

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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Draft Pending Adoption

Draft: 8/21/23

Receivership and Insolvency (E) Task Force
Seattle, Washington
August 14, 2023

The Receivership and Insolvency (E) Task Force met in Seattle, WA, Aug. 14, 2023. The following Task Force members participated: James J. Donelon, Chair (LA); Glen Mulready, Vice Chair, represented by Donna Wilson and Jamin Dawes (OK); Mark Fowler represented by Ryan Donaldson (AL); Andrew N. Mais represented by Jane Callanan (CT); Doug Ommen represented by Kim Cross and Daniel Mathis (IA); Dana Popish Severinghaus represented by Jacob Stuckey, Bruce Sartain and Susan Berry (IL); Vicki Schmidt represented by Philip Michael (KS); Sharon P. Clark represented by Jeff Gaither (KY); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented by Lindsay Crawford (NE); Justin Zimmerman represented by David Wolf (NJ); Judith L. French represented by Matt Walsh (OH); Andrew R. Stolfi represented by Brian Fjeldheim (OR); Michael Humphreys represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Michael Wise represented by Ryan Basnett (SC); Carter Lawrence represented by Stephanie Cope (TN); Cassie Brown represented by Brian Riewe (TX); Mike Kreidler represented by Charles Malone (WA); and Nathan Houdek represented by Levi Olson (WI).

1. Adopted its Spring National Meeting Minutes

Crawford made a motion, seconded by Biehn, to adopt the Task Force's March 23 minutes, which includes one edit (Attachment One). The motion passed unanimously.

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

Wilson said the Receivership Financial Analysis (E) Working Group plans to meet Aug. 14 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.

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

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

Slaymaker said the Receivership Law (E) Working Group held two conference calls on July 24 and May 23. On the May 23 call, the Working Group exposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)* related to coverage of policies that are subject to restructuring mechanisms, specifically insurance business transfers (IBTs) and corporate divisions (CDs), as well as revisions related to clarifying coverage for cybersecurity insurance.

Slaymaker said the Working Group received comments from three interested parties on the restructuring mechanisms amendments, which were discussed on the July 24 call. The focus of those comments was primarily on the assumed claims transaction provisions that are removed and the inclusion of related optional provisions for the few states that feel the need to include that language. The Working Group adopted the amendments to Model #540 on the July 24 call. Slaymaker said the Working Group is not asking the Task Force to adopt the amendments at this meeting.

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Slaymaker said on the July 24 call, the Working Group also heard a presentation from a data archeologist that requested that states consider extending their records retention of closed receivership estate records or transferring records to university libraries after the estate closes. The presentation raised some interesting topics, but no action was discussed.

Patrick Cantilo (Cantilo and Bennett LLP) said he submitted comments on the amendments to Model #540 (Attachment Two). He said his views are his own and not his clients. He said the goals of the IBT and CD amendments are to assure that the implementation of those transactions does not result in the loss of guaranty association coverage for policyholders. He said he supports that goal. The second goal, which will not be found in the description of the proposed amendments is to create an optional removal of amendments already adopted in 2009 for providing policyholder's guaranty association coverage in what are called assumed claims transactions. If this Task Force or the Receivership Law (E) Working Group has determined that there should be consideration of reversing the 2009 amendments, that should be described openly. He said the amendments that are represented do not readily identify that the purpose is to remove that 2009 coverage. He said he submitted to the Working Group a much simpler amendment that would accomplish the charge. He said the amendments as proposed go much further and create a mechanism to remove the 2009 extension of protection for the assumed claims transactions. He said that should be deliberated and interested parties encouraged to express their views on the removal of those protections.

Joe Torti (Fairfax U.S.) said he is vice president of regulatory affairs for Fairfax U.S. and chairman of the board of directors for the National Conference of Insurance Guaranty Funds (NCIGF). He said he is speaking at this meeting on behalf of the American Property Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC). He said he urges the Task Force to expose the draft restructuring and cyber amendments and move forward to adoption expeditiously. He said he is in favor of the coverage neutrality concept for claims resulting from restructured business, such that the guaranty association coverage should remain in place for claims that would have had guaranty association coverage if they had not been transferred from the original issuer, or conversely, coverage should not be created for claims that would not have been covered before the transaction. This concept is embodied in the draft amendments presented at this meeting. Restructuring transactions, while a useful tool, were never intended to afford coverage by guaranty associations on policy claims that were not covered before the transaction.

Cope made a motion, seconded by Biehn, to adopt the report of the Receivership Law (E) Working Group (Attachment Three). The motion passed unanimously.

4. Exposed Model #540 Amendments

Slaymaker said subsequent to the Receivership Law (E) Working Group call on July 24, Wake, a member of the drafting group, identified a few conflicts where certain assumed claims language in the drafting notes conflicts with the new optional provisions in Section 5G(3) and Section 8A(3). The exposure draft reflects removing those conflicting paragraphs, while still maintaining the key portions of the 2009 assumed claims transaction language in the drafting notes. The exposure draft also includes the correction of references in certain sections. She said while most of these changes are only to drafting notes, given past discussion over the assumed claims provisions, she recommends exposing these subsequent edits for a further 30-day public comment period.

Commissioner Donelon said hearing no objection, the amendments to Model #540 would be exposed for a 30-day public comment period ending Sept. 14, 2023.

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5. Exposed a U.S. Resolution Template

Jane Koenigsman (NAIC) said a template has been drafted that may be used by a U.S. lead state to describe the U.S. receivership regime within resolution plans or to facilitate dialogue with international supervisors during supervisory colleges and crisis management group (CMG) discussions. It is intended to be a summary to provide enough information to the international jurisdiction to gain an understanding of the U.S. receivership process. The template does not constitute a complete resolution plan. There are other aspects of a resolution plan that are specific to a company and its unique risks. It is the responsibility of the group-wide supervisor in consultation with the CMG to determine if the group-wide supervisor should develop a resolution plan and what to include in it.

Koenigsman said a state would need to modify the template for the individual state's laws, regulations, and receivership practices and supplement it with any regulations that apply to the insurer (e.g., life insurance versus property insurance, product types, or investment types).

Koenigsman asked states to review and provide feedback on the template, especially if the state has an internationally active insurer and understands what information would be most valuable to share with international regulators.

Commissioner Donelon said hearing no objection, the draft U.S. resolution template would be exposed for a 30-day public comment period ending Sept. 14, 2023.

6. Heard an Update on International Activities

Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group met at the end of May 2023 to work on the policyholder protection issues paper. The Working Group has also been discussing updates to the IAIS Insurance Core Principles (ICPs) that deal with resolution. Wake said this review of ICPs is in progress, and the Working Group is near to reaching a consensus to have a more topic-focused and outcomes-oriented approach to the appropriate resolution powers rather than a list of resolution powers.

Wake said he is pleased to welcome William Arfanis (CT) as a second NAIC representative on the IAIS Resolution Working Group. The Working Group is meeting next in September 2023.

Wake said the work on the holistic framework progress monitoring continues. One accomplishment is the work in progress that we exposed today on the U.S. resolution template.

7. Discussed Part A Financial Regulation and Accreditation Standards for Receivership and Guaranty Association Laws

Commissioner Donelon asked NAIC staff to explain the Part A Financial Regulation and Accreditation standards for states' receivership and guaranty association laws and the historical review performed by the Task Force.

Koenigsman said the Task Force has undertaken a review of the *Insurer Receivership Model Act* (#555), the *Life and Health Insurance Guaranty Association Model Act* (#520), and Model #540. Beginning in 2009, the former Critical Elements (E) Advisory Group reviewed these models to identify provisions that were non-controversial and critical for states to adopt. In 2014, the former Receivership Model Law (E) Working Group began with the previous work and narrowed the focus of the review to those provisions that were specific to a multi-state receivership. The Working Group further focused on reviewing U.S. laws in comparison to the Financial Stability Board's (FSB) *Key Attributes of Effective Resolution Regimes for Financial Institutions*. A memo was sent to states by the Financial Condition (E) Committee in 2017 to provide guidance and encourage states to adopt improvements in state laws regarding the recognition of stays and injunctions.

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Koenigsman said in 2018, the Task Force undertook further review of the U.S. receivership laws related to macroprudential surveillance. This work resulted in several recommendations, including:

- The new *Guideline for Definition of Reciprocal State in Receivership Laws* (#1985).
- Amendments to the *Insurance Holding Company System Regulatory Act* (#440) for the continuity of essential services and functions by affiliated entities.
- Updated guidance in the *Receiver's Handbook for Insurance Company Insolvencies*.
- Updated guidance for the implementation of the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), including resolution plans, which include the U.S. resolution template the Task Force exposed for public comment during this meeting.

Koenigsman said in 2020, an ad hoc group was formed to discuss Part A Financial Regulation and Accreditation standards, specifically interpretive guidance in the accreditation interlineations. Concerns were raised at that time that making any changes could be misinterpreted or have unintended consequences. The Task Force did not make any proposals to clarify the accreditation interlineations at that time.

Dan Schelp (NAIC) summarized the Part A Financial Regulation and Accreditation standards for receivership and guaranty association laws. He said substantially similar standards mean a state's laws, regulations, or administrative practices are substantially similar to the significant elements identified in the model. Receivership and guaranty association laws do not fit into this category. Substantially similar does not mean a state is required to adopt every significant element of the law or regulation. He said the standards are not a uniformity requirement but rather a minimum financial standards requirement. It is required that states demonstrate that the law, regulation, or administrative practice results in solvency regulation that is similar in force and no less effective than the model upon which it is based. A substantially similar standard does not result in uniformity; although, in a practical matter, that is often the case. There are some Part A standards that do not require substantially similar standards. These are regulatory framework standards, which include the guaranty fund models. A regulatory framework provides for a state to detect the occurrence of the solvency-related event or activity contemplated by the model law and to exercise appropriate oversight when such an activity or event occurs. It also states that if potential harm or activity occurs, a regulatory framework would have sufficient resources, including regulatory tools, vested in the state insurance department to take appropriate action.

Schelp said with respect to the guaranty fund models, a state must have a regulatory framework that addresses the payment of policyholder obligations when a company is deemed to be insolvent. There is a requirement that a guaranty fund addresses obligations owed to policyholders, but there is no significant element as to the amount of the obligation. Although many states are uniform, there is some variation among states on claims limits, as some are higher or lower than the model.

Schelp said the receivership standard is not substantially similar, nor is it a regulatory framework. State law must set forth a receivership scheme for the administration of an insurance company found to be insolvent, similar to Model #555. Although there is not much guidance on the definition of a scheme, historically, it has been interpreted to mean a regulatory framework. The benefit limit in Model #540 is \$500,000.

Commissioner Donelon asked what the lowest and highest guaranty association benefit limit is in states for property/casualty (P/C) insurance.

Doug Hartz (Private Citizen) said worker's compensation is unlimited.

Barbara Cox (Barbara Cox LLP), outside counsel for the NCIGF, said Michigan has a benefit limit that is a certain percentage of direct written premium, which could be upwards of \$5 million. New York has a \$1 million benefit

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limit. California has a homeowners benefit limit that includes various coverage components of \$1 million, resulting from recent catastrophe activity. Cox said workers' compensation has no limit in the 50 U.S. states.

8. Heard an Update on a Receivership Tabletop Exercise

Koenigsman said the NCIGF, and the National Organization of Life and Health Guaranty Associations (NOLHGA) proposed a receivership tabletop exercise at the Spring National Meeting. NAIC staff reached out to the states to get feedback on their interest and preferences for an exercise. Koenigsman said of the 29 states that responded most preferred an in-person session at the beginning of an NAIC national meeting. She said NAIC staff will look at the availability of time and space to schedule the exercise at the Fall National Meeting.

9. Heard an Announcement of the IAIR Technical Development Series

Wilson said the International Association of Insurance Receivers (IAIR) will host its annual Technical Development Series (TDS) Sept. 27–29 in San Diego, CA. TDS topics will include legal challenges in receivership, how to resolve them, and other issues of interest to receivers.

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

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

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

1. Adopted its 2022 Fall National Meeting Minutes

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

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

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

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

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

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

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

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

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

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

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

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

5. Heard an Update on International Activities

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

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

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

6. Heard a Presentation on a Proposed Receivership Tabletop Exercise

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

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

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

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

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

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

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

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

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

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August 10, 2023

The Honorable James J. Donelon, Chair
The Honorable Glen Mulready, Vice Chair
Receivership and Insolvency (E) Task Force
C/O Jane Koenigsman
Sr. Manager - Life/Health Financial Analysis
National Association of Insurance Commissioners
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BY ELECTRONIC MAIL

RE: MODEL 540 COMMENTS

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

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

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

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

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

PROPOSED VERSION 2

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

H. *“Covered claim” means the following:*

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

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

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

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

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

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

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

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

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

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

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

THE ASSUMED CLAIMS COVERAGE

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

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

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

THE RENEWED ATTACK

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

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

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

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

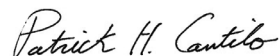
Among the responses to this argument, was that few states had adopted the 2009 amendments. That led me to propose the simple 4-line Version 2 that could be used in states that had not adopted the assumed claims language to assure that IBT and CD transactions would not result in loss of guaranty association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

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

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

I thank you for your kindness in considering my comments.

Very truly yours,



Patrick H. Cantilo

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

Attachment Two

Receivership and Insolvency (E) Task Force

8/14/22

AT RICHMOND, AUGUST 24, 2005

APPLICATION OF

RECIPROCAL OF AMERICA and
THE RECIPROCAL GROUP

CASE NO. INS-2003-00239

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

FINAL ORDER

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

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

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

² Application at 1.

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

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

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

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

⁴ Id.

⁵ Id. at 6-7.

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

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

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

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

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

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

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

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

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

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

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

¹¹ Statutory references are to the Code of Virginia.

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

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

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

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

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

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

¹⁶ Amendment at 6.

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

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

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

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

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

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

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

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

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

¹⁸ See Report at 116.

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

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

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

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

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

Discussion

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

Section 38.2-1509 B 1 ii of the Code provides, in pertinent part, that "[t]he Commission shall disburse the assets of an insolvent insurer as they become available in the following manner: 1. Pay, after reserving for the payment of the costs and expenses of administration, according to the following priorities: . . . (ii) claims of the associations for "covered claims" and "contractual obligations" as defined in §§ 38.2-1603 and 38.2-1701 and *claims of other policyholders arising out of insurance contracts apportioned without preference. . . .*" (emphasis added). We must determine if the SITs and GSIAAs or employers thereof constitute "policyholders arising out of insurance contracts" to determine whether they fall within this category of the asset disbursement scheme for insolvent insurers crafted by the General Assembly.

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

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

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

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

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

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

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

²³ See Report at 114-117.

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

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

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

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

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

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

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

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

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

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

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

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

²⁶ 871 A.2d at 592.

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

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

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

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

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

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

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

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

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

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

Apportioned without preference

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

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

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

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

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

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

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

³¹ Report at 127.

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

Conclusion

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

Accordingly, IT IS ORDERED THAT:

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

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

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

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

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

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

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

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

TROUTMAN SANDERS LLP

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December 22, 2005

Via Hand Delivery

Joel H. Peck, Esquire
Clerk
State Corporation Commission
Tyler Building, 1st Floor
1300 East Main Street
Richmond, Virginia 23219

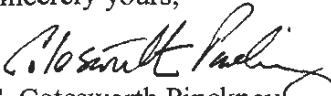
Re: Application of Reciprocal of America and the Reciprocal Group; For a
Determination Whether Certain Worker's Compensation Insurance Policy
Payments May be Made to Claimants Formerly Covered by SITs and GSIA's
Case No. INS-2003-00239; Notice of Withdrawal of Appeal

Dear Mr. Peck:

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

Thank you for your assistance in this matter.

Sincerely yours,


C. Cotesworth Pinckney

Enclosures

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

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ATLANTA • HONG KONG • LONDON • NEW YORK • NORFOLK • RALEIGH
RICHMOND • TYSONS CORNER • VIRGINIA BEACH • WASHINGTON, D.C.

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

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

NOTICE OF WITHDRAWAL OF APPEAL

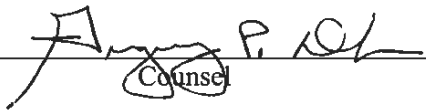
The Indiana Insurance Guaranty Association, Kansas Insurance Guaranty Association, Mississippi Insurance Guaranty Association and Tennessee Insurance Guaranty Association (the "Guaranty Associations"), the Virginia Property and Casualty Insurance Guaranty Association (the "Virginia Association"), the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

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

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

Dated December 21, 2005.

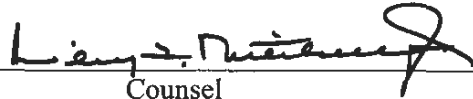
INDIANA INSURANCE GUARANTY
ASSOCIATION, KANSAS INSURANCE
GUARANTY ASSOCIATION, MISSISSIPPI
INSURANCE GUARANTY ASSOCIATION, and
TENNESSEE INSURANCE GUARANTY
ASSOCIATION

By  _____
Counsel

VIRGINIA PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION

By  _____
Counsel

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AND THE ALABAMA SUBSCRIBERS

By 
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THE KENTUCKY HOSPITALS

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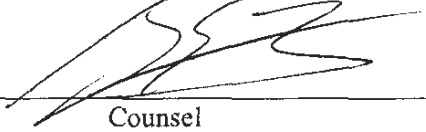
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CERTIFICATE OF SERVICE

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

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

and photocopies thereof were mailed by first class mail to:

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State Corporation Commission
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1424281

Draft: 8/16/23

Receivership Law (E) Working Group
Virtual Meeting
July 24, 2023

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force met July 24, 2023. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Michael Surguine (AR); Joe Holloway (CA); Jane Callanan (CT); Lorrie Arterburn (FL); Kim Cross (IA); Tom Travis (LA); Christopher Joyce (MA); Robert Wake (ME); Tom Mitchell (MI); Shelley Forrest (MO); Lindsay Crawford (NE); Brian Riewe (TX); and Charles Malone (WA). Also participating was: Dan Bumpus (VA).

1. Adopted its May 23 Minutes

Slaymaker said the Working Group met May 23 to expose proposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) for a 30-day comment period ending June 23.

Crawford made a motion, seconded by Arterburn, to adopt the Working Group's May 23 minutes (Attachment Three-A). The motion passed unanimously.

2. Adopted Amendments to Model #540

Slaymaker said the amendments to Model #540 aim to address guaranty fund coverage for policies included in insurance business transfers (IBTs) and corporate divisions (CDs) and to clarify guaranty association coverage of cybersecurity insurance. Regarding the IBT and CD amendments, the exposure included the optional language and a drafting note in Section 5G(3), as well as in other sections that were proposed for those states that may want to keep the assumed language that is proposed to be deleted. Slaymaker said NAIC staff made a few edits to section references, which are included in the materials. No comments were received on the cybersecurity insurance amendments. Three comment letters were received on the IBT and CD amendments.

Patrick Cantilo (Cantilo & Bennett LLP) summarized his comments (Attachment Three-B). Cantilo said the change necessary to accomplish the charge, which is to avoid the loss of coverage, is straightforward and can be done with the changes proposed in his comment letter. Cantilo said the only difference between his approach and the approach in the draft is that the draft allows the removal of the assumed claims coverage that was adopted in 2009, which is not necessary to assure guarantee association coverage remains for a CD transaction.

Slaymaker said a comment letter was received from Joe Torti (Fairfax (US) Inc.) (Attachment Three-C).

Barbara F. Cox (Barbara F. Cox LLC) summarized the National Conference of Insurance Guaranty Funds' (NCIGF's) comments (Attachment Three-D). She said NCIGF does not support the addition of Section 5G(3) in the covered claim definition, as it is contrary to NCIGF's adopted policy that if there were coverage before the transaction, there should be coverage after, and if there were no coverage, coverage should not be created. She said Fairfax (US) Inc. is not attending this meeting, but she believes it agrees with NCIGF. She said the 2009 amendments to Model #540, which are deleted throughout the draft, have only been adopted in three states. She said 12 states have adopted either IBT or CD transaction statutory authority. She said NCIGF supports the deletion of the 2009 amendments.

Joyce said his primary concern is that the 2009 assumed claims language in the current draft of Model #540 appears to contemplate potential coverage for situations that the Working Group would now be removing in these

amendments. He said he does not know what has changed since 2009 to warrant removing the language. He said he understands that part of the concern is that state insurance regulators will likely see more of these IBT and CD transactions where one party is assuming business from another due to the adoption of IBT and CD statutes in various states. If the need for the assumed claims transaction language was recognized in 2009, he is unsure what has changed. He said he is not convinced that the referral obligates the removal of potential coverage from the current Model #540 for policyholders who are subject to IBT and CD transactions to maintain their coverage. He said he very much supports the inclusion of some sort of optional language as proposed. Baldwin asked Joyce if optional Section 5G(3) would satisfy his concern with preserving the ability to cover the assumed transaction. Joyce said it would.

Cantilo said the referral is easily met by his proposal, which preserves guarantee association coverage for IBTs and CDs. He said he does not believe that anyone has suggested to the drafting group that it does not. The contrast between the two options is simply that one does what was intended, which is to preserve guarantee association coverage for these transactions, and the other option, which affects Section 5G(2) and other changes, is intended to also remove the assumed claims coverage, which is not necessary for the purpose of discharging what the referral intended. Cantilo said guarantee association coverage could be preserved both with and without the assumed claims language depending on what a state proposes by the amendment to the definition that is described in his comment letter.

Cox said Section 5G(3) does preserve some of the assumed claim business language. Section 5G(2) also preserves it to the extent the assumed claim transaction would flow from member to member or member to non-member.

Wake said Section 5G(3) captures everything substantively that was in all of the 2009 amendments that are proposed to be deleted. This puts back the substance in a much shorter paragraph.

Wake said he would be happy with either version of the proposed amendment, either with Section 5G(3) being optional or without it.

Bumpus said he supports the language, alternative language, and the comments that Cantilo raised, as they may be a workable solution. He said the issue of assumed claims came up in Virginia with a receivership 15 years ago, and it is covered in Virginia by the guarantee funds. He said he thinks that the proposed language from Cantilo most closely aligns with the charge to make sure that the guarantee fund coverage is unchanged. He said he has not had a chance to review the proposal with the optional language.

Cantilo asked what the more extensive revision to Model #540 accomplishes that is not also accomplished by his simpler, single-paragraph edition.

Wake said Cantilo's proposal looks more like the current version of Model #540, but compared to the current draft, Cantilo's proposal has four versions of a lengthy paragraph. He said he has stated in previous comments that he does not agree with Cantilo's explanation of his language and that it would need more editing. He said that, substantively, if a state insurance department adopts the optional Section 5G(3), the state insurance department would get the substance of Cantilo's proposal. If the state insurance department does not adopt Section 5G(3), it would get what NCIGF and Torti have proposed. He said this is a topic that has already been discussed.

Cox said NCIGF continues to support Section 5G(2) as a standalone provision. While NCIGF does not support Section 5G(3), it is preferable to the 2009 draft with the modifications. If state insurance departments want to adopt the optional Section 5G(3), that gives them a choice of how far they want to go to resolving restructuring transactions.

Slymaker said the amendments were exposed with the optional language, and based on the discussion, including the optional language may be the approach to move forward with. She asked for a motion to adopt either with or without the optional language.

Wake made a motion, seconded by Travis, to adopt the amendments to Model #540 (Attachment Three-E), including the optional language. The motion passed unanimously.

3. Heard a Presentation from Arcina Risk Group on Receivership Estate Records Retention

Richard Janisch (Arcina Risk Group) said Arcina is a 15-year-old company with roots in insurance archaeology, which is mostly uncovering old insurance liability policies. However, it could involve other types of coverage, such as maritime policies and workers' compensation programs. Driving Arcina's business are legacy claims, asbestos liabilities, other emerging legacy tort matters, and other emerging claims related to polyfluoroalkyl substances (PFAS) standards that are being imposed on states involving firefighting foam and other consumer products that include PFAS.

Janisch said Arcina's objective is to ask for some guidance and present a concept for preserving insolvent insurance estate records. He said he believes there is a labor force, sophisticated technology, and data tools to preserve these records more cost-efficiently than in the past. Legacy insurance policies are current space policies. Because of claims activities in the past, the primary coverages are exhausted or insolvent, which then means moving into excess layers. The excess insurance is dependent on what the policy form language was for the underlying coverage. When the underlying coverage is with an insolvent insurer, and those records are destroyed, it becomes a difficult archaeological task to try to uncover. He said he believes preserving the insolvent estate records for the long term would be a great public service with which Arcina would like to assist.

Janisch said some universities have risk management departments or risk management schools of study that have libraries and would be willing to accept some of these historical records and provide the labor to help support organizing those records. He said Arcina is interested in the policies. Other proprietary information in these records could be filtered out, and that is where Arcina would want some guidance on how that could be done and what nuances exist. There are some key states that are very active in liquidation proceedings that could provide guidance in that regard. There are emerging risks that still implicate policies, and he believes there will be more of these kinds of claims.

Rejo Mathew (Arcina) said that having reviewed the state statutes for California, Pennsylvania, and Texas, as well as the *Insurer Receivership Model Act* (#555), Arcina believes that commissioners/receivers are bestowed with broad authorities regarding estate records and that instead of destroying them, the records should be given to libraries and other public institutions for their preservation and future use. He said the purpose is to aid the public with future claims.

Mathew said the presentation materials include the next steps that Arcina would like the Working Group to consider, including stopping the destruction of any estate records that are pending or near closure (Attachment Three-F).

Mathew described an example of the loss of records from the Reliance Insurance Company estate and United Pacific Insurance Company, which wrote business to school districts. There are no longer records of how those programs were set up or the participants in the program. He said their work helps to diversify the risk absorbed by these entities and ease the impact across the industry. He said Arcina believes there is just cause for this, specifically through the verbiage of the insurance contract.

Janisch asked if it is due to cost versus the benefit that once the estate closes and distributions are made, there is no need to retain personnel, and records are shredded. Baldwin said the Working Group may not be able to answer that question for the states. A survey might be a way to compile answers.

Baldwin asked if policyholders or brokers have copies of these policies. Janisch said they do, but not all the time. He said that most of the time, they do not find the complete policy, correspondence, or past claims activity. For brokers, it is hit and miss, as they have a 10-year document destruction policy. On occasion, certain large brokers can uncover some of the placements for these claims.

Baldwin asked if, in contemplation of the concept of archaeology libraries, Arcina has undertaken any consideration of data privacy laws that might be applicable to those policyholders. Mathew said it is covered within Model #555. He said Arcina has reviewed it in terms of evidentiary standard considerations. As received by the commissioner, the policyholder record is considered prima facie evidence of coverage. Records should not be used against an insured or have the policy affected. However, Arcina hopes to maintain policyholder protections. If the category or designation the record is recognized as were to be changed from prima facie evidence to statistical, Arcina would have a better stance on this issue. This discussion concerns legacy claims that would probably be past most statutes of limitation. He asked if a plaintiff were to bring this documentation against the defendant that they had located these records, it is not actionable by its plaintiff. It is actionable by the defendant or the insured. The contract, because of the laws of privacy, is not going to act as a shield. This is why Arcina thinks this needs further discussion of what the specific rules are. This could also be access to records for clients who would be best served.

Janisch said that regarding data privacy, the Working Group would have to come up with some sort of gatekeeper protocol. He said data privacy is state-by-state driven, and he does not want to turn this into free access for the plaintiff's bar. The libraries would need to have safeguards with parameters of access or limitations.

Surguine asked how and by whom the expansion of scanning records to an electronic format would be paid. Janisch said that universities and some private sector funds may cover it. He said he didn't know if the liquidation office would be a partial funding source. He said it is prominent for these libraries to hold these collections. They have a student workforce. Fees could be charged for the duplication of these records to essentially sustain the maintenance of this collection. He said that he did not think the cost would be a factor. He said there is also an educational purpose in looking at these insolvencies later through data analytics.

Baldwin said the Working Group would take note of the topics in the presentation. No further Working Group members had comments or questions for the presenters. Baldwin asked Arcina to send any further comments it wishes to share with the Working Group.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/2023 NAIC Meetings/Summer National Meeting/E Committee/RITF/
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Draft: 6/20/23

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

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

1. Exposed Amendments to Model #540

A. ITBs and CDs Amendments

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

Wake summarized the proposed amendments in version one (Attachment Three-A1) and the document describing the amendments (Attachment Three-A2). He said the drafting group considered four different points of entry. There are various ways to get to the results, such as by amending the definitions of covered claim, insolvent insurer, or assumed claims transaction, or by expanding membership. The National Conference of Insurance Guaranty Funds (NCIGF) showed him a definition of a New Hampshire law that was simple and clean. After some technical work, proposed paragraph 5G(2) could be added to the definition of covered claim. He said he did not distinguish between other types of transactions because, with few exceptions, there was not any point in choosing which would get coverage preserved and which would not. He said the mandate was to start with IBTs and CDs, but he feels there is strong public policy consensus that the same thing is wanted for transactions like mergers and common law novation, except transactions where policies are commuted into a captive and still have guaranty fund coverage. Wake said the one complexity with version one is that he was asked to consider other transactions where a member insurer did not write the original coverage. Either it was self-insured or written in surplus lines or by a captive. He has not seen any real-life examples of such a transaction. Generally speaking, if an insurer wanted to bring something into the admitted market, it would write a substitute policy. Because some asked for language that did not take away anything, optional language was added with a long drafting note in paragraph 5G(3). He said version one is simpler because it gets rid of some definitions, but it does make a lot of changes to the existing model by deleting verbiage. He said his summary document includes a comparison matrix like the matrix provided for version two. He said he disagrees with what transactions in version two are covered.

Barbara F. Cox (Barbara F. Cox LLC) summarized the NCIGF comments on version one (Attachment Three-A3). She said NCIGF supports a stand-alone paragraph 5G(2) in the first paragraph of version one to the covered claim definition. She said NCIGF does not support 5G(3). She said NCIGF feels it goes beyond the charge. She said version two allows coverage for an IBT started with a nonmember insurer to a member. That is not consistent with the charge that says guaranty fund coverage should be unchanged or retained, nor is it consistent with the Restructuring Mechanisms (E) Working Group's latest drafts, which it has not finalized. She said every discussion

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

Patrick Cantilo (Cantilo and Bennett LLP) summarized the proposed amendments in version two (Attachment Three-A4) and the document describing the amendments (Attachment Three-A5). He said version two entails only changing paragraph 5H(1). It adds the language required to include IBTs and CDs so that claims arising under a policy assumed by doing IBTs or CDs would be covered. He said version two offers alternative language that works the same way in that they amend the same section. He said the reason for the alternatives in version two is that most states have not adopted the assumed claims language. He said if a state wants to have a version of the statute that does not refer to assumed claims language, then alternatives one and two accomplish that. Alternatives also address if the transferee is a nonmember and the transferor is a nonmember. Each alternative only amends paragraph 5H(1). He said he also offers a definition for IBT and CD that may or may not be necessary. Cantilo said the main difference between his version two and Wake's version one, aside from whether one is viewed as simpler, is that version two does not overtly eliminate the possibility of coverage that arose from a non-member to within guaranty association coverage once a member assumes it. Those transactions may be rare. It was an issue for the Reciprocal of America situation in which half of the workers' compensation business had been assumed from a self-insured trust. Reciprocal of America became insolvent before replacement policies were issued for much of that business. In that case, it eventually became a covered business and was treated like any other business. That situation may or may not happen again. Cantilo said if the Working Group only wants to ensure that Model #540 preserves coverage for IBTs and CDs, version two accomplishes that. If the Working Group wants to go further and eliminate the possibility of having assumed claim language, then additional amendments would be required. He said he does not believe that is part of the charge.

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

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

Wake made a motion, seconded by Mitchell, to expose version one without the optional language for a 30-day comment period ending June 23. The motion passed with Massachusetts opposing. Joyce said he understands Cantilo's position and has concerns about exposing version one without the optional language. Wake said he could expose it either way. Mitchell said he echoes Cox's comments referring to the scope of the original request to

modify the law. It seems outside the scope to create coverage rather than retain and continue coverage. However, if it is the will of the Working Group, he does not oppose exposing the optional language. Surguine said he liked the procedure under the assumption of reinsurance laws where policyholders get notice. A transaction does not bind policyholders unless they get notice and opt-in. He does not like the part of IBT laws that can force policyholders into a transaction. However, Arkansas has already enacted an IBT statute. Wake said he is sympathetic to Surguine. He said that even if a state has not passed an IBT statute, other states have adopted such statutes. He said policyholders should not be penalized.

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

B. Cybersecurity Insurance Amendments

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

Cox summarized the NCIGF's proposed amendments to Model #540 for cybersecurity insurance (Attachment Three-A6). She said cybersecurity insurance is different from what has been dealt with before in insolvencies. Along with indemnity coverage, cybersecurity insurance also includes various services such as mitigation of losses, notices to potential persons whose data have been breached, and even ransom negotiations and payments. One of the characteristics is the immediacy of the insurance company to respond. A member insurer presented to NCIGF and said the insurer is the firehouse, not the clean-up crew. If a breach occurs, the insurer needs to be prepared to respond immediately. The proposed amendments include:

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

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

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

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

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NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Scope

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

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

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

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

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

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

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

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

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

Section 4. Construction

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

Section 5. Definitions

As used in this Act:

[Optional:

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

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

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

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and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

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

Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a

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

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

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

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

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

EF. “Commissioner” means the Commissioner of Insurance of this State.

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

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

GH. “Covered claim” means the following:

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

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

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

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

(a) The original member insurer has no remaining obligations on the policy after the transfer;

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

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

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

Optional:

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

Commented [Staff1]: If the Working Group agrees to include a second alternative or optional “covered claim” provision, it would be labeled as “Alternative” provisions.

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

Drafting Note for Covered Claims definition: [TBD]

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

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

Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a

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

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

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

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

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Commented [Staff2]: If the Working Group agrees to include both G(3) options above rather than selecting one, they would be labeled Alternative One and Alternative Two. Staff recommends including an explanation of the differences between the two alternatives. (Yet to be drafted)

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

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

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

II. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, ~~when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.~~

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

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

JK. (1) “Member insurer” means any person who:

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

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

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

~~[Optional]~~

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

~~Drafting Note:~~ The optional version of Subsection K is for states that have adopted optional Subsection G(3).

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

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

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

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

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

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

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

~~The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be~~

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Commented [Staff3]: Similar comment as above. The RLWG can determine to keep two alternative definitions of K or select one corresponding to G(3).

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~~required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.~~

Section 6. Creation of the Association

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

[Alternate Section 6. Creation of the Association

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

- A. The workers' compensation insurance account;*
- B. The automobile insurance account; and*
- C. The account for all other insurance to which this Act applies.]*

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

Section 7. Board of Directors

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

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

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a board member, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board

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Commented [Staff4]: Drafter Comment: This drafting note was written before the assumed claims provisions created a pair of "alternative alternatives." For consistency with the drafting note and "Alternate 8B(6), we should probably restore the original schematic for 8B(3)"

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meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

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

Section 8. Powers and Duties of the Association

A. The association shall:

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

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

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

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

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

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

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

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

Commented [Staff5]: Drafter Comment: The existing Model has a matrix of four options because there are two independent toggles. We're getting rid of one of them, so we don't need two-level numbering anymore, and it should now be either "1 and 2" or "A and B." Also, the Model seems to have a typo in the second "Alternative" below.

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~~companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.~~

~~(3) [Alternative Section 8A(3)1b]~~

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

~~[Optional:~~

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

~~Drafting Note: Optional Paragraph (4) is for states that have adopted Alternative Section 5G(2) and choose to require an additional "assumption consideration" assessment when claim obligations are assumed from an entity other than a member insurer.~~

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

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Commented [Staff6]: Drafter Comment: See Comment to Section 6 Drafting Note

Commented [Staff7]: Drafter Comment: Note that the bracket was never deleted from the end of 1b and 2b when it was deleted from the beginning as the four-way mix-and-match was adopted.

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

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

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

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.
 - (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered

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claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.

- (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
 - (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
 - (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
 - (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
 - (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.
- B. The association may:
- (1) Employ or retain persons as are necessary to handle claims and perform other duties of the association;
 - (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
 - (3) Sue or be sued;
 - (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
 - (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
 - (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

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

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

C. Suits involving the association:

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

[Optional Section 8D

D. (1)

The legislature finds:

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
 - (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
 - (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.*
 - (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association,*

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assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.

- (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

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

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

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

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

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Section 9. Plan of Operation

- A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
- (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
- (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
- (2) Establish procedures for handling assets of the association;
- (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
- (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
- (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
- (6) Establish regular places and times for meetings of the board of directors;
- (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
- (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
- (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
- (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

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- A. The commissioner shall:
- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;
 - (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.
- B. The commissioner may:
- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;
 - (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
 - (3) Examine, audit, or otherwise regulate the association.

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

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

Section 11. Coordination Among Guaranty Associations

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

Section 12. Effect of Paid Claims

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

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- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to Statepriority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

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

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

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), "high net worth insured" shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] "high net worth insured" shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

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

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

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:

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- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
 - (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 3 for Section 13B

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

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used

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reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

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

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

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

- The credit shall be deducted from the lesser of:
- (i) The amount of the judgment or settlement of the claim; or
 - (ii) The policy limits of the policy of the insolvent insurer./
- (b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.
- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.
- (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
- (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
- (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
- (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.
- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

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

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered

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claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.

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

Section 16. Tax Exemption

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

Section 17. Recoupment of Assessments

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

[Alternative 1 for Section 17]

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
- (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.]

[Alternative 2 for Section 17]

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

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

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- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.
- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.]

[Alternative 3 for Section 17

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

Section 18. Immunity

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

Section 19. Stay of Proceedings

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

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

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

1970 Proc. 1 218, 252, 253-262, 298 (adopted).
1972 Proc. 1 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. 1 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. 1 44, 46, 126, 217 (amended).
1981 Proc. 1 47, 50, 175, 225 (amended).
1984 Proc. 1 6, 31, 196, 326, 352 (amended).
1986 Proc. 1 9-10, 22, 149, 294, 296-305 (amended and reprinted).
1986 Proc. II 410-411 (amendments adopted later printed here).
1987 Proc. 1 11, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 366, 376, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

MODEL 540 IBT/CD PROPOSED AMENDMENTS

VERSION #1 DESCRIPTION

Currently, a claim can only be a “covered claim” under the Model Act if the claim is made against an “insolvent insurer” and the policy under which the claim was made “was either issued by the insurer or assumed by the insurer in an assumed claims transaction.” Both of these restrictions, in their current form, can extinguish existing guaranty fund coverage after an insurance business transfer (IBT) or corporate division (CD), as well as a wide range of other policy transfers where there is a broad consensus among most regulators and stakeholders that coverage ought to be preserved.

Two specific obstacles are: (1) even though the “assumed claims transaction” provisions of the Model Act might appear at first glance as though they were designed to address policy transfers of all kinds, the primary “Alternative 1” definition does not allow coverage for a transfer without the consent of the policyholder, which is an essential feature of IBTs and CDs; and (2) the definition of “insolvent insurer” requires the insurer to have been licensed “either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred.” But IBTs and CDs only require approval by the domiciliary state, and an IBT transferee insurer or a CD resulting insurer might not seek or might not qualify for licensure in the state where the claim is presented, or might not obtain licensure until after the applicable date. Furthermore, only a handful of states have adopted the either version of the Model’s “assumed claims” provisions.

Therefore, the drafters of Version 1 approached the problem from a first-principles perspective: what is the clearest and simplest way to ensure that if guaranty fund coverage exists before an IBT, CD, or other policy transfer, it will continue to exist afterward? Proposed § 5(G)(2), which was inspired by language recently adopted in New Hampshire as its starting point, codifies this principle directly, with a limited exception for transactions in which the policyholder knowingly and voluntarily takes the policy out of the admitted market. It can be added to the definition of “covered claim” in the same manner regardless of whether or not the state has chosen to adopt the Model’s assumed-claim provisions. With the addition of this paragraph, claims are covered if either (1) the claim is made against a policy that was issued by a member insurer that was placed in liquidation; or (2) the claim is made against another insurer that took on a member insurer’s claim obligations and then was placed in liquidation.

Because proposed § 5(G)(2) also preserves existing guaranty fund coverage after a merger or assumption-reinsurance transaction, it removes the need for any additional assumed-claims language unless the state chooses to provide guaranty fund coverage for transactions involving the transfer of claim obligations from a self-insurer or a non-member insurer to a member insurer in certain scenarios where the member insurer fails to issue a replacement insurance policy or where some of the “assumed claims” might not otherwise qualify as covered claims against the replacement policy. Because the vast majority of states have not chosen to cover these relatively unusual scenarios, the drafters of Version 1 believe the NAIC should acknowledge the optional nature of such coverage and provide states with a clean version of the Model Act that is readily available for their use. Accordingly, the “baseline” language of Version 1 deletes the following verbiage: both of the alternative definitions of “assumed claims transaction”; the substantive clauses where that term appears; the related definitions of “assumption consideration” and “novation”; and two of the four alternative versions of § 8(A)(3)).

In addition, some optional language was drafted to accommodate states that wish to provide coverage for the full range of nonmember-to-member assumed claims transactions that would be covered under the existing (but not widely-adopted) Model. Version 1’s modular approach allows states to add this optional language without replacing any of the other “baseline” language of Version 1. The optional language highlighted in blue is based on Model Act Alternative 1. Model Act Alternative 2 would also add the language highlighted in green. The drafters do not endorse this language and would not object if the Task Force chose to eliminate it as a formal option within the Model Act and treat it instead as state-by-state variation.

The drafters of Version 1 were also asked to prepare a comparison matrix to facilitate discussions within the drafting group. Although the classic IBT/CD scenarios are straightforward, there are some weedy, lower-frequency scenarios where the two versions differ because Version 1 is not expressly limited to IBTs and CDs, and does not rely on interpretations of the assumed claims language in the Model. This is why the drafters included the footnotes below. Please note that the footnotes reflect the Version 1 drafters’ analysis of Version 2, and the Version 2 drafter is not always in agreement with that analysis.

	VERSION #1
IBT/CD MEMBER TO MEMBER	Always covered
OTHER MEMBER TO MEMBER(*a)	Always covered
IBT/CD MEMBER TO NONMEMBER(*b)	Always covered
OTHER MEMBER TO NONMEMBER(*b) (*c)	Not Covered
IBT/CD NONMEMBER TO MEMBER(*d)	Not covered
OTHER NONMEMBER TO MEMBER(*d) (*e)	Optional (G3)
NONMEMBER TO NONMEMBER	Not covered

(*a) “Other” member-to-member transactions are only covered under Version #2 if the state has assumed-claims language, which leaves out Alternatives 1 & 2. Other transactions, such as common-law novations, do not qualify as assumed-claims transactions, so coverage could be lacking or could be open to dispute even under the default & Alternative 3. There could also be questions about where exactly to draw the line between “IBT/CD” and “Other” transactions, and we would agree with not making the proposed definition of IBT/CD mandatory because it might raise as many questions as it answers.

(*b) Within Version #2, Alternatives 2 & 3 provide “nonmember transferee coverage” for IBTs and CDs; in other words, claims are covered even if the transferee did not seek or was not granted a license in This State. But the default and Alternative 1 do not have that language, and thus require the transferee to be an “insolvent insurer,” which by definition must be or have formerly been a member insurer at the relevant time (which also means Version #2 would require a revision to the “insolvent insurer” definition to add the time of an IBT or CD). And even under Version #2 Alternatives 2 & 3, coverage is not provided for “other” transactions, because it is only triggered by “such a” transaction, *i.e.* an IBT or CD.

(*c) Although Version #1 does not explicitly distinguish between “IBT/CD” and “Other” transactions, the reason it makes “regulatory or judicial approval” the trigger for coverage is to include IBTs/CDs and similar transactions but exclude voluntary transactions, such as a policyholder commuting an admitted policy and transferring the risk to its own captive.

(*d) Under all four variations of Version #2, coverage is provided as long as a revision to the definition of “insolvent insurer” is added to include insurers that were members at the time they picked up the claim in an IBT/CD. However, nonmember-to-member IBTs/CDs seem like a highly unusual transaction, and coverage would seem to be an unintended consequence – I’m picturing something like an insurer that’s admitted in its state of domicile and has written surplus lines in this state, and then transfers business to an insurer that purely by coincidence happens to have a license here. The “nonmember-to-member IBT/CDs “ line of Version #1 is “no coverage with an asterisk” because the proposal doesn’t provide any coverage without the original policy being issued by a member insurer unless either (1) the transaction would qualify as an “assumed claims transaction” under at least one of the 2009 versions of the Model, in which case coverage is provided in states that elect “Optional G(3)” or (2) coverage already existed under the Model even before the 2009 amendments (for example, “tail coverage” clauses in claims-made policies and perhaps “take-out policies” issued when a self-insurance program is terminated), and those would not be taken away by either Version when a valid covered claim is made against such a policy. If we read the 2009 Model correctly, there’s a lot of overlap between assumed claims transactions and IBTs/CDs on the member-to-member side but very little on the nonmember-to-member side.

(*e) Finally, because coverage under Version #2’s “other” nonmember-to-member transactions depends on whether they qualify as “assumed claims transactions” under the existing language of the Model, this will in turn depend on which of the two alternate definitions the state chooses. Version #2’s Definition 2 appears, as written, to make coverage optional, on a case-by-case basis, for nonmember-to-member assumed-claims transactions. If the member chooses to buy guaranty fund coverage for the policies it has assumed, it apparently must enter into some sort of agreement to pay “assumption consideration” to all “applicable guaranty associations,” and failure to pay one of them appears as currently written to result in the loss of coverage in all states with substantially similar legislation. Version #1’s optional Paragraph 8(A)(4) takes a simpler approach, making assumption consideration obligatory but providing guaranty fund coverage even if the insurer defaults in whole or part on that obligation (the purpose of guaranty funds, after all, being to protect claimants when insurers default on their obligations). If that’s not the intended outcome, this paragraph would need to be rewritten.

NCIGF Comment on Version #1

Here are some comments on the substance of Bob's draft:

NCIGF supports the standalone g(2) language regarding divisions in the Bob Wake draft. We believe that g(2) reflects the most recent draft best practices being considered by the Restructuring Mechanisms Working Group which indicate that GA coverage should not be changed as a result of an IBT or division transaction.

Regarding g(3), while some may regard this as an option that should be made available to states, we do not support the enactment of g(3). We feel coverage for claims originating from an uncovered entity could create moral hazard. Moreover, it is unfair to charge the cost of such claims to the guaranty fund created for licensed business. If safety net coverage is desired for such claims it can, and has in some jurisdictions, been created. As a practical matter, we sense that non-member to member transactions would be rare.

Regarding the provisions in the Bob Wake draft relating to assessment consideration for cases covered in g(3), such consideration is not a part of the NCIGF policy on restructured business. While we are neutral regarding its enactment, we do observe that the language adds an additional layer of complexity to the amendment package this working group is currently considering.

We understand drafter of Version 1 would be fine with eliminating the Optional Clauses if the Working Group wants to go that route and would also be happy to get rid of the green language if they wanted to simplify it.

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PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Scope

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

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

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

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

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

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

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

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

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

Section 4. Construction

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

Section 5. Definitions

As used in this Act:

[Optional:

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

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

- A. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. "Association" means the [State] Insurance Guaranty Association created under Section 6.

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

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

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

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

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

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

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

- E. "Claimant" means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.
- F. "Commissioner" means the Commissioner of Insurance of this State.

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

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

VERSION #2 PROPOSAL

H. "Covered claim" means the following:

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

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

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

- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
- (b) The claim is a first party claim for damage to property with a permanent location in this State.

[OPTIONAL H(c) – TO DEFINE IBT AND CD IF DEEMED NECESSARY]

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

Commented [Staff1]: Drafter Explanation:

If IBT and CD are deemed to need further definition the attachment provides suggested optional language. It is not necessary in order to accomplish the goal but might be helpful.

A couple of notes about this proposal:

1) This language lends itself well to amendment of existing state laws. For example, 215 ILCS/534.3 (the Illinois statute, could be amended as follows:

(a) "Covered claim" means an unpaid claim for a loss arising out of and within the coverage of an insurance policy to which this Article applies, including specifically a policy assumed in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the Director, and which is in force at the time of the occurrence giving rise to the unpaid claim, including claims presented during any extended discovery period which was purchased from the company before the entry of a liquidation order or which is purchased or obtained from the liquidator after the entry of a liquidation order, made by a person insured under such policy or by a person suffering injury or damage for which a person insured under such policy is legally liable, and for unearned premium, if:

(2) This approach does not remove any actual or possible coverage from what is currently provided by Model 540; but

(3) This approach does NOT expressly provide GA coverage when the transferor is a member insurer but the transferee insurer is not a member or licensed insurer. However, if the goal of the RLWG includes providing GA coverage in those cases, that could be done by additional language as shown on the attachment.

This last point is important. It arises because the definition of "insolvent insurer" requires that it be licensed (thereby making it a member insurer). In my view, requiring GA coverage when the insolvent insurer was not a member insurer (which effectively means it was not licensed in the state) can be problematic. However, I propose language to accomplish that if the Working Group determines that it is part of their charge. (see Alternatives 2 & 3)

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

H. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer’s state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and
 - (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.

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

H. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer’s state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile, and
 - (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.

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

H. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act

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and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and in such a transaction subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile, and

- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
- (b) The claim is a first party claim for damage to property with a permanent location in this State.

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

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

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

- I. "Insolvent insurer" means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed

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claims transaction, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile.

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

- J. "Insured" means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.
- K. (1) "Member insurer" means any person who:
- (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
 - (b) Is licensed to transact insurance in this State (except at the option of the State).
- (2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer's license.
- L. "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.
- M. "Novation" means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.
- N. "Person" means any individual, aggregation of individuals, corporation, partnership or other entity.
- O. "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

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

- P. "Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.
- Q. **[Alternative 2b]** "Assumption Consideration" shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed

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claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.

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

Section 6. Creation of the Association

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

[Alternate Section 6. Creation of the Association

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

- A. The workers' compensation insurance account;*
- B. The automobile insurance account; and*
- C. The account for all other insurance to which this Act applies.]*

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

Section 7. Board of Directors

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

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

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable

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expenses incurred by them as members of the board of directors.

- D. Any board member who is an insurer in receivership shall be terminated as a *board member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

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

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

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

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be

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incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

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

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

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

[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the

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

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

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

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

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

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.

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- (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
 - (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
 - (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
 - (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

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

[Alternate Section 8B(6)

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

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

C. Suits involving the association:

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

[Optional Section 8D

D. (1)

The legislature finds:

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
 - (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
 - (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in*

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this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.

- (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
- (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

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

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

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

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

Section 9. Plan of Operation

- A.
 - (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
 - (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.

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- C. The plan of operation shall:
- (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

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

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

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

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

Section 11. Coordination Among Guaranty Associations

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

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.
- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to State priority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

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Section 13 [Optional] Net Worth Exclusion

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

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

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

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

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

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
- (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
- (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

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- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise./

[Alternative 3 for Section 13B

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

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

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

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

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

The credit shall be deducted from the lesser of:

- (i) The amount of the judgment or settlement of the claim; or
 - (ii) The policy limits of the policy of the insolvent insurer.]
- (b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.
- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.
- (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
- (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
- (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
- (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.

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

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

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.
- C. Reports and recommendations provided under this section shall not be considered public documents.

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Section 16. Tax Exemption

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

Section 17. Recoupment of Assessments

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

[Alternative 1 for Section 17

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect./

[Alternative 2 for Section 17

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

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

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

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- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made./

[Alternative 3 for Section 17

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

Section 18. Immunity

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

Section 19. Stay of Proceedings

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

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

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

1970 Proc. 1 218, 252, 253-262, 298 (adopted).
1972 Proc. 1 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. 1 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. 1 44, 46, 126, 217 (amended).
1981 Proc. 1 47, 50, 175, 225 (amended).
1984 Proc. 1 6, 31, 196, 326, 352 (amended).
1986 Proc. 1 9-10, 22, 149, 294, 296-305 (amended and reprinted).
1986 Proc. II 410-411 (amendments adopted later printed here).
1987 Proc. 1 11, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 366, 376, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

MODEL 540 IBT/CD PROPOSED AMENDMENTS

VERSION #2 DESCRIPTION

	VERSION #2
IBT/CD MEMBER TO MEMBER	Always covered
OTHER MEMBER TO MEMBER	Always covered
IBT/CD MEMBER TO NONMEMBER	Always covered
OTHER MEMBER TO NONMEMBER	Default and Alternative 3
IBT/CD NONMEMBER TO MEMBER	Always covered
OTHER NONMEMBER TO MEMBER	Default and Alternative 3

Overriding observations.

1. Version #2 proposal:
 - a. Is far simpler (in all cases only one section need be edited),
 - b. Accomplishes the goal of preserving IBT and CD GA coverage whether or not the state has adopted the assumed claims provision, and
 - c. Does not take away any coverage currently provided by the Model Act.
2. Where the proposals differ is that (unlike Version #2) Version #1 proposal provides a mechanism for the NAIC to reverse the 2009 inclusion of optional assumed claim coverage. That is to say, one version of their proposal can be adopted by the NAIC to achieve this result. The states already have that option and have exercised it by either adopting or not adopting that language from the 2009 amendments.
3. Version #1 highlights narrow areas in which one might interpret existing law (state or model) as excluding GA coverage, but those instances are unrelated to IBT and CD transactions and, at least in my view, are contrary to current custom and practice or so exotic as to never having arisen.

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PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 17.	Recoupment of Assessments
Section 18.	Immunity
Section 19.	Stay of Proceedings

Section 1. Title

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

Section 2. Purpose

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

Section 3. Scope

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

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

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- E. Other than coverages that may be set forth in a cybersecurity insurance policy, insurance Insuree—of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;
- F. Title insurance;
- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

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

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

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

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

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

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

Section 4. Construction

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

Section 5. Definitions

As used in this Act:

[Optional:

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

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

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

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

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

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

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

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the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or

- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
 - (3) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.
- E. "Claimant" means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.
- F. "Commissioner" means the Commissioner of Insurance of this State.

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

- G. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.
- H. "Covered claim" means the following:
 - (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and: the policy was either issued by the insurer or assumed by the insurer in an assumed claims transaction; and

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

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

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

Note: This definition is optional.

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J. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

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

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

L.(1) “Member insurer” means any person who:

- (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
- (b) Is licensed to transact insurance in this State (except at the option of the State).

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

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

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

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

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

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

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

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

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

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

Section 6. Creation of the Association

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

[Alternate Section 6. Creation of the Association

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

- A. *The workers' compensation insurance account;*
- B. *The automobile insurance account; and*
- C. *The account for all other insurance to which this Act applies.]*

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

Section 7. Board of Directors

- A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the

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approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term “director” shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

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

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a *board member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

- A. The association shall:
 - (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
 - (i) The full amount of a covered claim for benefits under a workers’ compensation insurance coverage;

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

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

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

(b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

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

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

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

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

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

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.

(3) **[Alternative 1a]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent

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

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

(3) **[Alternate 1b]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member

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

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

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

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

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

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
- (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.
 - (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
 - (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order,

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decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.

- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
- (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
- (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

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

[Alternate Section 8B(6)

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

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

C. Suits involving the association:

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

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

[Optional Section 8D

D. (1)

The legislature finds:

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
- (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
- (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
- (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
- (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*

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

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- (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
- (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

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

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

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

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

Section 9. Plan of Operation

- A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
- (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

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- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
- (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

- A. The commissioner shall:
- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against

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a member company at the same time that the complaint is filed with a court of competent jurisdiction;

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

B. The commissioner may:

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

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

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

Section 11. Coordination Among Guaranty Associations

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

Section 12. Effect of Paid Claims

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

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- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to State priority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

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

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

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

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

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

[Alternative 1 for Section 13B

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

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

Note: This revision- would only be a consideration in states with a net worth exclusion.

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
 - (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) ~~The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.~~
- (5) ~~The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this Section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this Section.~~

Note: This revision would only be a consideration in states with a net worth exclusion.

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[Alternative 3 for Section 13B]

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

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

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

The credit shall be deducted from the lesser of:

- (i) The association's covered claim limit;
- (ii) The amount of the judgment or settlement of the claim; or
- (iii) The policy limits of the policy of the insolvent insurer.]

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

The credit shall be deducted from the lesser of:

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- (i) The amount of the judgment or settlement of the claim; or (ii)
The policy limits of the policy of the insolvent insurer.]

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

- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.
- (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
- (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
- (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
- (b) Any amount payable by or on behalf of a self-insurer.
- (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.
- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

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

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.
- C. Reports and recommendations provided under this section shall not be considered public documents.

Section 16. Tax Exemption

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

Section 17. Recoupment of Assessments

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

[Alternative 1 for Section 17

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect./

[Alternative 2 for Section 17

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

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number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

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

- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.
- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.]

[Alternative 3 for Section 17

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

Section 18. Immunity

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

Section 19. Stay of Proceedings

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

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

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

- 1970 Proc. I 218, 252, 253-262, 298 (adopted).
- 1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
- 1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
- 1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
- 1979 Proc. I 44, 46, 126, 217 (amended).
- 1981 Proc. I 47, 50, 175, 225 (amended).
- 1984 Proc. I 6, 31, 196, 326, 352 (amended).
- 1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
- 1986 Proc. II 410-411 (amendments adopted later printed here).

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1987 Proc. 111, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol 1111, 139, 188, 288-317 (amended).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. CODE §§ 27-42-1 to 27-42-20 (1981/2009) (Uses separate account option).	
Alaska		ALASKA STAT. §§ 21.80.010 to 21.80.190 (1970/2004) (uses separate account option) (previous version of model).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-661 to 20-680 (1977/2014) (previous version of model).
Arkansas		ARK. CODE ANN. §§ 23-90-101 to 23-90-123 (1977/1999).
California		CAL. INS. CODE §§ 1063 to 1063.15 (1969/2013).
Colorado		COLO. REV. STAT. §§ 10-4-501 to 10-4-519 (1963/2002) (uses separate account option) (previous version of model).
Connecticut		CONN. GEN. STAT. §§ 38a-836 to 38a-853 (1971/2011) (uses separate account option) (previous version of model).
Delaware		DEL. CODE ANN. tit.18, §§ 4201 to 4221 (1982/1991) (previous version of model).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
District of Columbia		D. C. CODE §§ 31-5501 to 31-5515 (1993) (previous version of model).
Florida		FLA. STAT. §§ 631.50 to 631.70 (1982/2010) (previous version of model).
Georgia		GA. CODE ANN. §§ 33-36-1 to 33-36-19 (1970/2005).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. REV. STAT. §§ 431:16-101 to 431:16-117 (1988/2003) (previous version of model).
Idaho		IDAHO CODE ANN. §§ 41-3601 to 41-3621 (1970/2014) (previous version of model).
Illinois	215 ILL. COMP. STAT. 5/532 to 5/553 (1977/2013) (Uses separate account option).	
Indiana		IND. CODE §§ 27-6-8-1 to 27-6-8-19 (1973/2013) (uses separate account option) (previous version of model).
Iowa	IOWA CODE §§ 515B.1 to 515B.26 (1970/2010).	IOWA CODE §§ 518C.1 to 518C.19 (2000) (separate fund for state and county mutuals).
Kansas		KAN. STAT. ANN. §§ 40-2901 to 40-2919 (1970/2005) (previous version of model).
Kentucky		KY. REV. STAT. ANN. §§ 304.36-010 to 304.36-170 (1972/1990) (previous version of model).
Louisiana	LA. REV. STAT. ANN. §§ 22:2051 to 22:2070 (1970/2010).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 4431 to 4452 (1969/2009) (uses separate account option) (previous version of model).
Maryland		MD. CODE ANN., INS. §§ 9-301 to 9-316 (1971/1997) (previous version of model); BULLETIN 2012-13 (2012).

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Massachusetts		MASS. GEN. LAWS ch. 175D, §§ 1 to 16 (1970/2004) (previous version of model).
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Michigan		MICH. COMP. LAWS §§ 500.7901 to 500.7949 (1969/1982); BULLETIN 2010-10-INS; BULLETIN 2010-04-INS (2010); BULLETIN 2014-12-INS (2014).
Minnesota		MINN. STAT. §§ 60C.01 to 60C.20 (1971/2003) (uses separate account option) (previous version of model).
Mississippi		MISS. CODE ANN. §§ 83-23-101 to 83-23-137 (1970/1992) (previous version of model).
Missouri		MO. REV. STAT. §§ 375.771 to 375.780 (1971/2013) (uses separate account option) (previous version of model).
Montana		MONT. CODE ANN. §§ 33-10-101 to 33-10-117 (1971/2013) (previous version of model).
Nebraska		NEB. REV. STAT. §§ 44-2401 to 44-2418 (1971/1990) (uses separate account option) (previous version of model).
Nevada		NEV. REV. STAT. §§ 687A.010 to 687A.160 (1971/2005) (previous version of model).
New Hampshire		N.H. REV. STAT. ANN. §§ 404-B:1 to 404-B:18 (1970/2004) (uses separate account option); §§ 404-H:1 to 404-H:20 (2004) (previous version of model).
New Jersey		N.J. STAT. ANN. §§ 17:30A-1 to 17:30A-20 (1974/2003) (previous version of model); N.J. INS. ORDER A12-108 (2012); N.J. INS. ORDER A13-110 (2013); N.J. BANKING & INS. ORDER A16-111 (2016).
New Mexico		N.M. STAT. ANN. §§ 59A-43-1 to 59A-43-18 (1985/1989) (uses separate account option) (previous version of model); §§ 59A-30A-1 to 59A-30A-18 (1999) (Title insurance fund).

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New York		N.Y. INS. LAW §§ 7601 to 7614 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-48-1 to 58-48-130 (1971/2009) (uses separate account option) (previous version of model).

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
North Dakota		N.D. CENT. CODE §§ 26.1-42.1-01 to 26.1-42.1-15 (1999) (previous version of model).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3955.01 to 3955.21 (1970/2005) (uses separate account option) (previous version of model).
Oklahoma		OKLA. STAT. tit. 36, §§ 2001 to 2019 (1980/2014) (uses separate account option) (previous version of model).
Oregon		OR. REV. STAT. §§ 734.510 to 734.710 (1971/2003) (previous version of model).
Pennsylvania		40 PA. CONS. STAT. §§ 41-201 to 41-220 (1995) (previous version of model).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 3801 to 3819 (1974/1980) (previous version of model).
Rhode Island	R. I. GEN. LAWS §§ 27-34-1 to 27-34-19 (1988/2010) (Uses separate account option).	
South Carolina		S. C. CODE ANN. §§ 38-31-10 to 38-31-180 (1988/2001) (uses separate account option) (previous version of model).
South Dakota		S.D. CODIFIED LAWS §§ 58-29A-54 to 58-29A-109 (2001/2013) (Uses separate account option) (previous version of model).
Tennessee		TENN. CODE ANN. §§ 56-12-101 to 56-12-119 (1971/1999) (previous version of model).
Texas		TEX. INS. CODE ANN. §§ 462.001 to 462.351 (2007) (previous version of model).

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Utah		UTAH CODE ANN. §§ 31A-28-200 to 31A-28-220 (1986/2002) (uses separate account option) (previous version of model); UTAH ADMIN. CODE r. 71-3 (1971).
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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Vermont		VT. STAT. ANN. tit. 8, §§ 3611 to 3633 (1969/1979) (uses separate account option) (previous version of model).
Virgin Islands		V.I. CODE ANN. tit. 22, §§ 231 to 247 (1984/1986) (previous version of model).
Virginia		VA. CODE ANN. §§ 38.2-1600 to 38.2-1623 (1986/2014) (previous version of model).
Washington		WASH. REV. CODE §§ 48.32.010 to 48.32.930 (1971/2005) (uses separate account option) (previous version of model).
West Virginia		W. VA. CODE §§ 33-26-1 to 33-26-19 (1970) (uses separate account option) (previous version of model).
Wisconsin		WIS. STAT. §§ 646.01 to 646.73 (1979/2013) (“Insurance Security Fund”).
Wyoming		WYO. STAT. ANN. §§ 26-31-101 to 26-31-117 (1971/2013) (previous version of model).

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Proceedings Citations
Cited to the Proceedings of the NAIC

A regulator discussed the history of revising this model in relation to the new NAIC model law process. He stated that the draft was re-exposed for new comments. **2008 Proc. 1st Quarter Vol. II 10-440.**

The Financial Condition (E) Committee adopted amendments to this model. The Committee summarized the more significant changes including the Task Force’s recommendation on the assumed business options. **2008 Proc. 4th Quarter Vol. II 10-5.**

The joint Executive Committee/Plenary adopted amendments to this model. A commissioner noted that an interested party provided a comment requesting reconsideration of the optional net worth exclusion provision. The commissioner reiterated that the provision was optional and intended to provide uniform language for states interested in implementing a net worth exclusion. **2009 Proc. 1st Quarter Vol. I 3-5.**

Section 1. Title Section 2. Purpose

In 1969 the NAIC prepared a statement of position on automobile insurance. One part of that study concerned automobile insurer insolvencies. It was stated that the “... position of the NAIC [is] that no innocent person should suffer as a result of the insolvency of an insurer...” and the association vowed to take action to assure that end. They recommended serious consideration be given to the establishment of an industry facility regulated by the states to guarantee solvency and to indemnify the public against the insolvency of any casualty insurer. A federal guaranty corporation was suggested in a congressional bill, but a resolution was adopted by the NAIC in opposition to this proposal. The resolution emphasized the fact that the NAIC was recommending a program in each state to establish a means to guarantee the payment of claims against insolvent insurers. **1969 Proc. II 549-552.**

Every insurance company failure undermines public confidence in, and the value of, the insurance institution whose continued existence is the result of the public’s desire and need to be secure from risk. Like taxes, the over-all cost of the solvency of an individual company and of such industry-wide schemes as guaranty funds ultimately falls upon the consumer. **1970 Proc. I 262.**

An insurer association recommended that Section 2 be deleted because it added no substance to the model. **1994 Proc. 2nd Quarter 510.**

The working group decided instead to retain the section, but decided to replace the word “avoid” with “the extent provided in this act, minimize.” The group also deleted a phrase that said one of the purposes was “the detection and prevention of insurer insolvencies.”

The working group felt that the two changes made the section better reflect the purpose of the guaranty association. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 3. Scope

In a report comparing losses of insurance companies and banks, it was pointed out that the property/casualty insurance industry is quite different from the life insurance industry. **1969 Proc. II 564.** The first priority was drafting legislation implementing the NAIC position on automobile insurance problems. **1970 Proc. I 252.**

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Basic to drafting a model bill is the determination of its scope. What types of insurance and insurers should be included and excluded? The existing bills range from including only automobile insurance to one embracing both life and property coverages. What contacts must there be with the state before recourse may be had against the fund? **1970 Proc. I 263.**

Section 3

The task force was charged with the task of considering whether the term “direct” needed to be defined. There has been litigation and many questions arising as to the types of coverage considered “direct” by the model act language. Courts have found large self-insured groups who purchase excess and aggregate stop loss coverage to be covered by the guaranty associations since there was no underlying contract of insurance, even though the coverage was more in the nature of reinsurance coverage. **1989 Proc. II 331.**

A. The drafters intended that a state choose the term “health insurance,” “disability insurance,” or “accident and sickness insurance” to conform to the terminology found elsewhere in the insurance code of the state in question. **1973 Proc. I 157.**

Amendments proposed in 1985 were considered a “radical departure” from the original model by the task force chair. The proposed amendments excluded products unless they were specifically listed as included. That meant new products would be excluded unless they fit under a generic term. Some of the items not included under the industry-suggested approach were based on a desire to exclude them, such as financial guarantee insurance. Other exclusions resulted from the belief that, recognizing the extraordinary nature of a guaranty fund, many insured exposures did not represent an extreme hardship to the person involved. Still others may have resulted from drafting difficulties. **1985 Proc. II 473-475.**

By the time the amendments were adopted at the end of 1985, the mechanics of the scope section had changed from the earlier draft. Rather than limiting coverage only to stated types of insurance, the list excluded certain types of coverage. One listed item was removed just before adoption of the model. It had provided an exclusion from the act for errors and omissions insurance for directors and officers of for-profit organizations. **1986 Proc. I 294.**

B. The task force was unanimously in favor of excluding financial guaranty insurance from the coverage of the guaranty fund. **1986 Proc. I 431.**

C. After the insolvencies of two large writers of surety business the federal government urged the NAIC to consider coverage of surety bonds under the guaranty association. It had not been the policy to do so because such bonds were generally associated with commercial ventures. **1986 Proc. I 429.**

D. Clarification of the subsection was made in 1986. Originally the model only said “credit insurance” but the additional language was inserted to make clear other types of collateral protection insurance similar to credit insurance were also originally intended to be excluded. **1987 Proc. I 450.**

E. In 1995 the NAIC considered an amendment to Subsection E to amplify the exclusion of coverage for insurance of warranties or service contracts. This provision was included in the package of amendments adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter 571.**

I. When model amendments were adopted in 1985, consideration was given to adding a subsection to exclude coverage for claims covered under a governmental insurance program. The exclusion was not adopted at that time, but instead Section 12 was amended to add a requirement to exhaust governmental benefits before the guaranty fund would be responsible for the claim. **1986 Proc. I 296, 304.** In 1986 the Section 12 limitation was deleted and the exclusion contained in Subsection I added. **1987 Proc. I 421.**

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An industry association suggested that the comment at the end of the section be amended to note that the Life and Health Insurance Guaranty Association Model Act addresses some of the lines of coverage excluded by this provision. **1994 Proc. 2nd Quarter 510.**

When considering amendments to the model in the latter part of 1995, the working group agreed to add a comment at the end of Section 3. It contained a definition of ocean marine insurance for states whose codes did not contain a definition, so that there would be no question as to the coverages encompassed by the exclusion of ocean marine insurance. The working group agreed to limit the exclusion to craft used for commercial purposes. The working group also decided not to include within the **Section 3**

definition coverage written pursuant to the Jones Act or the Longshore and Harbor Worker's Compensation Act. It was the opinion of the group that these coverages were properly classified as workers' compensation insurance. **1995 Proc. 3rd Quarter 586.**

Section 4. Construction

An industry association recommended that Section 4 be deleted because it added no substance to the model act. **1994 Proc. 2d Quarter 510.**

The working group recommended that the section be retained to encourage appropriate construction of the Act by the courts and to lessen the likelihood that courts would strain to interpret the Act in a manner inconsistent with the intentions of the drafters. The group did remove one word so that the model no longer said *liberally* construed. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 5. Definitions

F. "Covered claim" was considered for modification in 1985. An industry draft suggested a net worth exclusion under which no protection was extended to wealthy persons. The draft recommended exclusion of coverage for any claim in favor of a person having a net worth of \$50 million or more. It was their belief that an insured with that much net worth ought to buy insurance intelligently enough so that it would not be insured by an unsound insurer. They suggested it was not good public policy to send bills for such wealthy persons' losses or claims to all of the homeowners and small business insureds to pay. **1985 Proc. II 474.**

The net worth exclusion was adopted because of potential capacity problems for guaranty funds. The advisory committee felt the suggested change would provide a more even balance between those who really need the protection of guaranty funds and giant corporations. **1985 Proc. II 510.**

Just before adoption of the model revisions in December 1985, the Guaranty Fund Task Force voted to remove a net worth limit of \$10 million that had been included in the draft. A net worth provision was added instead to Section 11. **1986 Proc. I 294.**

The National Committee on Insurance Guaranty Funds approved a document called "Guiding Principles for Settling Disputes Between Property and Casualty Insurance Guaranty Associations as to Responsibility for Claims" and asked the NAIC's acceptance of the program. The purpose was to answer questions about which state's fund should handle the covered claim. **1986 Proc. I 457-459.**

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A suggestion made to the working group considering amendments to the model in 1994 was to revise the definition of “covered claim” to make it clear that unearned premium claims are covered by the guaranty fund in the state where the policyholder resided at the time the policy was issued. **1994 Proc. 2nd Quarter 510.**

The working group did not follow the suggestion because of a concern that the proposed revised language would be construed to limit the claims that would be covered. **1994 Proc. 3rd Quarter 419.**

Just before adoption of the amendments by the working group, further discussion was held on the suggestion to assign coverage of an unearned premium claim to the guaranty association in the state where the insured resided at the time of issuance of the policy. One regulator said the proposed amendment would place an additional burden on receivers of insolvent insurers, who often must deal with policy records that are unorganized, inadequate or non-existent. Another

Section 5

regulator agreed the proposal could cause delays in paying claims and increase the workload of both receivers and guaranty associations. The working group agreed to defer action on the suggestion. **1994 Proc. 4th Quarter 575.**

Amendments were considered again later in 1995 and Paragraph (2) was revised. It clarifies which guaranty association is primarily liable for the claim for property damage and does not narrow coverage. **1995 Proc. 3rd Quarter 586.**

At a hearing on the proposed amendments held in early 1996 one regulator objected to this proposed amendment. An interested party responded that the amendment does not restrict guaranty association coverage, but only determines the guaranty association that has primary responsibility for a property damage claim. The purpose of the amendment is to clarify that the guaranty association in the jurisdiction where the property giving rise to the claim is located has primary responsibility for the claim. **1996 Proc. 1st Quarter 569.**

An association of guaranty funds recommended that the exclusion from “covered claim” be expanded to exclude claims for reinsurance recoveries, contribution and indemnification brought by other insurers and to prohibit insurers from pursuing such claims against an insured of an insolvent company up to the guaranty fund limits. **1994 Proc. 2nd Quarter 510.**

Paragraph (3)(d) was added in the 1994 revisions. It contains a net worth exclusion for first party claims by an insured whose net worth exceeds \$25 million. The association of guaranty funds had suggested \$10 million as the appropriate level. **1994 3rd Quarter 419.**

G. “Insolvent insurer” was modified in 1972 to change the definition from an insurer “authorized” to transact to one “licensed” to transact insurance. It was the intent of the NAIC committee which drafted the bill to provide coverage only for carriers licensed in the state. In other words, coverage was not to be included for unauthorized insurers since they were not subject to the state’s regulation for solvency. “Authorized” might have been construed to include eligible surplus lines insurers. **1973 Proc. I 155.**

At the June 1976 meeting the industry advisory committee submitted a recommendation for an amendment to the definition of “insolvent insurer.” They contended the law was designed to apply to companies being liquidated, but the language of the model was not sufficiently precise to accomplish that limited objective. The suggestion to add specific language to clarify this point was not acted upon at that time. **1978 Proc. I 277.** It was, however, adopted in December 1978. **1979 Proc. I 217.**

The definition was revised in 1994 to require a final order of liquidation with a finding of insolvency. A drafting note explaining that “final order” means an order that has not been stayed was also included in the amendments. **1994 Proc. 3rd Quarter 419.**

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H. Paragraph (2) was added in 1994 to incorporate language concerning termination of membership and liability for assessment in the event of a termination. **1994 Proc. 3rd Quarter 419.**

Section 6. Creation of the Association Section 7. Board of Directors

A. This provision was modified to allow vacancies to be filled by a majority vote of the remaining board members. By the terms of the original model, it would have been necessary to call a meeting of all member insurers, which would have been extremely cumbersome. **1972 Proc. I 480.**

An advisory group was asked to consider the issue of public representation on guaranty association boards in 1992. The committee report recommended against it, but one member proposed that a drafting note be added to include a provision for public representation on the board where the state had a premium tax offset. **1993 Proc. IB 703.**

Section 7

One member of the advisory group submitted a minority report explaining her reasons for recommending public representation on guaranty association boards. The main reasons given by the consumer representative were because the public ultimately bears the cost of guaranty fund assessments, because a different perspective is needed, and because accountability is needed. **1993 Proc. I 707.**

As a follow-up from that minority report, the working group decided to draft amendments to both the Life and Health Insurance Guaranty Association Model Act and the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, which were designed to add two public representatives as members of the board of directors of the guaranty associations without increasing the overall number of members on the boards. The amendments also addressed potential conflicts of interest by requiring that the public representatives not be employed or contracted by any entity regulated by the state insurance department or required to register as a lobbyist in the state, or related to either. **1993 Proc. 2nd Quarter 619.**

A representative from an association of guaranty funds said an earlier suggestion for public representatives failed to gain support because of a perception that the commissioner was the representative of the public. Another association representative said his organization's position was that it was a public policy question for the legislatures to determine. The underlying question related to the individual members themselves: their expertise, accountability and responsibility. **1993 Proc. 2nd Quarter 619.**

The consumer representative who authored the minority report restated her position. She believed that because the public ultimately bears the burden of insolvencies either through increased taxes or policy surcharges, the public was entitled to representation on the boards. Any problem experienced with incentive to attend meetings or structure of the board should be addressed separately from the overall issue of representation and should not result in a denial of representation of the public. **1993 Proc. 2nd Quarter 619.**

In a letter of comment on the exposure draft providing for public representation, one association said it had developed a position opposed to public representation when the model was originally drafted. The association's position was that there were substantial conflicts of interest in having consumers and other public representatives on the board. The state guaranty funds stand in the shoes of the insolvent insurer and must pay claims and decide coverage issues as the insolvent insurer would have done. Had the insolvent insurer remained solvent, it would not have had consumers involved in its internal claims process. **1993 Proc. 2nd Quarter 605.**

The consumer representative said insurers also faced a conflict of interest because their interests were not aligned with those of policyholders either, but rather with the solvent insurers who paid the assessment. **1993 Proc. 2nd Quarter 619.**

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Another insurer association gave conditional support for the amendment. Its experience had been that qualified public representatives can make a positive contribution to board deliberations. The association expressed some concern about selecting qualified individuals who should be knowledgeable about the insurance industry. It recommended the draft be revised to require only one public member, who should not be eligible to serve as the chair of guaranty fund boards. **1993 Proc. 2nd Quarter 604.**

Before the Executive Committee voted on adoption of the amendment regarding public representatives, further discussion took place. The chair of the Financial Condition Subcommittee said the purpose of the amendment was to improve communication among regulators, the insurance industry and consumers on guaranty fund and insurer insolvency issues. The addition of public representatives to the governing boards would provide consumers with access to the guaranty fund process and a direct means to express concerns. The addition of public representatives also recognizes the impact of insurer insolvencies on the general revenues of states and taxpayers. Another commissioner stated that he occupied a position on the guaranty association boards and acted as a public representative since it was his function to protect the public interest. A third commissioner said that public input into the guaranty fund process would be valuable, and that even though the commissioner's function was protection of the consumers, the issue was one of direct public access. He did not favor inclusion of this provision in the financial regulation standards for accreditation. The chair of the subcommittee responded that this was not being recommended. **1993 2nd Quarter 32.**

Section 7

Before final adoption the NAIC plenary body considered the matter again. Concern was expressed that this amendment would be required for a state to be accredited. After assurance that the amendments were not being considered, indeed were not even related to financial solvency, the model amendment was adopted. **1993 Proc. 2nd Quarter 12.**

In 1994 language was added to Section 7A to allow the commissioner to appoint the initial members of the board of directors if not selected by the member insurers within 60 days. A provision was also added to allow the commissioner to fill any vacancies in position held by public representatives. **1994 Proc. 3rd Quarter 419.**

Late in 1995 the working group reviewing suggestions for change to the model recommended that Subsection A be amended to simplify the qualifications for serving as a public member of the board of directors of a guaranty association. **1995 Proc. 3rd Quarter 586.**

The amendment to Subsection A was adopted in 1996, as well as the drafting note following the subsection. **1996 Proc. 1st Quarter 573.**

Section 8. Powers and Duties of the Association

One of the major areas of concern when initially drafting the model was the manner in which the guaranty function was to be performed. Should the program be administered by the commissioner or through an industry association? What functions should the group perform? Shall they be authorized to delegate functions to a servicing insurer? **1970 Proc. I 263.**

A. The drafters started with the promise that the first draft should be a post-assessment rather than a prefunded plan. Then a number of decisions needed to be made in determining those assessments. Should insurers be assessed by lines of business? What, if any, should the maximum rate of assessment be? Should assessments be recognized in the making of premium rates? **1970 Proc. I 263.**

Paragraph (3) of this subsection was amended in December 1971. As the model existed before, if the amount raised by a maximum assessment was insufficient to pay all covered claims, the association would have to marshal all the claims before it

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could make any payment on any one particular claim. Language was added giving the association the right to pay claims in the order it deemed reasonable, thus avoiding administrative problems and delay. **1972 Proc. I 480.**

A second amendment in December 1971 provided that if a company had deferred payment of an assessment due to its financial condition, that company could not pay any dividends to shareholders or policyholders during the period of deferment, and would have to pay the deferred amount as soon as payment would not reduce capital or surplus below required minimums. **1971 Proc. I 480.**

A December 1978 amendment added a sentence to the last paragraph of Subsection A(1) to eliminate claims filed after the final date set by the court for filing claims against the liquidator. **1979 Proc. I 217.**

The model originally contained a \$100 deductible provision that was deleted in December 1980. At the same time a sentence was added at the end of Subsection A(1) to pay only the amount of unearned premium over \$100. The reasoning for this was that certain consumers bore a disproportionate share of the losses; if there were no deductibles, the losses would be borne more equitably by all insureds. The administrative costs of handling the deductibles were high in relation to the amounts involved, sometimes exceeding what would have been paid out in claims. **1981 Proc. I 225, 228.**

The most notable of the amendments to the model act considered in 1994 included deletion of the \$100 deductible for unearned premium claims. **1994 Proc. 4th Quarter 574.**

The working group was asked to consider deletion of the provision that allows the guaranty fund to pay only that portion of an unearned premium claim in excess of \$100. In support of his proposal, the regulator said his state's receiver spent \$91.18 in costs to adjudicate each policyholder claim for the deductible. He said the substantial number of these claims filed also

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creates an administrative burden, as well as depleting assets of the insolvent insurer. An industry spokesperson said the industry favored the deductible because it had the effect of spreading the loss due to insolvency and also reduced the cost of each insolvency to the guaranty association. The working group decided to recommend the deletion of the provision for the deductible. **1994 Proc. 3rd Quarter 419.**

Several industry associations commented on the proposal to delete the \$100 deductible and indicated a desire to retain the provision. A regulator responded that the costs to the estate associated with the deductible were out of proportion to any benefit to policyholders. Another regulator said she received numerous complaints from policyholders about the application of the deductible to their claims. Another regulator said that, although guaranty associations might initially derive some cost savings from the deductible, those savings were offset by the cost to the estate, which ultimately results in less money available for distribution to policyholders, guaranty associations and other creditors. Another added that the necessity of processing claims for the deductible unnecessarily prolongs the administration of estates, which is detrimental to the guaranty association. A guaranty association representative argued that the cost savings related to the deductible was important to guaranty associations. He said in one state it was estimated that the deductible had resulted in savings of more than \$13 million. He suggested other options for addressing the issue, including an exclusion of nominal claims from payment by the receiver and lowering the priority of claims for reimbursement of the deductible. He said costs of the guaranty associations are passed on to the public through rate surcharges and premium tax offsets, and that it was appropriate for policyholders to share some of the costs associated with an insolvency. After much discussion the working group decided to dispense with the deductible for unearned premium claims. **1994 Proc. 4th Quarter 574-575.**

The amendments adopted in December 1985 included a revision of this section, including a limit of \$10,000 per policy for claims on return of unearned premiums. The advisory committee also suggested a limit of \$50,000 on non-economic loss, but this suggestion was not adopted. **1986 Proc. I 300, 344.**

In 1986 an alternative provision was drafted to give the liquidator authority to sell a limited optional reporting period to insureds of an insolvent company that would provide coverage for the time period for filing claims with the liquidator. To prevent inconsistencies the time period was set for 18 months. **1986 Proc. II 409-411.** This provision was adopted six months later. **1987 Proc. I 421.**

Revisions were made to this section in 1994 to eliminate the alternative section that had been included for states with a provision in the liquidation law giving the liquidator authority to sell a limited extended reporting period for claims made policies. **1994 Proc. 3rd Quarter 424-425.**

The last sentence of the subsection originally read “Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.” That sentence was deleted as being unnecessary and a potential cause of conflict. **1987 Proc. I 450.**

Section 8A(1) was amended to be consistent with the revised definition in Section 5G by replacing “determination of insolvency” with “order of liquidation.” Language was added at the end of Paragraph (1) that provided that the association’s duty to defend ceased upon payment or tender of an amount equal to the lesser of the association covered claim limit or the applicable policy limit. **1994 Proc. 3rd Quarter 419.**

Late in 1995 a working group considering amendments to the model discussed a proposal from a group suggesting a change to the provision regarding the date at which liability to the guaranty association is cut off and discussed the exclusion from coverage of policyholder protection claims. After lengthy discussion the regulators decided not to recommend the proposed amendments. The group also considered amending Paragraph (1)(b) to provide for an aggregate limit of \$10 million per insured. **1995 Proc. 3rd Quarter 586.**

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Members of the working group expressed their support for the idea of an aggregate limit per insured in general, but raised some specific concerns with the proposal. These concerns included the difficulty of application of the aggregate limit if not adopted uniformly by all states and whether the amendment would create an incentive for a guaranty association to delay **Section 8A** (cont.)

claim payments so that payments by other guaranty associations would satisfy the limit, thereby avoiding its statutory responsibility. Another concern was that guaranty association coverage would be exhausted by those who filed claims early, leaving other claimants without any coverage. **1996 Proc. 1st Quarter 569.**

The working group decided to adopt the proposed package of amendments without including the aggregate limit, but to consider a revised proposal in the future. **1996 Proc. 1st Quarter 570.**

A provision was added to Paragraph (2) authorizing the association to pursue and retain salvage and subrogation as to claims paid by the association. **1994 Proc. 3rd Quarter 419.**

An association of guaranty funds recommended that the guaranty funds have the exclusive right to appoint and direct legal counsel retained to defend liability claims. The working group decided to add a provision to Paragraph (4) giving the association the right to choose legal counsel for the defense of covered claims. **1994 Proc. 3rd Quarter 419. Section 8** (cont.)

B. A suggestion was made by an association of guaranty funds to amend Subsection B(3) to afford guaranty associations the right to intervene in a proceeding involving an insolvent insurer. Some members of the working group expressed concern that this provision would result in the estate incurring unnecessary litigation expenses. Another concern expressed was that other creditors would, by extension, also be granted a right to intervene. One regulator felt that guaranty associations should not have rights superior to those of other creditors. No amendments to this subsection were included in the recommendations adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter.**

C. The working group agreed to create an optional Subsection C providing a method of raising funds in excess of the association's normal assessment capacity to pay claims resulting from a natural disaster. This provision was patterned after legislation already enacted in one state. **1995 Proc. 3rd Quarter 586.**

The amendments adopted in 1996 included an optional Subsection C and a comment on that subsection. **1996 Proc. 1st Quarter 576.**

Section 9. Assessments Section 10. Plan of Operation

To supplement the model bill a separate model plan of operation was also adopted. **1970 Proc. IIB 1092-1096.**

When considering revisions to the model in 1994, a suggestion was made to the working group that provision be made for disposition of dividends and other advances received by a guaranty fund from an estate. **1994 Proc. 2nd Quarter 510.**

Section 11. Duties and Powers of the Commissioner

A. The second sentence was added to Paragraph (1) in December 1972. Receipt of a copy of the commissioner's petition for insolvency upon the filing of such a petition with a court would assist the guaranty funds in beginning to prepare to handle a insolvency once declared by a court of competent jurisdiction. **1973 Proc. I 156.**

B. Subsection B contained a provision requiring the association to notify insureds and other interested parties of the insolvency. This provision was deleted in 1994. **1994 Proc. 3rd Quarter 420.**

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Section 11. Effect of Paid Claims (Previous version of model)

In 1975 the drafters considered an amendment which would have given guaranty funds immediate access to insolvent company assets, declare the guaranty funds priority creditors, and offer a “rescue” funding mechanism. **1976 Proc. I 296.**

The recommendation was not adopted by the executive committee, but was sent back to the drafting task force. **1975 Proc. I 9.**

B. On a close vote the Guaranty Fund Task Force decided to include an amendment to this section limiting covered claims to claimants whose net worth was under \$50 million. All of Subsection B was new material added in December 1985. **1986 Proc. I 340, 347.**

The task force generally favored the net worth exclusion as long as third-party liability claimants who may not have a sufficient net worth were protected. This approach would serve as an incentive to risk managers for commercial insureds to shop wisely in placing their insurance. **1986 Proc. I 431.**

The footnote in Subsection B was added to clarify the original drafter’s intent that the net worth provision apply to workers’ compensation claims. **1987 Proc. I 451.**

A working group considering amendments in 1995 was asked to lower the net worth exclusion to \$25 million but declined to make that recommendation. **1995 Proc. 3rd Quarter 586.**

C. In 1994 Subsection C was substantially amended to clarify the rights of the association as claimant in the estate of an insolvent insurer and to require receivers to accept settlements of covered claims and determination of covered claim eligibility by guaranty associations. **1994 Proc. 3rd Quarter 420.**

In late 1995 an amendment was proposed to Subsection C to address the concern of some members that guaranty association determination of covered claims not affect the receiver’s adjudication of excess claims. **1995 Proc. 4th Quarter 728.**

A second issue identified by the working group was whether the receiver should be bound to accept the guaranty fund’s determination of a covered claim and the amount paid by the guaranty fund in satisfaction of the claim. The suggested amendments addressed the concerns of regulators. **1995 Proc. 4th Quarter 728.**

Section 12. Exhaustion of Other Coverage (Previous version of model)

Section 12 was titled “Nonduplication of Recovery” from the time the original model was adopted in 1962. The title was changed in 1996 to better reflect the intent of the section. **1996 Proc. 1st Quarter 570.**

A new Subsection B was added in December 1985 requiring a person with any right of recovery under a governmental insurance program to exhaust his right there first before submitting a claim to the guaranty association. **1986 Proc. I 296, 304.** A year later this paragraph was deleted and the model returned to its original language. Instead Section 3 was amended to add an additional subsection excluding any insurance provided by or guaranteed by the government. This would have the effect of excluding flood and crop hail insurance guaranteed by the federal government from covered claims. **1987 Proc. I 421.**

A. In 1994 Subsection A was amended to clarify that “other insurance” was not limited to coverage provided by a member insurer. **1994 Proc. 3rd Quarter 420.**

Section 12. Prevention of Insolvencies

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Protection against insolvency is one of the paramount objectives of insurance regulation. Two approaches are used to achieve this objective. First, insolvency funds have been created to afford protection when insolvencies actually occur. Second, statutes have armed insurance departments with various regulatory standards, procedures and tools to prevent or reduce the likelihood of insolvencies. The drafters also questioned whether additional insolvency preventive measures should be incorporated in the model bill. **1970 Proc. I 263.**

The section was rewritten in 1983 at the urging of the guaranty funds because they felt the section imposed duties on the guaranty funds boards which were more appropriately carried out by insurance departments. **1983 Proc. I 350.** The recommended changes allowed interaction between the guaranty funds and the insurance commissioners. **1984 Proc. I 326.**

A. The old Subsection A was deleted in 1994 to address antitrust concerns. It had required the board of directors to make recommendations to the commissioner for ways to detect and prevent insolvency and to discuss and make recommendations about the status of any member insurer whose financial condition might be hazardous to its policyholders. This was replaced with a provision authorizing the board of directors to make general recommendations concerning solvency regulation. **1994 Proc. 3rd Quarter 420.**

Section 13. Credits for Assessments Paid (Tax Offsets) – OPTIONAL

A regulator stated that the E Committee requested the Task Force reconsider a solution regarding assumed claims transactions. Another regulator stated that the Working Group considered the topic twice and agreed that something should be covered by the guaranty associations. A regulator suggested optional language to avoid controversy and ensure a timely response. After extensive discussion, the Task Force agreed to further study the issue. **2008 Proc. 2nd Quarter Vol. II 10-490 to 10-492.**

A regulator recommended including two options – one option where assumed business was covered, and a second option where assumed business was not covered. Another regulator explained a third option as having two parts. This alternative would be a way to take care of all assumed claims, not necessarily with guaranty fund coverage but by means of a segregated account. The Task Force discussed comments received on these options and whether drafting notes would resolve the issue. A commissioner summarized the four existing options and the potential fifth option. The Task Force decided to draft a background summary and finalize a decision at the 2008 Fall National Meeting. **2008 Proc. 3rd Quarter Vol. II 10-368 to 10-370.**

A commissioner stated that the Committee requested that the Task Force reconsider the assumed business language by considering optional language. A regulator stated that Option Three appeared to be an interim step for when insolvency takes place before a company issues their own policies. This option would be a way to handle the previous incurred losses before the assumption. The Task Force discussed issues related to this option. **2008 Proc. 4th Quarter Vol. II 10-622.**

A commissioner stated that Option Four followed Virginia Law. An interested party stated that Option Four is the mechanism by which Virginia implemented Option One. A regulator asked for clarification on the options. Another regulator said that Option Five was an attempt to be in the middle ground. The Task Force discussed the various aspects of Option Five. An interested party stated that he had an alternative that achieved Option Five's goal through a different mechanism. Another interested party stated that the option they were most supportive of was Option Three. This option leaves parties as close as possible to the position into which they put themselves while still providing relief on a going forward basis for those people finding themselves with a new insurer, but after the transaction date, their claims would be covered just as if they had been issued by the assuming carrier. The Task Force discussed the pros and cons of Option Three. A regulator polled the members on the different options. Options One and Five, received positive support from the majority. Options Two and Three did not receive support. **2008 Proc. 4th Quarter Vol. II 10-624 to 10-625.**

The Task Force voted to send Option One and Option Five to the Financial Condition (E) Committee as optional language within the model. **2008 Proc. 4th Quarter 10-626.**

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations
Cited to the Proceedings of the NAIC

Section 14. Miscellaneous Provisions Section 15. Examination of the Association; Annual Report Section 16. Tax Exemptions Section 16. Recognition of Assessments in Rates

At the December 1972 meeting of the NAIC Property and Liability Guaranty Fund Subcommittee, it was suggested that a task force consisting of both regulators and industry actuaries and rate-making personnel create a recoupment formula under the model law. **1973 Proc. I 395.**

The task force made the following recommendations: (1) In making rates consideration should be given to past assessments paid. It is the intent of the guaranty fund law that the assessments are to be borne by the policyholders eventually through their premium payments. (2) The language is quite clear on the point that, if assessments have been paid, rates are not to be considered excessive because they contain an amount to recoup the assessments paid. Because rate-making is prospective in nature, the rating law required that due consideration be given to prospective expenses as well as past expenses. (3) The task force recommended numeric formulas considering available information from prior insolvencies covered by guaranty funds. **1973 Proc. II 396-397.**

In 1995 the working group recommended the deletion of the assessment recoupment formula because it appeared that the formula had not been utilized by any state. **1995 Proc. 3rd Quarter 586.**

Section 17. Immunity

An amendment to this section was made in December 1986. The words "... for any action taken *or any failure to act* by them ..." were added to strengthen the immunity and reflect more clearly the intent of the drafters. **1987 Proc. I 451.**

A provision was added in 1994 amendments to extend immunity to those persons substituting for a member of the board of directors. **1994 Proc. 3rd Quarter 420.**

Section 18. Stay of Proceedings

Three years after the model was originally adopted, a change was made allowing a proceeding to be stayed for six months instead of the 60 days in the original model. It was found that the records of an insolvent company were in many cases nonexistent, and it took time to determine what actions were pending. The amendment allowed the association up to six months within which to prepare a proper defense, and such time thereafter as the court may grant in its discretion. **1973 Proc. I 156.**

The liquidator of an insolvent insurance company was reluctant, in some cases, to turn over the insolvent company's claims files to the servicing carrier. Because the association couldn't function without access to the insolvent company's files, the second paragraph of Section 18 was added. **1973 Proc. I 156-157.**

The language in the first sentence of this section was modified to remove the words "up to" which had preceded "six months." It was the view of the committee that the words "up to six months" imposed an unnecessary restriction upon the staying power of the court. **1987 Proc. I 451.**

An association of guaranty funds recommended that the stay be extended to the claim filing deadline to allow the guaranty funds more time to obtain and review claim files and determine what actions need to be taken. **1994 Proc. 2nd Quarter 511.**

The drafting group declined to follow the suggestion and recommended retention of the six-month period. The group did, however, add a provision allowing the association to waive the stay in instances where circumstances justify or require quicker action. **1994 Proc. 4th Quarter 588.**

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations
Cited to the Proceedings of the NAIC

Section 18 (cont.)

A set of general comments had been included after Section 18 with further suggestions for drafters. When amendments were considered in 1994, one suggestion was to omit these comments. An insurer association suggested that many comments in the model were outdated and no longer applicable and should be deleted. **1994 Proc. 2nd Quarter 521.**

Chronological Summary of Actions

June 1969: Model adopted.

December 1971: Amended Section 7 to provide method for filling board vacancies and Section 8 to allow payment of claims in any order deemed reasonable.

December 1972: Amended definition of insolvent insurer and added procedures to assist the guaranty association in its duties.

June 1973: Recoupment formula adopted.

December 1978: Revised definition of insolvent insurer and added sentence to limit covered claims to those timely filed.

December 1980: Eliminated \$100 claims deductible but added sentence to retain \$100 unearned premium deductible.

December 1983: Modified Section 13 to aid in detection and prevention of insolvencies.

December 1985: Extensive amendments adopted to clarify and limit scope of act, to add definitions of "claimant" and "control" and to expand section on limits of payments. The net worth limit in Section 11 was added.

December 1986: Amendments adopted to provide for extended reporting period endorsement of a claims-made policy, to exclude flood and crop hail damage insurance provided or guaranteed by the federal government, and to make technical amendments.

September 1993: Adopted amendment to Section 7 to provide for public representatives on the guaranty fund board.

March 1995: Adopted amendments to clarify and update the model.

June 1996: Adopted amendments to clarify and update the model.

January 2009: Adopted amendments to clarify and update the model.

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June 2, 2023

Ms. Laura Lyon Slaymaker Co-Chair
Mr. Kevin Baldwin, Co-Chair
Receivership Model Law (E) Working Group
C/O Jane Koenigsman
Sr. Manager - Life/Health Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

BY ELECTRONIC MAIL

RE: MODEL 540 COMMENTS

Dear Ms. Lyon Slaymaker and Mr. Baldwin:

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

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

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

H. *“Covered claim” means the following:*

(1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an*

Ms. Lyon Slaymaker and Mr. Baldwin
June 2, 2023, page 2

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

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

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

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

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

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

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

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

Ms. Lyon Slaymaker and Mr. Baldwin
June 2, 2023, page 3

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

ALTERNATIVE 3: Provides coverage for assumed claims transactions and transfers to non-member insurers.

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

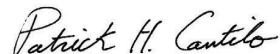
This contrasts with the very extensive and complicated edits of the Act (including extensive deletions of current provisions) required to implement Version 1, the one selected by the RLWG. The simple explanation for the difference is that, unlike my proposal, Version 1 is structured to permit the NAIC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

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

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

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

Very truly yours,



Patrick H. Cantilo

EXHIBIT 1

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

H. "Covered claim" means the following:

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

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

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

EXPLANATION

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

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

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

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

was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile, and

Here's how the final would look:

WITH ASSUMED CLAIMS LANGUAGE AND WITHOUT NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

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

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

H. "Covered claim" means the following:

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

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

H. "Covered claim" means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile, and

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

H. “Covered claim” means the following:

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer’s state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and in such a transaction subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile, and*

- (a) *The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or*
- (b) *The claim is a first party claim for damage to property with a permanent location in this State.*

OPTIONAL

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



2850 LAKE VISTA DRIVE, SUITE 150
LEWISVILLE TX 75067

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

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

Dear Kevin and Laura:

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

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

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

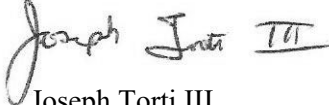
E-mail: jtorti@fairfaxinc.com

Landline: 401.231.3195

Mobile: 401.209.4538

Thank you for your attention to my comments.

Sincerely yours,



Joseph Torti III

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

June 20, 2023

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

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

Dear Kevin and Laura:

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

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

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


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

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

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

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

Very truly yours,



President & CEO
National Conference of Insurance Guaranty Funds

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

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Scope

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

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Other than coverages that may be set forth in a cybersecurity insurance policy, insurance insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

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

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

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

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

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

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

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

Section 4. Construction

MO-540-2

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7/7/23 DRAFT, with formatting and reference edits (in Yellow)
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This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

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

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

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

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

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

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

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

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

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

~~EF.~~ “Commissioner” means the Commissioner of Insurance of this State.

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

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

~~GH.~~ “Covered claim” means the following:

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- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and: the policy was either issued by the insurer or assumed by the insurer in an assumed claims transaction; and
 - (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.
- (2) “Covered claim” includes claim obligations that arose through the issuance of an insurance policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:
 - (a) The original member insurer has no remaining obligations on the policy after the transfer;
 - (b) A final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member’s coverage obligations by a court of competent jurisdiction in the insurer’s State of domicile;
 - (c) The claim would have been a covered claim, as defined in Section Paragraph 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and
 - (d) In cases where the member’s coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.

[Optional Section 5G(3):

- (3) “Covered claim” includes claim obligations that were originally covered by a non-member insurer, including but not limited to a self-insurer, non-admitted insurer or risk retention group, but subsequently became the sole direct obligation of a member insurer before the entry of a final order of liquidation with a finding of insolvency against the member insurer by a court of competent jurisdiction in its State of domicile, if the claim obligations were assumed by the member insurer in a transaction of one of the following types:
 - (a) A merger in which the surviving company was a member insurer immediately after the merger;
 - (b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or
 - (c) A transaction entered into pursuant to a plan approved by the member insurer’s domiciliary regulator.]

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

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

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

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

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

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-

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admitted insurer and risk retention group; or

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

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

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

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

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

- (3~~2~~) Except as provided elsewhere in this section, “covered claim” shall not include:
- (a) Any amount awarded as punitive or exemplary damages;
 - (b) Any amount sought as a return of premium under any retrospective rating plan;
 - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
 - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

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- (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
- (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
- (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
- (h) Any claims for interest; or
- (i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

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

[Optional Section 5H:

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

HI. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, ~~when the obligation with respect to the covered claim was assumed under an assumed claims transaction,~~ or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

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

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

- JK.
- (1) “Member insurer” means any person who:
 - (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
 - (b) Is licensed to transact insurance in this State (except at the option of the State).
 - (2) An insurer shall cease to be a member insurer effective on the day following the termination or

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

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

[Optional Section 5K:]

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

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

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

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

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

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

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

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

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

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~~calendar year of the transaction.~~

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

Section 6. Creation of the Association

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

[Alternate Section 6. Creation of the Association

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

- A. The workers' compensation insurance account;*
- B. The automobile insurance account; and*
- C. The account for all other insurance to which this Act applies.]*

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

Section 7. Board of Directors

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

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

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a board *member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

- A. The association shall:
 - (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
 - (i) The full amount of a covered claim for benefits under a workers’ compensation insurance coverage;
 - (ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (iii) An amount not exceeding \$500,000 per claimant for all other covered claims.
 - (iv) In no event shall the Association be obligated to pay an amount in excess of \$500,000 for all first- and third-party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of

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claims made or the number of claimants.

- (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

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

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

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

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

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

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.
- (3) **[Alternative 1a]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the

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

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

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

~~f — [Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer~~

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

- (3) **[Alternative 1b2]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

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

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

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

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

[Optional:

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

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

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

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

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the domiciliary receiver.

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

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preceding fiscal year in a form approved by the commissioner.

B. The association may:

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

[Alternate Section 8B(6)

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

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

C. Suits involving the association:

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

[Optional; Section 8D

D. (1) *The legislature finds:*

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
- (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue*

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burdens on the State, the affected units of local government, and the community at large;

- (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.*
 - (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
 - (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
 - (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of*

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the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].

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

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

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

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

Section 9. Plan of Operation

- A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
- (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
 - (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;

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- (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

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

B. The commissioner may:

- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to

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pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;

- (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
- (3) Examine, audit, or otherwise regulate the association.

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

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

Section 11. Coordination Among Guaranty Associations

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

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.
- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to State priority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall

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preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

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

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

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

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

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

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.^f
- i. The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(1). In that case, the Association shall recover from the high net worth insured under this sSection all amounts paid on its behalf, all

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allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this sSection.]

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

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
- (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
- (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.
- (5) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this sSection all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this sSection.]

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

[Alternative 3 for Section 13B

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

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- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

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

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

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

- The credit shall be deducted from the lesser of:
- (i) The amount of the judgment or settlement of the claim; or
 - (ii) The policy limits of the policy of the insolvent insurer.]
- (b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.
- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to

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defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.

- (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
 - (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
 - (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
 - (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.
- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

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

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.
- C. Reports and recommendations provided under this section shall not be considered public documents.

-Section 16. Tax Exemption

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

Section 17. Recoupment of Assessments

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

[Alternative 1 for Section 17]

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.]

[Alternative 2 for Section 17]

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

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

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

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- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.]

[Alternative 3 for Section 17

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

Section 18. Immunity

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

Section 19. Stay of Proceedings

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

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

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

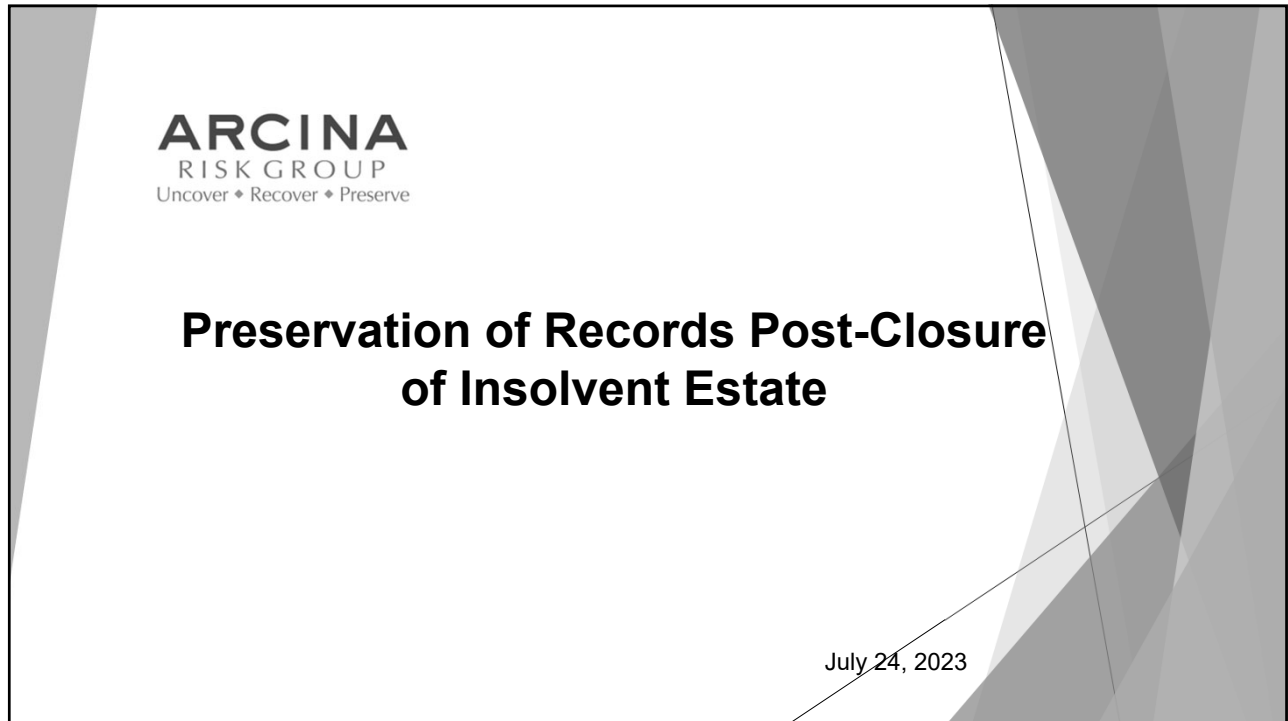
1970 Proc. I 218, 252, 253-262, 298 (adopted).
1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. I 44, 46, 126, 217 (amended).
1981 Proc. I 47, 50, 175, 225 (amended).
1984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

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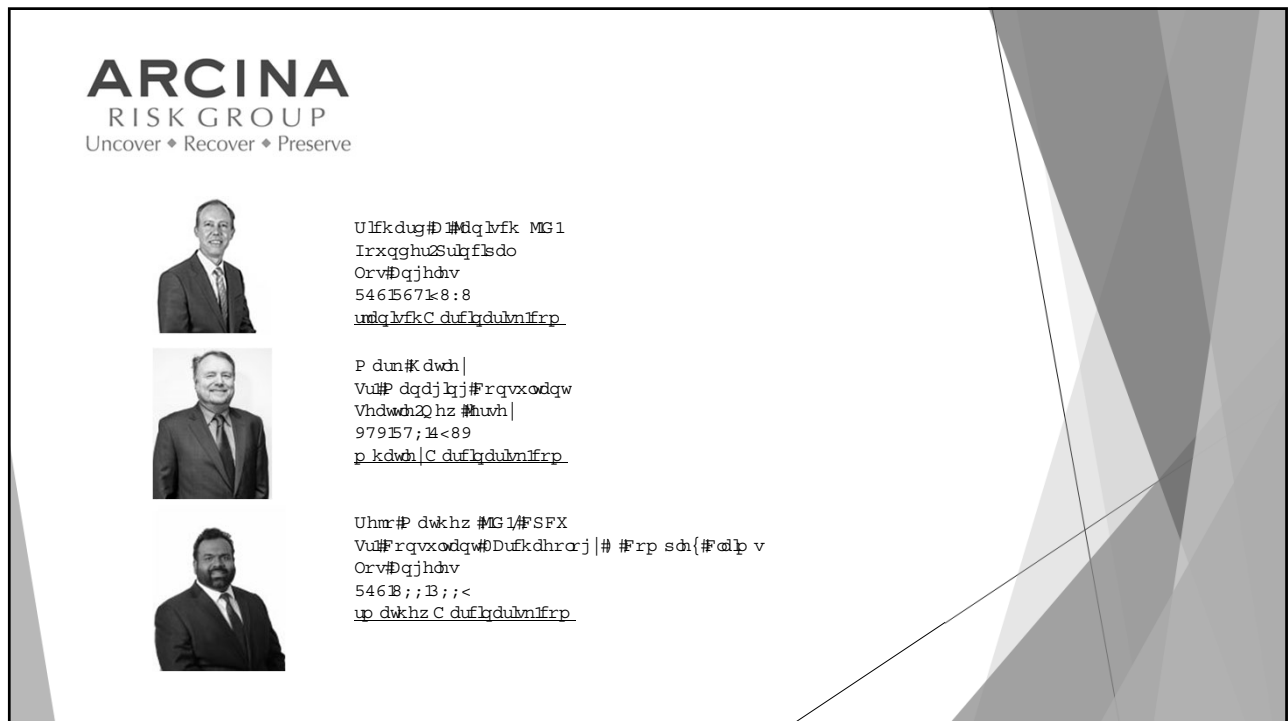
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1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).

2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).



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Next Steps

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

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