rules or mandatory standards in place to protect policyholders or claimants.
- There is a risk that similarly situated creditors will be treated differently or that they will receive payments that are less than they would receive in an insolvency proceeding.
- Alternative mechanisms adopted in any given state may not be enforceable across state lines, leaving the company at risk of further exposure, litigation, and ongoing collection activity that may disrupt efforts to implement a restructuring plan.
- Alternative mechanisms are not appropriate for compromising the claims of consumer policyholders due to lack of sophistication and the existence of extensive consumer protections built into insolvency laws.

- In the absence of strong regulatory involvement, there is a risk that policyholders and creditors will not receive adequate or accurate information on which to base their decisions.
- The interests of management may not be the same as the interests of policyholders and creditors.

III. TYPES OF ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

MECHANISMS AVAILABLE TO INSURERS WITHIN THE UNITED STATES AND RELATED TERRITORIES

A. RUN-OFF OF TROUBLED INSURER

1. DESCRIPTION

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

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

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

a. STATUTORY BASIS FOR SUPERVISED RUN-OFF PLANS

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

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

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

A mandatory control level event is defined under the statute as an RBC Report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC. Under this statutory mechanism, if there is a mandatory control level event at a company that has ceased writing new business and the company is engaged in a voluntary run-off, the Director has the discretion to either seek a receivership order or to allow the company to continue its run-off under the Director's supervision.[65] In order to persuade the Director to exercise the supervised run-off option, the company must prepare and present a comprehensive run-off plan, including financial projections, that establishes that the plan is viable, that there is a high probability that the run-off can be conducted without putting policyholders at greater risk, and that all claim obligations will be satisfied.

The specific content of the run-off plan may vary depending upon the nature of the business being run-off and the financial circumstances of the troubled company. (See a sample outline for a run-off plan at VII. *Appendix C.*) However, the primary goals of the plan should include and achieve consumer protection, satisfaction of all policyholder obligations, and the maintenance of positive surplus and sufficient liquidity. Typically, the components of such a plan would include substantial cost-cutting measures, commutations of reinsurance agreements, collection of outstanding premium, recovery of statutory deposits, policy buy-backs, novations, and claim settlements.[66] A key element of such a plan would be a discussion of the benefits to the policyholders of a run-off rather than a receivership, including the impact of any state guaranty fund or guaranty association coverage.

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

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

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

still comply with Generally Accepted Accounting Principles. Any such adjustments should be based upon credible forecasts and other available information.

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2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

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

DISADVANTAGES

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

- Guaranty funds may be disadvantaged in a subsequent receivership if non-guaranteed creditors were paid more than the ultimate distribution from the receivership.

B. New York Regulation 141

1. Description

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

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

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

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

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

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

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

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

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

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

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

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

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

provisions calling for the preservation and production of all communications between the troubled company and its cedents.

In addition, and as previously noted, the commutation agreements executed pursuant to an approved Regulation 141 plan will not take effect "unless … the plan shall eliminate the insurer's impairment or insolvency" and restore surplus to policyholders to levels required under the insurance law or an amount that the Superintendent deems "is adequate in relation to the insurer's outstanding liabilities or financial needs."
Although the troubled company's directors must consent to an order of rehabilitation or liquidation if the company's surplus has not been restored to the required minimum, the Superintendent need not consider any plan proposed pursuant to Regulation 141 "in lieu of taking any other action" against the company. This gives the Superintendent full discretion to decide whether to allow the troubled company to propose a plan or to take other action against the company, including supervision, rehabilitation, or liquidation.

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

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

2. Advantages/Disadvantages

Advantages

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

Disadvantages

- As an offer under this regulation is based on the assuming reinsurer's books at a given date, discrepancies between the ceding and assuming insurers' books are likely to occur.

- Timing could become problematic if the regulator does not enforce strict deadlines regarding the consideration and execution of offers.
- Regulation 141 does not require an audited balance sheet to confirm the extent of the troubled insurer's financial condition.
- Many subjective considerations must be used by the troubled insurer to determine in advance what percentage of approval is needed for the plan to work.

C. Rhode Island Statute and Regulation for Voluntary Restructuring of Solvent Insurers

1. Description

Rhode Island's Title 27, Chapter 14.5[67] provides for voluntary restructuring of solvent insurers. The statute was intended to provide an alternative to a traditional run-off by bringing "solvent schemes of arrangement" (which are discussed further in the next section) to the United States. It allows solvent companies that are in run-off to reach a court-ordered (and department of insurance supervised) agreement with all of its creditors in order to accelerate completion of the run-off, bringing certainty of payment to creditors and reducing administrative costs often associated with lengthy run-offs.

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

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

All creditors and interested parties (such as Guaranty Funds) are granted full access to the plan and all information related to the plan. Both creditors and interested parties are given an opportunity to file comments or objections to the plan with the court (R.I. Gen. Laws § 27-14.5-4(b)(3)). Ultimately, all creditors must be given an opportunity to vote on the commutation plan, and approval of the plan

[67] The Rhode Island statute was adopted in 2002 and amended in 2007. See R.I. Gen. Laws § 27-14.5-1 *et seq*., "Voluntary Restructuring of Solvent Insurers," and R.I. Insurance Regulation 68 (Commutation Plan regulations).
[68] Plan approval is done by the court; however, the department has the statutory authority to intervene in any proceeding brought under this statute. According to the Rhode Island Division of Insurance Regulation, it is highly unlikely that the court would approve a plan over the Division's objection.

requires consent of at least i) 50% of each class of creditors, and ii) the holders of 75% in value of the liabilities owed to each class of creditors (R.I. Gen. Laws § 27-14.5-4(b)(4)). However, it is important to note that only the claims of creditors present or voting through proxy at the meeting of the creditors are counted toward determining whether the requisite majorities have been achieved. (See Insurance Regulation 684(e)(i).)

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

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

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

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

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

The definition of "Commercial Run-off Insurer" under the statute was expanded by amendment in 2007 to include companies newly formed or re-activated under Rhode Island law solely for the

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

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

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

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

DISADVANTAGES

- Permits an insurer to terminate coverage and extinguish liabilities over the objections of policyholders and creditors who are in the minority.
- Creditors are bound by the plan whether they had notice or not, and only those present or voting through proxy are counted toward establishing the requisite majority, which may create incentives to manipulate notice (though the department and court could take steps to prevent such manipulation).
- Although the process is limited to solvent insurers and the intent therefore is that full value will be paid to all creditors, there are no guarantees that all policyholders will receive full value, or even present value for their claims (especially those with IBNR claims).
- There is no reference to segregating and preserving reserve assets for excluded lines, or any explanation as to how policies and claims would be administered and paid during the interim period prior to completion of the plan.
- Questions concerning the enforceability of any such plan across state lines may leave companies exposed to further risk, litigation and disruption or termination of a plan—i.e., even if the Rhode Island court did approve the plan, it is possible that policyholder or claimant

actions could arise in other states' courts, (or perhaps federal courts), resulting in enforcement and implementation issues for the company attempting the restructuring.[69]

- Although the Rhode Island plan is available only to commercial insurers and reinsurers in run-off, the plan is not exclusively limited to "troubled" companies; thus, any commercial run-off insurer could conceivably use this mechanism to cease operations and eliminate ongoing claims payment liability.
- Despite the fact that there is significant statutorily delineated regulatory guidance included in the Rhode Island framework (unlike UK solvent schemes), parties may view Rhode Island's "commutation plan" statute as simply a domestic version of the UK's solvent schemes and attribute all of the disadvantages associated with UK-like solvent schemes of arrangements (listed below in D-2) to the Rhode Island system.
- Because the Rhode Island statute allows for the formation or reactivation of a domestic company and the transfer of assets and liabilities to that company, certain parties view this as allowing a "ring-fence" of assets, unfairly shielding assets from creditors.

MECHANISMS AVAILABLE TO INSURERS OUTSIDE THE UNITED STATES AND RELATED TERRITORIES

D. UK-LIKE SOLVENT SCHEMES OF ARRANGEMENTS

1. DESCRIPTION

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

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

- Stresses that the scheme must comply with principles for businesses (e.g., treating policyholders fairly and communicating in clear terms).
- Established an FSA schemes review committee.
- Stated that the run-off should be at least five years old.
- Distinguishes between individual retail and small commercial policyholders, large commercial policyholders and other risk carriers.
- Distinguishes between insolvent risk carrier, marginally solvent risk carrier and substantially solvent risk carrier.

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

- In case of substantially solvent risk carrier, the FSA is likely to object to a scheme unless the risk carrier offers benefits designed to ensure that policyholders are not in a worse position than in a solvent run-off.
- Provides for a role of policyholder advocate.
- The FSA may not object to a scheme, even if it fails to satisfy the criteria stipulated, if the risk carrier can demonstrate that the scheme treats policyholders fairly (e.g., through suitable additional benefits for policyholders and/or safeguards for dissenting procedures).

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

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

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

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

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

DISADVANTAGES

- Schemes may undermine the value of insurance contracts by not honoring contractual obligations.

- Lost coverage may hurt policyholders at the expense of American citizens and the economy.
- Schemes could pose a formidable collective action problem.
- Schemes could undermine the reliability of insurance institutions.
- Schemes may allow for the reduction or cancellation of contractual obligations outside the scope of the current receivership system by not adhering to the statutory priority of distribution rules. Under such a scheme, a troubled company could force certain policyholders to commute (or buy- back) mutually agreed-upon insurance coverage despite their objections.
- The use of terms "debtor" and "creditor" used in the restructuring arena may tactically create a new environment for insurance where risk transfer is not necessarily part of the product purchased.
- Enforceability across state lines.
- Schemes could be used by companies to simply reorganize their corporate structure to move reinsurance operations unencumbered by old claims under a different name.
- In its latest proposal, the Reinsurance (E) Task Force had a provision where an insurer engaging in solvent schemes would not be allowed to take a reduction of collateral.
- Chapter 15 is a relatively new provision of the Bankruptcy Code with relatively little case law to support it, thus leaving the ability for judges' discretion and leeway in its application.
- Schemes can involve reinsurers, where the reinsurance contract with an insurance company is negatively affected.
- Schemes could provide an opportunity for solvent insurers to avoid insurance and reinsurance obligations and return the risk to insureds of ceding companies who purchased the coverage in good faith.
- Schemes force creditors to trade insurance coverage for payments based on estimations of future claims that are inexact and possibly unfair.
- The individuals chosen to adjudicate claims under a scheme may lack expertise in the necessary legal issues.
- There is no oversight of solicitation by the company of scheme acceptances. Thus, some accepting creditors may have already achieved favorable settlements, while dissenting creditors are left to litigate their claims in an unfavorable forum.
- Schemes do not allow dissenting policyholders to opt out of the scheme.
- Schemes do not ensure continuation of coverage.
- Schemes do not include a safety net of guaranty association protection.
- Schemes do not allow a policyholder to seek judicial review of its claims against the insurer.

E. PART VII PORTFOLIO TRANSFERS

1. DESCRIPTION

Part VII of the Financial Services and Markets Act 2000 (FSMA) allows for a transfer of insurance business under a statutory and court process. The transfer allows a reinsurer to move all or certain of its reinsurance business (assets and liabilities) to another reinsurer without the consent of each and every policyholder but with the sanction of the UK High Court. The main statutory requirements are: 1)

policyholder notification; 2) a report by an independent expert; 3) UK High Court approval; and 4) no objection by the FSA or other regulators and interested parties, including policyholders.

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

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

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

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

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

The two primary aspects for the protection of affected parties are as follows: 1) the independent expert's report, which needs only to consider the effect on policyholders; and 2) the court is required to be satisfied that the transfer as a whole is fair as between the interests of different classes of persons affected by the transfer.

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

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

Overall, a loss portfolio transfer is a means of transferring outstanding net or gross legal liability from one insurer to another insurer. It has been viewed as a form of retrospective reinsurance. The transfers must be sanctioned by the court, and are subject to review and opinion by an independent expert that is approved by the FSA. Notice of the proposed transfer is usually required to be sent to all policyholders of the parties

unless the court decides otherwise. A detailed report must also be provided setting out all the details and the independent expert's opinion. The FSA and any party who feels adversely affected by the transfer can make representation to the court for consideration.

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

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

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

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

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

The foregoing tables compare schemes of arrangement and Part VII transfers with analogous mechanisms available under U.S. law. While it appears that the mechanisms are similar in many respects, in practice they have proven to be quite different. Under UK schemes of arrangement, policyholders have been forced to accept payouts based on estimations of their claims so that equity holders can recapture the capital of the company. Under UK Part VII transfers, policyholders have been forced to accept the credit of another insurer in order to permit the insurer from whom they bought the policy to exit business and recapture its

capital. Current U.S. practice, with the possible exception of the Rhode Island statute, would not enable these results. Policyholders are only required to accept payment based on estimation in the U.S. where the company is insolvent and shareholders will not receive a return of their capital. Also, under current U.S. practice, policy transfers to a new insurer are not made involuntarily except where there is an insolvency of the transferor. While UK regimes certainly have safeguards in the form of voting (in the case of schemes) and court review (in the case of schemes and Part VII transfers), the ultimate risk is left on the policyholder.

2. Advantages/Disadvantages

Advantages

- Permits more efficient management of transferred books of business, allows dedicated capital and focused solutions to be applied to run-off liabilities, and promotes efficient use of capital for ongoing business.
- Options can be explored to strengthen policyholder protections and reach regulator approval, such as altering deductibles, strengthening reserves, obtaining reinsurance, and other arrangements to share the risk.
- Might attract new capital to insurance businesses insofar as it can be invested directly in run-off liabilities, and strengthens ongoing companies by permitting the separation of those liabilities.
- Can reduce risk of exposure.
- A recent amended UK rule introduces a simpler alternative where no court sanction is required for pure reinsurance business transfers if all the policyholders affected by the transfer consent to the proposal.
- Substantial regulatory oversight is required.

Disadvantages

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

IV. Observations and Considerations Before Using Alternative Mechanisms

A. Existing Statutory Authority and Requirements

1. State Receivership/Guaranty Fund Laws

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

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

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

2. Priority Distribution Statutes/Preferential Treatment

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

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

B. Consumer Protections and Public Policy Considerations

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

1. Honor Contractual Obligations to Policyholders. Alternative mechanisms should not be a way for an insurance company to sidestep its contractual obligations to policyholders. There should be no

involuntary restructuring of policies or impairment of policy benefits or claims permitted outside of receivership. This would preclude any changes to policies, or reductions to policy claims or benefits, without the express, informed, voluntary consent of individual policyholders. Accordingly, there should be no cram-down approval of a mechanism by majority vote over the objection of policyholders; no involuntary transfer of risk back to policyholders through forced commutation of claims or otherwise; and no cancellation, termination, or non-renewal of coverage, except as permitted under the express terms of the policy. In short, every policyholder should be entitled to continue coverage and to receive all policy benefits for the full term of their policy.

2. Meaningful Notice and Information Sharing. This contemplates accurate, consistent, and timely notice and disclosures to all policyholders, creditors, and guaranty associations of meaningful information (including financial information, status plans, and any proposed assumption reinsurance or other significant transactions) at inception and on an established schedule thereafter. Disclosures should also identify creditors (at least below the policy level) in order to permit some meaningful, organized discussion among creditors.

3. Adherence to Priority Scheme. Alternative mechanisms should require adherence to statutory liquidation priority schemes. They should not provide a mechanism for circumventing the distribution priority to benefit the company, its shareholders, employees, other stakeholders, or specific groups of policyholders at the expense of other classes of policyholders. Controls on preferences and the outflow of assets are needed, and will require regular ongoing review. The company and/or equity shareholders should not be permitted to retain assets unless all claims having priority, as measured under state liquidation laws, have been satisfied in full.

4. Coherent, Comprehensive Financial Planning. Any alternative mechanism should be based on a fully developed and comprehensive financial plan that includes complete and meaningful financial data, and projections based on reasonable and realistic financial assumptions. There should be full disclosure and transparency in financial planning, monitoring, and reporting as a condition to approval of any such plan and throughout implementation. In addition, any such mechanism should provide a global solution addressing all in-force policies and pending policy claims. There should be no ring-fencing or piecemeal disposition of assets and liabilities that may result in unequal treatment of policyholder claims, and give rise to preference and priority concerns. Moreover, the fairness and reasonableness of any mechanism cannot be reasonably assessed on a transaction-by-transaction basis without consideration of the overall impact on other policyholders and creditors.

5. Procedural Safeguards. Any alternative mechanism should provide substantive procedural safeguards, including clear standards for disclosure, reporting, and external review; appropriate and timely notice; access to information and the opportunity for informed participation for all stakeholders; court and/or regulatory approval for all significant actions to be taken; and meaningful compliance monitoring and reporting.

V. Observations and Considerations When Using Alternative Mechanisms

C. Existing Statutory Authority and Requirements

1. Use of Permitted Practices

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

2. Modifications to Existing Statutory Authority

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

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

D. Surveillance Monitoring by State Insurance Regulator

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

1. Supervision Orders/Consent Agreements/Letter of Understanding

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

If a supervision order is taken under the commissioner's administrative provisions, the insurer's management will generally remain in place subject to restrictions in the supervision order and the direction of the supervisor. The supervision can be voluntary or involuntary and confidential or public. Confidential supervisions are becoming more infrequent, as disclosures of such regulatory actions have become more

necessary under federal law for insurers within publicly traded groups. Some states may require court approval, as well.

2. Financial Reporting/Analysis/Examination

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

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

3. Communications

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

E. Benefits, Risks and Controls: For U.S. Claimants/Policyholders When a Non-U.S. Insurer or Reinsurer Restructures

1. Introduction

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

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

attributable to the pace of economic development, others to fundamental cultural differences, and still others to specific national public policies.

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

2. Potential Advantages And Risks Of Restructuring Mechanisms

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

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

a. Such mechanisms typically offer at least a realistic prospect of a faster resolution of the underlying financial challenge.

b. Often, these mechanisms are cheaper and therefore consume fewer scarce resources in the implementation of the process itself.

c. Often these mechanisms serve to preserve coverage that might otherwise have to be terminated in the context of formal proceedings.

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

a. Reduced regulatory and judicial oversight resulting in diminished policyholder protection.

b. Greater likelihood that policyholder interests will be compromised for the sake of other constituencies, such as owners, managers, and other creditors.

c. The probability that policyholders will have less influence in the process and a diminished ability to protect themselves from potentially adverse outcomes.

3. Key Considerations

In the U.S., state insurance regulators are accustomed to the fundamental principle that the interests of policyholders (used here as including insureds), especially consumers, should take precedence over those of unsecured non-policyholder creditors. This principle is not mandated in non-insurer bankruptcies in the U.S. and may not have the same importance in non-U.S. jurisdictions. It is helpful to identify the likely principal interests of policyholders (including insureds), as they may be affected in insurer restructuring.

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

a. Right of Payment

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

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

b. Continuation of Coverage

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

c. Claim Priorities

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

d. Guaranty Association Coverage

Over the last four decades the U.S. insurance sector has implemented nearly universal guaranty fund mechanisms, providing at least basic protection for the insureds of most failed insurers. There are, of course, notable exceptions like HMOs, risk retention groups, surplus lines carriers and certain lines (separate account annuities, fiduciary bonds, etc.) in the main; however, this "safety net" serves to soften the impact of insurer failure and effectively provides a standard against which are measured the anticipated results of restructuring. Most non-U.S. jurisdictions have not implemented nearly as comprehensive an insolvency protection scheme. The guaranty association mechanism is typically not available to reinsureds in the U.S. or elsewhere.

e. RIGHT TO VOTE

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

f. CRAM DOWN

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

g. VOICE IN REPLACEMENT

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

h. TRANSPARENCY

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

i. ACCOUNTABILITY

The individual or entity responsible for managing the restructuring may be a private practitioner engaged by the restructuring entity's management, a group of creditors, or a regulatory authority. Alternatively, the process may be placed in the hands of a public official. The degree to which the individual or entity in charge of the process is accountable to a superior or independent authority can be critically important

in ensuring the fairness and efficacy of the process. In those instances in which oversight consists principally of court supervision, the independence of the tribunal is important, as is the degree to which interested parties have access to that tribunal.

j. REGULATORY PROTECTION

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

k. ENFORCEMENT IN THE UNITED STATES

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

l. STANDING TO APPEAR

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

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

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

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

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

n. POLITICS

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

VI. CONCLUSION

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

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

VII. APPENDIX

A. CASE STUDIES

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

1. RESTRUCTURED TROUBLED REINSURANCE COMPANY

Company characteristics, circumstances, and concerns:

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

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

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

PRELIMINARY ACTIONS. The Department had several telephone conferences with RTRC management whereby the Department was informed that a capital contribution from RTRC's ultimate parent would be forthcoming as a result of the significant adverse development discussed above. Management then

contacted the Department for a meeting on the premise that the Chairman was in town and wanted a face-to-face meeting to discuss what was going on at the group. During that meeting, the Department was informed that RTRC and its direct subsidiary would be placed in run-off and neither would it receive a capital infusion as originally discussed. A firm was hired by RTRC's parent to assist in the development of a strategic plan for a solvent run-off.

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

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

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

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

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

2. NEW YORK REGULATION 141 PLAN

Company characteristics, circumstances, and concerns:

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

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

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

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

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

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

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

PRELIMINARY ACTIONS. As a result of its 2002 impairment, and pursuant to New York Insurance Law § 1321 and Insurance Regulation 141 (11 NYCRR Part 128) (Regulation 141), ABC submitted to the New York Insurance Department a plan to eliminate capital impairment pursuant to Regulation 141. As required under Regulation 141, ABC's board and the company's sole shareholder stipulated that if ABC's implementation of the Regulation 141 Plan failed to restore ABC's surplus to policyholders to the

minimum required as determined in accordance with Regulation 141, ABC would not oppose a petition to again liquidate the company pursuant to New York Insurance Law Article 74.

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

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

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

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

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

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

3. COMMERCIAL INSURANCE COMPANY RUN-OFF

Company characteristics, circumstances, and concerns:

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

- Parent sought to provide sufficient capital support to its subsidiary.

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

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

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

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

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

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

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

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

4. RESTRUCTURED TROUBLED LONG-TERM CARE COMPANY

Company characteristics, circumstances, and concerns:

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

BACKGROUND. Restructured Troubled Long-Term Care Company was a writer of predominately long-term care business, operating in most of the 46 states, D.C., and the U.S. Virgin Islands. It had held a firm

niche position in the long-term care market with profitable operations and a conservative balance sheet. The long-term care block of business was written by the Company and its predecessor companies prior to being acquired by the Company in the 1990s.

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

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

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

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

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

5. LIABILITY OF INSURERS TRANSFERRED TO THIRD PARTY – EUROPE

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

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

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

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

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

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

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

The unusual position of these particular re/insurers, should they wish to avail themselves of Part VII, was recognized at the time Part VII first became law. However, additional changes to the legislation had to be made to facilitate this transaction, and they became law in 2008. In particular, the Part VII provisions in the FSMA were extended to a further cohort of these particular re/insurers.
Under the Part VII transfer procedure, there are two court applications. The first gives directions as to notices to be served and other technical requirements allowing any opposing reinsureds or outwards reinsurers to object to the transfer. In the case of the XYZ Part VII, certain requirements were dispensed with taking into account the high volume of notices that would have to be given to individual names and other relevant parties. An essential part of the procedure is the report provided by an independent expert whose identity is approved by the Financial Services Authority (FSA). Furthermore, the FSA itself provides a report indicating its views that is made available to those interested in the transfer. Time is allowed for any objectors to produce their own case in the context of the independent expert report and the FSA's report. In the case of the XYZ transfer, the FSA indicated that it would not object to the transfer.

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

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

ENFORCEMENT IN OTHER JURISDICTIONS. Part VII of the FMSA originates from EU Directives. The sanction order is thereby recognized throughout the EEA. A further step would be needed to ensure enforcement in the United States and other countries where policyholders were located. However, the shape of the scheme is such that enforcement in the United States and other jurisdictions is most probably unnecessary. Policyholders would be entitled to drawdown on trust funds located in the United States,

Canada, Australia and South Africa, providing them with security for amounts accruing due to them over time should there be any default payment.

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

B. SAMPLE DOCUMENTS

1. SAMPLE SUPERVISION CONSENT ORDER

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

CONSENT ORDER

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

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

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

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

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

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

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

6. RTRC has ceased underwriting activities and has determined that it is in the best interests of its policyholders and creditors to run-off the existing operations of RTRC in such a manner as would maximize the availability of funds to satisfy the interests of policyholders, creditors, and other constituents.

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

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

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

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

IT IS THEREFORE ORDERED AND AGREED THAT:

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

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

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

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

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

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

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

(a) Dispose of, convey, or encumber any of its assets or its business in force. (b) Withdraw any of its bank accounts.
(c) Lend any of its funds.

(d) Invest any of its funds.
(e) Transfer any of its property.
(f) Incur any debt, obligation, or liability.
(g) Merge or consolidate with another company.
(h) Write new or renewal business.
(i) Enter into any new reinsurance contract or treaty.
(j) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except for nonpayment of premiums due.
(k) Release, pay, or refund premium deposits, unearned premiums, or other reserves on any insurance policy, certificate, or contract.
(l) Make any material change in management.
(m) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

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

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

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

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

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

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

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

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

_____ (name)

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

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

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

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

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

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

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

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

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

_____

(name)
Insurance Commissioner

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

By:

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(name)
President
(Corporate Seal)

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

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

_____

(name), (Title)

2. SAMPLE REINSURER LETTER AGREEMENT

November , 20XX

President
Restructured Troubled Reinsurance Company XXX Street Anywhere,
XX 00000

Dear _____:

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

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

of the operating subsidiaries of RTG from B+ to B-. Subsidiary Insurance Company was lowered from B to C++.

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

1. RTRC shall not take any of the following actions without the prior written approval of the Insurance Commissioner or her designee:

    a. Dispose of, convey, or encumber any of its assets or its business in force.
    b. Withdraw any of its bank accounts except in the ordinary course of business.
    c. Settle any intercompany balances.
    d. Lend any of its funds.
    e. Transfer any of its property.
    f. Make any investments other than cash equivalents.
    g. Incur any debt, obligation, or liability, except liabilities in the ordinary course of business.
    h. Make any material change in management.
    i. Make any material change in the operations of the Company.
    j. Move any books and records from its office in Stamford, Connecticut.
    k. Pay any dividends, ordinary or extraordinary.
    l. Enter into any affiliated reinsurance contracts, affiliated commutation agreements, or settlement agreements.
    m. Enter into any unaffiliated insurance or reinsurance contracts that would constitute new or renewal business, or any unaffiliated commutation agreements or settlement agreements in excess of $1 million not in the ordinary course of business.
    n. Enter into affiliated transactions of any nature.

2. Senior management shall meet with the Department, in person or by conference call, with such frequency as may be deemed necessary by the Insurance Commissioner or her designee, to provide updates on the status of the parent and any changes in the status of the Company.

3. A monthly financial statement consisting of a balance sheet and income statement shall be filed with the Department on the 25th day of each month as of the prior month end.

4. The above-described terms shall continue in effect until such time as the Insurance Commissioner shall deem they are no longer necessary or issues an order that supersedes this agreement.

5. RTRC acknowledges that nothing contained herein shall in any way limit any power or authority given the Insurance Commissioner under the laws of the State of Connecticut, including the right to initiate any further actions as she deems in her discretion to be necessary for the protection of RTRC's policyholders/reinsureds and the public.

I have enclosed two originals of this letter to your attention. Please sign and date both originals,

retain one for your file, and return one executed original to me. Sincerely,

_____, Chief Examiner
Financial Analysis & Compliance

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

C. Sample Outline for Run-Off Plans

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

I. Introductory Overview

A. Executive Summary: Providing an executive level summary of the history, current business conditions, recent significant transactions, and proposed run-off solution.

1. Status
2. Mission
3. Business (Guiding) Principles

B. Plan Objectives: Describing the ability of the plan to fully and timely settle all valid policyholder claims in compliance with the liquidation priorities of state distribution scheme.

C. Advantages

D. Benefits

II. Corporate History

A. Summary

B. Recent Happenings: Description of business plans, significant transactions, prior restructuring plans, and financial performance related thereto.

1. Mergers & Acquisitions
2. Employment
3. Internal Growth
4. External Factors
5. Current Position

C. Business Description: Including a comprehensive description of organizational and corporate structure, lines of insurance, nature of policyholder and other risks, and claim-handling function associated with the run-off.

1. Lines
2. Programs
3. Markets

D. Reserve Development

1. Environmental Issues
2. Underwriting Issues
3. Adverse Development
4. Reserves by Line – Summary

E. Financial Condition: Summary of recent financials

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

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

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

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

A. Summary

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

1. Key Factors
2. Assumptions
3. Revenues
4. Expenses
5. Surplus Projection
6. Liquidity Projection

C. Initiatives

1. Surplus Enhancing
    a. Policy Buybacks
    b. Expense Reductions
        i. Operating Expenses
            a. Staffing
            b. Real Estate
            c. Fixed Costs
            d. Insurance/Benefits
            e. Information Technology
        ii. Allocated Loss Adjustment Expenses
    c. Reinsurance Commutations
2. Liquidity
    a. Asset Portfolio Assessment
    b. Encumbered Assets
    c. Unencumbered Assets
    d. Statutory Deposits

D. Risk Factors: Description and projection of risks associated with Run-Off Plan, including regulatory concerns, preferences, and risks associated with policyholders, and guaranty funds/associations, including identification of critical elements for plan success.

1. Define Uncertainties
    a. Business
    b. Economic
    c. Regulatory

2. Additional Adverse Loss Reserve Development
3. Increased Reinsurance Disputes
4. Unexpected Liabilities
5. Drastic Asset Value Changes
6. Financial Market – Investments

E. Voluntary Run-off vs. Receivership: Analysis and comparison between the alternative mechanisms from best interests of policyholders, claimants, and guaranty funds/associations.

F. Regulatory Reporting: Description of proposed regulatory supervision and reporting requirements—e.g., monthly statutory basis financial statements (balance sheet, statement of income and statement of cash flow), including comparison of actual results to Plan projections; quarterly reports demonstrating reinsurance recoverables and premium receivables past due, in dispute, litigation or arbitration; report demonstrating material credit exposures, related collateral held, and identity of credit impaired transactions; unpaid losses on state-by-state basis; weekly cash flow report; periodic review of loss reserves and amortization of any permitted loss reserve discounting, including appropriate actuarial certification; copies of all internal and external audit reports within five business days of issue; approval of all transactions exceeding pre-determined thresholds; and identification of prohibited transactions.

G. Corporate Governance: Description of proposed governance and internal controls.

Attachment B-Attachment Two

D. Relevant NAIC Model Laws & Regulations and State Statutes

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

1. NAIC Model Laws & Regulations

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

2. Rules and Regulations of the State of New York – Title 11 Insurance Department – Chapter IV Financial Condition of Insurer and Reports to Superintendent – Subchapter D Reinsurance – Part 128 Commutation of Reinsurance Agreements (Regulation 141)

(Text is current through February 15, 2008.)

Section 128.0. Purpose.
Section 1321 of the Insurance Law authorizes the Superintendent of Insurance to permit an impaired or insolvent domestic insurer or an impaired or insolvent United States branch of an alien insurer entered through this state to commute reinsurance agreements as a means of eliminating such an impairment or insolvency. This Part sets forth applicable standards that the superintendent will use in determining whether such commutations will be approved.

Section 128.1. Applicability.
This Part shall be applicable to any domestic insurer or United States branch of an alien insurer entered through this state, other than a life insurance company as defined in section 107(a)(28) of the Insurance Law.

Section 128.3. General provisions.
(a) Nothing in this Part shall require the superintendent to give prior consideration to a plan which contains the commutation of reinsurance agreements in lieu of taking any other action against an impaired or insolvent insurer in accordance with the Insurance Law, including proceeding against such insurer pursuant to article 74 of the Insurance Law.
(b) All the terms and conditions of any plan which contains the commutation of reinsurance agreements are subject to approval by the superintendent and no such plan will be approved by the superintendent unless the effect of the plan shall eliminate the insurer's impairment or insolvency and restore the insurer's surplus to policyholders to the greater of the minimum amount required to be maintained pursuant to the applicable provisions of the Insurance Law or to the amount the superintendent determines is adequate in relation to the insurer's outstanding liabilities or financial needs. The

determination regarding the adequacy of the insurer's surplus to policyholders shall be made in accordance with the factors set forth in section 1104(c) of the Insurance Law.

Section 128.4. Requirements.

(a) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall provide that:
  (1) the offer to commute reinsurance agreements is made to each and every ceding insurer to which the impaired or insolvent insurer has obligations;
  (2) the terms of the commutation agreement to be offered to each and every ceding insurer are the same, except that the percentage by which the impaired or insolvent insurer proposes to discount obligations due to each ceding insurer may vary in regard to the type of business being commuted. Any variance by type of business shall be reasonable, actuarially sound and supported by documentation justifying such a variance; and
  (3) the impaired or insolvent insurer agrees to enter into a stipulation with the superintendent consenting to an order of rehabilitation or liquidation in the event that the implementation of the plan by the insurer does not result in restoring the insurer's surplus to policyholders to the minimum required as determined in accordance with section 128.3(b) of this Part.

(b) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall include:
  (1) a balance sheet that reflects the insurer's impairment or insolvency as determined by the superintendent, a pro forma balance sheet reflecting the financial condition of such insurer subsequent to the effective date of the plan, and a reconciliation between both balance sheets;
  (2) an exhibit setting forth the obligations due to each and every ceding insurer as of the proposed effective date of such plan and the consideration to be offered each and every ceding insurer for the commutation of such obligations. The obligations shall be classified in accordance with the categories contained in the definition set forth in section 128.2(c) of this Part; and
  (3) details regarding any retrocessionaire's participation in the plan.

Section 128.5. Procedures.

(a) Any plan which contains the commutation of reinsurance agreements shall be submitted to the superintendent by the impaired or insolvent insurer within a period designated by the superintendent, which shall not be more than 90 days from the determination of the insurer's impairment or insolvency.

(b) If the superintendent has no objection to any of the plan's terms and conditions and determines that the impaired or insolvent insurer's surplus to policyholders will be restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the proposed plan shall be approved and the insurer shall offer the commutation proposals to its ceding insurers. No commutation agreement shall become effective and no consideration for any commutation agreement shall be paid by the impaired or insolvent insurer until the superintendent determines that, as a result of the commutation proposals agreed to and executed by the ceding insurers, along with the effect of any other components of the plan, the impaired or insolvent insurer's surplus to policyholders is restored to the minimum required.

(c) Within 10 days after the superintendent approves the plan, the impaired or insolvent insurer shall deliver the proposed commutation agreements to each ceding insurer. The terms of any commutation agreement shall not be subject to negotiation between the impaired or insolvent insurer and the ceding insurer.

(d) The impaired or insolvent insurer shall submit to the superintendent, within a designated period as determined by the superintendent, copies of the executed commutation agreements from those ceding insurers agreeing to the proposed terms, copies of rejections of the commutation agreements by those

ceding insurers not agreeing to the proposed terms and copies of any other correspondence pertaining to all such offers made to the ceding insurers. This submission shall include a balance sheet that reflects the effect of the executed agreements, together with any other components of the plan, upon the insurer's impairment or insolvency as determined by the superintendent. The insurer shall also submit copies of executed agreements with any retrocessionaires which either modify, commute or assign any retrocession agreement.

(e) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the executed commutation agreements shall become effective.

(f) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is not restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the superintendent may proceed against the insurer in accordance with the stipulation executed pursuant to section 128.4(a)(3) of this Part.

Section 128.6. Reporting requirements.

Any impaired or insolvent insurer which eliminates such impairment or insolvency using commutations approved by the superintendent in accordance with the provisions of this Part shall exclude all historical data pertaining to such commutations from the loss development schedules contained in future financial statements filed in accordance with applicable provisions of the Insurance Law. The historical data pertaining to the business commuted shall be reported on a supplemental loss development schedule in a form consistent with the schedule contained in statutory financial statements as filed with this department. The supplemental schedule shall show the aggregate experience of such business as of the effective date of commutation agreement.

3. Rhode Island Statute and Regulation – Voluntary Restructuring of Solvent Insurers Title 27 Chapter 14.5 and Regulation 68

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

(a) The court considering applications brought under this chapter shall have the same jurisdiction as a court under chapter 14.3 of this title.

(b) Venue for all court proceedings under this chapter shall lie in the superior court for the county of Providence.

(c) The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this chapter. No provision of this chapter providing for the raising of an issue by a party in interest shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of process.

§ 27-14.5-3 Notice.

(a) Wherever in this chapter notice is required, the applicant shall, within ten (10) days of the event triggering the requirement, cause transmittal of the notice:

(1) By first class mail and facsimile to the insurance regulator in each jurisdiction in which the applicant is doing business;

(2) By first class mail to all guarantee associations;

(3) Pursuant to the notice provisions of reinsurance agreements or, where an agreement has no provision for notice, by first class mail to all reinsureds of the applicant;

(4) By first class mail to all insurance agents or insurance producers of the applicant;
(5) By first class mail to all persons known or reasonably expected to have claims against the applicant including all policyholders, at their last known address as indicated by the records of the applicant;
(6) By first class mail to federal, state, and local government agencies and instrumentalities as their interests may arise; and
(7) By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in any other locations that the court overseeing the proceeding deems appropriate.

(b) If notice is given in accordance with this section, any orders under this chapter shall be conclusive with respect to all claimants and policyholders, whether or not they received notice.
(c) Where this chapter requires that the applicant provide notice but the commissioner has been named receiver of the applicant, the commissioner shall provide the required notice.

§ 27-14.5-4 Commutation plans.

(a) Application. Any commercial run-off insurer may apply to the court for an order implementing a commutation plan.
(1) The applicant shall give notice of the application and proposed commutation plan.
(2) All creditors shall be given the opportunity to vote on the plan.
(3) All creditors, assumption policyholders, reinsurers, and guaranty associations shall be provided with access to the same information relating to the proposed plan and shall be given the opportunity to file comments or objections with the court.
(4) Approval of a commutation plan requires consent of: (i) fifty percent (50%) of each class of creditors; and (ii) the holders of seventy-five percent (75%) in value of the liabilities owed to each class of creditors.
(1) The court shall enter an implementation order if: (i) the plan is approved under subdivision (b)(4) of this section; and (ii) the court determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders.
(2) The implementation order shall:
(i) Order implementation of the commutation plan;
(ii) Subject to any limitations in the commutation plan, enjoin all litigation in all jurisdictions between the applicant and creditors other than with the leave of the court;
(iii) Require all creditors to submit information requested by the bar date specified in the plan;
(iv) Require that upon a noticed application, the applicant obtain court approval before making any payments to creditors other than, to the extent permitted under the commutation plan, payments in the ordinary course of business, this approval to be based upon a showing that the applicant's assets exceed the payments required under the terms of the commutation plan as determined based upon the information submitted by creditors under paragraph (iii) of this subdivision;
(v) Release the applicant of all obligations to its creditors upon payment of the amounts specified in the commutation plan;
(vi) Require quarterly reports from the applicant to the court and commissioner regarding progress in implementing the plan; and
(vii) Be binding upon the applicant and upon all creditors and owners of the applicant, whether or not a particular creditor or owner is affected by the commutation plan or has accepted it or has filed any information on or before the bar date, and whether or not a creditor or owner ultimately receives any payments under the plan.

(3) The applicant shall give notice of entry of the order.
(1) Upon completion of the commutation plan, the applicant shall advise the court.
(2) The court shall then enter an order that:
(i) Is effective upon filing with the court proof that the applicant has provided notice of entry of the order;
(ii) Transfers those liabilities subject to an assumption reinsurance agreement to the assumption reinsurer, thereby notating the original policy by substituting the assumption reinsurer for the applicant and releasing the applicant of any liability relating to the transferred liabilities;
(iii) Assigns each assumption reinsurer the benefit of reinsurance on transferred liabilities, except that the assignment shall only be effective upon the consent of the reinsurer if either:
(A) The reinsurance contract requires that consent; or
(B) The consent would otherwise be required under applicable law; and
(iv) Either:
(A) The applicant be discharged from the proceeding without any liabilities; or (B) The applicant be dissolved.
(3) The applicant shall provide notice of entry of the order.

(e) Reinsurance. Nothing in this chapter shall be construed as authorizing the applicant, or any other entity, to compel payment from a reinsurer on the basis of estimated incurred but not reported losses or loss expenses, or case reserves for unpaid losses and loss expenses.

(f) Modifications to plan. After provision of notice and an opportunity to object, and upon a showing that some material factor in approving the plan has changed, the court may modify or change a commutation plan, except that upon entry of an order under subdivision (d)(2) of this section, there shall be no recourse against the applicant's owners absent a showing of fraud.

(1) The commissioner and guaranty funds shall have the right to intervene in any and all proceedings under this section; provided, that notwithstanding any provision of title 27, any action taken by a commercial run-off insurer to restructure pursuant to chapter 14.5, including the formation or re-activation of an insurance company for the sole purpose of entering into a voluntary restructuring shall not affect the guaranty fund coverage existing on the business of such commercial run-off insurer prior to the taking of such action.
(2) If, at any time, the conditions for placing an insurer in rehabilitation or liquidation specified in chapter 14.3 of this title exist, the commissioner may request and, upon a proper showing, the court shall order that the commissioner be named statutory receiver of the applicant.
(3) If no implementation order has been entered, then upon being named receiver, the commissioner may request, and if requested, the court shall order, that the proceeding under this chapter be converted to a rehabilitation or liquidation pursuant to chapter 14.3 of this title. If an implementation order has already been entered, then the court may order a conversion upon a showing that some material factor in approving the original order has changed.
(4) The commissioner, any creditor, or the court on its own motion may move to have the commissioner named as receiver. The court may enter such an order only upon finding either that one or more grounds for rehabilitation or liquidation specified in chapter 14.3 of this title exist or that the applicant has materially failed to follow the commutation plan or any other court instructions.
(5) Unless and until the commissioner is named receiver, the board of directors or other controlling body of the applicant shall remain in control of the applicant.

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

Section 2 *Purpose*

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

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

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

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

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

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Agenda item 2024-06 Risk Transfer Analysis of Combination Reinsurance Contracts
Illustrated Revisions

The revisions adopted at the Summer National Meeting by Statutory Accounting Principles (E) Working Group and the Accounting Practices and Procedures (E) Task Force at the Summer National Meting from agenda item *2024-06 Risk Transfer Analysis of Combination Reinsurance Contracts* are shown below along with a minor clarification proposed for the effective date.

- ***SSAP No. 61—Life, Deposit-Type and Accident and Health Reinsurance***

Effective Date - **For SSAP No. 61, the minor shaded clarification below is recommended to the effective date paragraph in SSAP No. 61**. The Working Group chose year-end 2026 to allow companies that may have existing contracts adequate time to allow for industry and regulator assessment. At the Summer Meeting, the Working Group did not support grandfathering of existing contracts due to concerns of market inconsistency, creating conflicts with current guidance or recent state actions. After the Summer Meeting, discussions with companies and certified public accountants, noted that it would be helpful to be explicit that the change for existing contracts is reflected as a **change in accounting principle**. This clarification, which is shown as shaded text below, does not change the scope of the affected contracts from what was unanimously adopted at the Working Group, and is helpful to be explicit to avoid prior year restatements. The wording is consistent with the Working Group's intended prospective treatment of existing contracts as of the Dec. 31, 2026 reporting date.

94. The disclosure for compliance with Model #787 or AG 48 shall be effective for reporting periods ending on or after December 31, 2015. The revisions adopted in November 2018 to expand liquidity disclosures are effective year-end 2019, concurrent with the inclusion of data-captured financial statement disclosures. The disclosures captured in paragraphs 78-84 which help to identify certain reinsurance contract features are effective for reporting periods ending on or after December 31, 2020. Clarifications of existing guidance adopted in August 2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19 are effective immediately for new/ newly amended contracts. For existing contracts, the clarification shall be accounted for as a change in accounting principle in accordance with *SSAP No. 3—Accounting Changes and Corrections of Errors*, on or before December 31, 2026.

- Below is remainder of the adopted language to SSAP No. 61:

17. **Transfer of Risk** Reinsurance agreements must transfer risk from the ceding entity to the reinsurer in order to receive the reinsurance accounting treatment discussed in this statement.

a. If the terms of the agreement violate the risk transfer criteria contained herein, (i.e., limits or diminishes the transfer of risk by the ceding entity to the reinsurer), the agreement shall follow the guidance for Deposit Accounting. In addition, any contractual feature that delays timely reimbursement violates the conditions of reinsurance accounting.

b. For purposes of evaluating whether a reinsurance agreement/contract (for this paragraph "contract") transfers risk under statutory accounting, the determination of what constitutes a contract is essentially a question of substance. It may be difficult in some circumstances to determine the boundaries of a contract. Multiple contracts, whether on one or multiple blocks of policies, must be evaluated together for risk transfer purposes where considerations to be

exchanged under one contract depend on the performance of the other contract(s) whether they are entered into together, or separately, directly or indirectly, that achieve one overall planned effect.

c. For contracts that contemplate reinsurance on both a YRT and coinsurance basis, where there are interdependent features such as a combined experience refund or an inability to independently recapture, each of the YRT and coinsurance reinsurance components satisfying risk transfer requirements on their respective bases is necessary but not sufficient for the contract as a whole to satisfy risk transfer. When evaluated in its entirety, such contract(s) cannot 1) potentially deprive the ceding insurer of surplus at the reinsurer's option or automatically upon the occurrence of some event; 2) potentially require payments to the reinsurer for amounts other than the income realized from the reinsured policies, nor; 3) contain any of the other conditions prohibited by Appendix A-791 related to risk transfer.

18. This paragraph applies to all life, deposit-type and accident and health reinsurance agreements except for yearly renewable term reinsurance agreements and non-proportional reinsurance agreements such as stop loss and catastrophe reinsurance. All reinsurance agreements covering products that transfer significant risk shall follow the guidance for reinsurance accounting contained in this statement. All reinsurance contracts covering products that do not provide for sufficient transfer of risk shall follow the guidance for Deposit Accounting.

19. Yearly renewable term (YRT) reinsurance agreements that transfer a proportionate share of mortality or morbidity risk inherent in the business being reinsured and do not contain any of the conditions described in Appendix A-791, paragraphs 2.b., 2.c., 2.d., 2.h., 2.i., 2.j. or 2.k., shall follow the guidance for reinsurance accounting, including paragraphs 55-57 of this statement that apply to indemnity reinsurance. Contracts that fail to meet the requirements for reinsurance accounting shall follow the guidance for Deposit Accounting. For all treaties entered into on or after January 1, 2003, the deferral guidance in paragraph 3 of A-791 shall also apply to YRT agreements. YRT agreements shall follow the requirements of A-791, paragraph 6, regarding the entire agreement and the effective date of agreements. Since YRT agreements only transfer the mortality or morbidity risks to the reinsurer, the recognition of income shall be reflected on a net of tax basis, as gains emerge based on the mortality or morbidity experience. See paragraph 17.b. for additional requirements if a YRT agreement has interdependent contract features with reinsurance on a different basis (such as coinsurance).

- Appendix *A-791, Life and Health Reinsurance Agreements* **adopted revisions** to the first Q&A

Q – Aside from assumption reinsurance, what other types of reinsurance are exempt from the accounting requirements?

A – Yearly renewable term (YRT) and certain nonproportional reinsurance arrangements, such as stop loss and catastrophe reinsurance are exempt because these do not normally provide significant surplus relief and therefore are outside the scope of this Appendix. If a catastrophe arrangement takes a reserve credit for actual losses beyond the attachment point or the unearned premium reserve (UPR) of the current year's premium, there will most likely be no regulatory concern.

Similarly, if a YRT treaty provides incidental reserve credits for the ceding insurer's net amount at risk for the year with no other allowance to enhance surplus, there will most likely be no regulatory concern.

For purposes of this exemption, a treaty labeled as YRT does not meet the intended definition of YRT if the surplus relief in the first year is greater than that provided by a YRT treaty with zero first year reinsurance premium and no additional allowance from the reinsurer.

For contracts that contemplate reinsurance on both a YRT and coinsurance basis, where there are interdependent features such as a combined experience refund or an inability to independently recapture, risk transfer can only occur if there is no potential for payments out of surplus at the reinsurer's option or automatically upon the occurrence of some event, meaning that in all cases there would be an established liability to absorb any possible payments. The YRT premium simply being at or below the valuation net premium does not ensure that payments from surplus are not possible.

Additional pertinent information applicable to all YRT treaties and to non-proportional reinsurance arrangements is contained in paragraphs 19 and 20 of SSAP No. 61.