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## I. INTRODUCTION

This chapter of the Receivers' Handbook is intended to provide helpful information about receivership legal matters. Although case law has been cited, this handbook is not intended to be cited as binding legal authority and 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. Every effort has been made to provide correct and accurate cases to assist the receiver in targeting useful information. For further details, including any additional adoptions, the statutes and regulations cited should be consulted in each receivership.

### A. Goal

This chapter's goal is to introduce, in as neutral a manner as possible, the legal issues that a receiver may encounter in administering the receivership of an insurer. The following caveats and limitations apply to the chapter:

- The insurance industry in the U.S. is regulated on a state, rather than a federal, level. Each state has its own insurance laws that may somewhat differ from those of any other state. While these materials include information that is generally true throughout the U.S., it is essential that receivers and other practitioners examine the laws of each state involved. Federal law should also be consulted concerning certain issues.

- These materials are not an adequate substitute for advice of legal counsel. They are designed to assist the reader in effectively communicating with legal counsel and in understanding the relevant legal issues. They do not and cannot make the utilization of legal counsel unnecessary. Competent legal counsel must be retained to act on behalf of the receiver and participate in the administration of the insurer's affairs.

- The law relating to insolvent insurers is evolving. While these materials are intended to be current as of date of publication and will be periodically updated, it is suggested that counsel be consulted on all legal issues.

### B. Diversity of Law

Historically, insurers and reinsurers have been excluded from the provisions of federal bankruptcy law.[1] They are governed instead by state receivership laws, even though the insurer's parent company and other non-insurance affiliates may be within the jurisdiction of the federal bankruptcy courts. When entities affiliated with an insurer in receivership are in federal bankruptcy proceedings, coordination of the proceedings may be advantageous, even essential, to bringing about an effective resolution of each proceeding.[2]

Insurers generally do not limit their business to the geographical confines of a single jurisdiction, so, when an insurer is declared insolvent, the laws of more than one state may be implicated. Consequently, during the takeover and administration of an insolvent insurer, it is of the utmost importance to consult the laws of each jurisdiction in which the insurer conducted business.

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[1] See 11 U.S.C. § 109(b)(2). What constitutes an "insurance company" excluded from bankruptcy is a matter of federal law and may depend on whether the insurance department desires to assert jurisdiction over the entity. Compare *In re Estate of Medicare HMO,* 998 F.2d 436 (7th Cir. 1993) (HMO excluded from bankruptcy) with In re *Grouphealth Partnership, Inc.,* 137 B.R. 593 (Bankr. E.D.Pa. 1992) (HMO not so excluded).

[2] See e.g., *In re Baldwin-United Corp. Litigation,* 765 F.2d 343 (2d Cir. 1985) (insolvent insurers' settlement with state insurance administrators supervising their rehabilitation was conditioned on federal court confirmation of a plan of reorganization for the parent company under federal bankruptcy laws*);* see also In re *Kearns*, 161 B.R. 701 (D. Kan. 1993) (discussing split of authority regarding jurisdiction over effect of automatic stay on nonbankruptcy proceedings).



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Most states have enacted insurer delinquency proceeding statutes modeled after either the Uniform Insurers Liquidation Act (Uniform Act), the *Insurers Rehabilitation and Liquidation Model Act* (Liquidation Model Act) or the *Insurer Receivership Model Act* (#555), also known as IRMA,—collectively, the Model Acts.[3] Because of the widespread influence of the Uniform Act and the Liquidation Model Act, they both serve as logical bases for any general analysis of legal issues involved in the takeover and administration of an insolvent insurer. For this reason, both acts, along with case law, were used in preparing this chapter. IRMA is the most recent NAIC model act, so references to relevant provisions of IRMA are also included, where appropriate. Be aware, however, that the law of a particular state may deviate from the model acts, so counsel should be consulted.

### C. Administration of Receivership

The model acts provide that the regulator of the state in which the insurer is domiciled, if a domestic insurer, will administer the insurer in receivership. Likewise, if the insurer is an alien insurer, i.e., an insurance company formed according to the legal requirements of a foreign country that gained admission to the U.S. market through a "port-of-entry," the regulator of the state through which the insurer gained admission will administer the U.S. deposit and/or trust assets of the insolvent insurer in receivership. The model acts dictate that a state's insurance regulator, as receiver, will administer all insurer receiverships under the supervision of the state courts, usually those courts located either in the county (or parish) of the domiciliary state's capital or the insurer's principal office.

## II. TAKEOVER AND ADMINISTRATION

Editor's Note—This subchapter deviates from the practice in the rest of the chapter of referring to all official proceedings as "receiverships" and all regulators assigned to administer the estate as "receivers." Instead, this subchapter, where appropriate, refers to "conservations," "rehabilitations" and "liquidations." This was done in an effort to avoid confusion where the different types of receivership require different treatment. Similarly, the term "regulator" is used to describe the state regulatory authority acting prior to the appointment of a "receiver," again to avoid confusion.

The takeover and administration of an insolvent insurer is a complicated process involving the rights and liabilities of the insolvent insurer and of its policyholders and claimants against policyholders, agents and intermediaries, cedents and reinsurers, creditors, former management, and local, state and federal governments, as well as coordination with state guaranty associations. While the practical aspects of the takeover and administration of an insurer are addressed in Chapter 1, this section will pay particular attention to those legal details and issues which may arise in the process. This section's goals are threefold. First, it identifies particular legal issues. Second, it illustrates the problems which may arise from those issues. And finally, it provides guidelines on how those issues may be resolved under statutory and case law.

### A. Pre-Takeover/Informal Actions

The regulator may intervene in an insurer's business operations if the insurer is in financial difficulty. Some states provide grounds for informal supervisory action if an insurer is in a certain condition. If the regulator determines that an insurer is operating in a manner that poses a hazard to the insurer's policyholders, creditors or the public, the regulator may serve a corrective or supervisory order upon the insurer to provide short-term relief.[4] Oftentimes, the regulator may issue this order without formal court proceedings, but such orders are subject to administrative review. The orders are generally confidential.

[3] See Uniform Insurers Liquidation Act, 13 U.L.A. 328 (1986 and Supp. 1991) [hereinafter Uniform Act]; NAIC Insurers Rehabilitation and Liquidation Model Act (1991) [hereinafter Liquidation Model Act]; and NAIC Insurer Receivership Model Act (2006) [hereinafter IRMA].
[4] See Liquidation Model Act, *supra,* at Section 5, IRMA at Sections 201, 206, and 215 ILCS 5/186.1-186.2.



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## B. Seizure Orders

Most states have a statutory process for a judicial action that can be taken against an insurer prior to a formal delinquency proceeding.[5] This process is referred to as a "seizure" proceeding in the Liquidation Model Act and IRMA, and this term is generally used in most states. However, the use of this term is not necessarily universal, and some states may have a different term for a substantively similar process. A seizure order enables the regulator to determine the insurer's condition and the course of action that should be taken to rectify its condition. The order is also intended to protect the assets of an insurer while the regulator determines if it is necessary to seek an order of rehabilitation or liquidation. The regulator is authorized to file a petition for a seizure order with respect to a domestic insurer, an unauthorized insurer or a foreign insurer under § 201 A of IRMA.

The regulator may obtain such an order by filing a petition with a court of competent jurisdiction. A seizure order can usually be issued by the court on an *ex parte* basis. Ex parte orders are allowed in order to prevent the diversion of funds or destruction of records. It should be noted, however, that an ex parte seizure order is subject to subsequent court review to protect the insurer's right to due process.

The Liquidation Model Act, IRMA and a number of state statutes based on these models provide for the confidentiality of both the pleadings and the proceedings related to a seizure proceeding. The sequestered nature of the proceeding may continue until the regulator or the insurer subsequently requests that the matter be made public. This confidentiality may permit the receiver to resolve the insurer's problems without public disclosure and resulting damage to the insurer's ongoing business.

1. Grounds for Order

Generally, a petition for a seizure order must allege that there are grounds justifying a formal delinquency proceeding and that the interests of policyholders, creditors or the public are endangered by a delay in entering such an order. Specific requirements for obtaining a seizure order vary from state to state. See IRMA, § 201 A.

2. Contents of Order

Generally, the order appoints the regulator to take possession and control of all or part of the property, books, accounts, documents and other records of the insurer. Further, the order generally gives control of the insurer's physical premises to the regulator. The order will usually be accompanied by an injunction enjoining the insurer, its officers, directors, managers, agents and employees from disposing of property or transacting the business of the insurer except upon the permission of the receiver or further court order.

3. Duration of Order

Depending on the applicable statute and the practice in a jurisdiction, the seizure order will either state the period that the order will remain in effect or state that it will remain in effect until such time that the regulator determines the condition of the insurer. IRMA § 201 D provides that:

a. the receivership court shall specify the duration of the seizure order, which shall be the time the court deems necessary for the regulator to ascertain the condition of the insurer;

b. the regulator may request an extension or modification of the order if necessary to protect policyholders, creditors, the insurer or the public; and

c. the court shall vacate the order if the regulator fails to institute a rehabilitation or liquidation proceeding after having had a reasonable opportunity to do so.

[5] Section 104 J of IRMA defines a "formal delinquency proceeding" as a conservation, rehabilitation or liquidation proceeding.



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4. Review of Order

If the insurer wishes to contest a seizure order, it may petition the court for a hearing and review of the order. The Liquidation Model Act and § 201 F of IRMA provide that the court shall hold such a hearing not more than 15 days after the request.

5. Powers and Duties of the Regulator Under Order

The seizure order typically directs the regulator to take possession and control of the property, accounts and records of an insurer and its premises. The order will also usually enjoin the insurer and its officers, managers, employees and agents from disposing of the insurer's property and transacting its business, except with the regulator's consent. See § 201 B of IRMA.

## C. Conservation

The term "conservation" is used in insurance regulation in a number of different contexts, depending on the circumstances and the jurisdiction. Statutes may use the term to apply to an administrative proceeding; a proceeding similar to a seizure action (see [I.B], above); a proceeding involving foreign insurers (see [I.C.2] below); or a rehabilitation proceeding (see [I.D], below). Finally, the term is used under Article III of IRMA to refer to a type of formal delinquency proceeding.

1. Conservation under Article III of IRMA

IRMA provides for conservation as an additional remedy available to a regulator to determine if an insurer's condition can be rectified and if not, to determine the appropriate action that should be taken. Unlike a seizure proceeding, conservation under IRMA is a formal delinquency proceeding, a term that also includes a rehabilitation or liquidation proceeding. However, unlike a rehabilitation or liquidation proceeding, a conservation proceeding is strictly limited in duration, and ultimately concludes with the insurer being released from delinquency proceedings or being placed into rehabilitation or liquidation. While conservation is not a prerequisite to a rehabilitation or liquidation proceeding, it can be instituted to ascertain whether rehabilitation or liquidation should be sought.

a. Conservation Orders

A conservation order under IRMA appoints the regulator as conservator, and directs the conservator to take possession of the insurer's assets and administer them under the court's supervision. A conservation order must require accountings to the court by the conservator at intervals specified by the order, no less frequently than semi-annually. See § 301 of IRMA.

b. Powers and Duties of Conservator

In some respects, the conservator's powers under IRMA are similar to those of the rehabilitator. The conservator is authorized to take necessary or appropriate action to reform and revitalize the insurer, including canceling policies (except life or health insurance or annuity contracts) or transferring policies to a solvent assuming insurer. The conservator also has: all the powers of the directors, officers and managers of the insurer; the authority to manage, hire and discharge employees; and the power to deal with the property and business of the insurer, pursue legal remedies on behalf of the insurer, and assert defenses available to the insurer. See § 302 of IRMA.

c. Termination of Conservation

The conservator must conduct an analysis of the insurer to determine if it is possible to correct the problems that precipitated the need for conservation. The conservator must then file a motion



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requesting that the insurer be either released from conservation, or placed in rehabilitation or liquidation. The motion must be filed within 180 days of the conservation order, unless the court grants a 180-day extension. See IRMA § 302. The conservator is required to coordinate with guaranty associations to ensure an orderly transition in the event of liquidation. See IRMA § 303.

2. Conservation of Property of Foreign or Alien Insurers

Most state receivership statutes provide that a regulator may apply to the court for a conservation order of the property of an alien or foreign insurer not domiciled in the regulator's state. The grounds and terms of such an order generally include those necessary to obtain a similar order against a domiciliary insurer, but there may be some differences. Usually if the alien or foreign insurer has property sequestered in an official action in its domiciliary state or foreign country, or if its certificate of authority in the state has been revoked or was never issued, the regulator may seek an order of seizure. A conservation order against a non-domiciliary insurer may not be confidential.

IRMA § 1001 provides for ancillary conservation of a foreign insurer that is separate and distinct from the process contained in Article III of IRMA.

**D. Rehabilitation**

A regulator may petition a court of competent jurisdiction for an order of rehabilitation that may be used in an effort to remedy an insurer's problems.

1. Grounds

The grounds upon which a regulator may petition the court for an order of rehabilitation vary from state to state. A regulator must allege and prove a specific statutory ground for rehabilitation. Per § 207 of IRMA, the grounds upon which a regulator may petition the court are the same whether the requested order is for conservation, rehabilitation or liquidation. Examples of the grounds can include by are not limited to certain Risk Based Capital (RBC) level and other non-financial grounds.

An order of rehabilitation is usually obtained through a formal proceeding that entails certain due process requirements, such as: the filing of a petition by the regulator, usually brought in the name of the people of the state; service of process upon the insurer; an opportunity for the insurer to be heard prior to the issuance of the rehabilitation order; and a formal order from which an appeal may be taken.

2. Burden of Proof

Generally, courts hold that if a regulator presents uncontroverted evidence that an insurer is in need of rehabilitation, entry of the order is justified. IRMA § 208 provides that if the regulator establishes any of the grounds for a receivership, the receivership court shall grant the petition and issue the order of conservation, rehabilitation or liquidation requested.

3. Contents of a Rehabilitation Order

An order of rehabilitation generally appoints the regulator as rehabilitator; vests the rehabilitator with possession or title to all of the insurer's assets, books, records, accounts, property and premises[6]; and directs the rehabilitator to take possession of the insurer's assets and to administer those assets under general court supervision, and to conduct the insurer's business (IRMA, §401(A)). The order should be recorded with the county clerk or recorder of deeds for the county in which the insurer resides and where any real property is located, so that creditors and the public are put on notice of the rehabilitation. Additionally, the order should be served on all financial institutions where the insurer maintains accounts or has other assets.

[6] See Liquidation Model Act, at Section 12; Uniform Act, Section 2(2); IRMA, §401.



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The rehabilitation order may require that the rehabilitator file reports and accountings with the court. The receivership act may provide for a filing of a rehabilitation plan for the court's review and approval. The rehabilitator is charged with implementing the restrictions, limitations and requirements set forth in the order of rehabilitation.

The receivership act typically provides that the rehabilitator has the power to take any legal action that is deemed necessary or appropriate to reorganize and revitalize the insurer. In accordance with the applicable receivership act, the order will typically suspend the insurer's directors, officers and managers powers, except as the rehabilitator delegates. The rehabilitator retains all powers not expressly delegated (IRMA, §402).

The order may prohibit the insurer from writing new business or may severely limit the amount and type of new business written. Similarly, the order might impose significant restrictions or prohibit the renewal of business when the renewal is at the option of the insurer. In some cases (particularly with guaranteed renewable or non-cancellable business), the order may require that certain policies be renewed. The order may also: (1) require the insurer to modify or even cancel certain managing general agent ("MGA"), third-party administrator ("TPA") and general agency agreements; (2) suspend claims payments; (3) halt the transfer of cash or loan values on life insurance contracts; (4) provide that reinsurance agreements may not be canceled and that the insurer may not obtain any new reinsurance without the approval of the receiver; and (5) address other issues particular to the insurer.

The rehabilitator will be empowered under the order to take control of the insurer's physical and liquid assets immediately and perform an inventory of these assets. In addition, the order will likely suspend the payment of any dividends to shareholders, affiliates and subsidiaries. The rehabilitator may restrict new investments and may, in fact, liquidate certain investments. If previously discussed by the regulator and agreed to by the insurer's parent or shareholders, the order may require infusion of capital into the insurer. In those states that leave directors and officers in power during rehabilitation, the order may provide for a change or suspension of their authority.

4. Rehabilitation Plan

The receivership act may allow, or require, the rehabilitator to file a plan of rehabilitation ("plan") by a specified date. At other times, the timing of that filing is left to the discretion of the rehabilitator. Under IRMA the filing of a plan is mandatory; § 403 A. requires that a plan be filed within one year after entry of the rehabilitation order or such further time as the court may allow. In contrast, some receivership acts require that a plan be filed only if the rehabilitator proposes to reorganize, convert, reinsure or merge the insurer.

The plan should not treat creditors less favorably than they would be treated in liquidation.[7] It should be noted that the Model Acts do not require that the plan provide for the emergence of the insurer from rehabilitation as a going concern. Thus, a plan for a run-off may be permissible. After formulating the plan, the rehabilitator must submit it to the supervising court for approval. The court will either approve, disapprove or modify the plan. State law typically requires that the court give notice and hold hearings upon any proposed plan. The court's review of the rehabilitator's proposed plan is generally a limited one, subjecting the rehabilitator's proposal to an abuse of discretion standard.[8]

[7] See generally Liquidation Model Act, *supra* note 3, at Section 12; Uniform Act, Section 2(2); IRMA §403 C. provides that the holder of a particular claim may agree to less than favorable treatment than would occur in liquidation; see also *Gersenson v. Pennsylvania Life and Health Ins. Guar. Assoc.*, 729 A.2d 1191 (Pa. Super. App. 1999) (court, not rehabilitator, empowered to compromise value of policies).

[8] *Foster v. Mutual Fire, Marine & Inland Ins. Co.,* 531 Pa. 598, 614 A.2d 1086 (1992)*, cert. denied*, *Allstate Ins. Co. v. Maleski,* 506 U.S. 1080, 122 L.Ed.2d 356, 113 S.Ct. 1047; and cert. denied, *Rhine Reinsurance Co., Ltd., v. Mutual Fire, Marine & Inland Ins. Co.*, 506 U.S.



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IRMA §403C lists four requirements for every plan:

1. The plan must assure that each class of claimants will receive "no less favorable treatment" than those claimants would receive if the insurer is liquidated unless the claimant agrees to accept different treatment or if the claim is for a *de minimis* amount,

2. Provide adequate means for the plan's implementation,

3. The plan must provide sufficient financial data to allow the claimants and the receivership court to evaluate the potential for success of the plan, and

4. The plan must provide for the disposition of the books and records of the estate.

. Subsection D of §403 provide suggestions for other items which the rehabilitator may wish to consider, including:

1. Payment of claims. Depending on the sufficiency and liquidity of the estates' assets, the rehabilitator may wish to propose payment of administrative expenses and policy benefit claims on a current basis, while deferring payments to subordinate classes.

2. Transfer of the insolvent insurer's book of business, wholly or in part, to a solvent carrier.

3. Imposition of regulatory market conduct standards on third party administrators or assuming carriers.

4. Engaging a third-party administrator or guaranty fund (for property/casualty business) to handle claims for the rehabilitator.

5. Periodic audits of third-party administrators.

6. Establishing a termination date for the estate's non-policy liabilities.

Rehabilitation plans for life insurers may impose liens on policies if the rights of shareholder are waived. They may impose a one-year moratorium on cash surrenders or policy loans. The term of the moratorium can be extended by the receivership court.

Other considerations when drafting a rehabilitation plan include the following:

1. Whether to retain the insurer's former management or install new individuals in management positions.

2. A business plan.

3. A work-out plan for the insurer's creditors.

4. A marketing plan for the insurer.

5. Hardship provisions.

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1080, 122 L.Ed.2d 356, 113 S.Ct. 1051; and cert. denied, *Republic Ins. Group v. Maleski,* 506 U.S. 1087, 122 L.Ed.2d 371, 113 S.Ct. 1066 (1993); and *Kuekelhan v. Fed. Old Line U.S. Co.,* 74 Wash.2d 304, 444 P.2d 667 (1968). But see In re *Executive Life,* 38 Cal. Rptr.2d 453, 32 Cal. App. 4th 344 (Cal. App. 2d Dist. 1995), as modified on denial of rehearing (Mar. 15, 1995), and review denied (May 11, 1995).



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6. An underwriting plan in the event the insurer is permitted to write new business.

7. Continuation of periodic reporting to the court, and ancillary states in which the insurer is licensed, including updated cash flows and projections to enable the court to determine whether the plan should be modified or terminated, and whether the insurer can ultimately meet its obligations. Under §117 of IRMA, quarterly financial reporting to the court is required unless such reporting is excused for good cause shown. Tax reporting should continue uninterrupted and statutory financial reporting should continue uninterrupted if required by the state regulator . Coordination of the plan with other jurisdictions in which the insurer was licensed. The rehabilitator may wish to solicit acceptance of the plan in other jurisdictions in which the insurer was licensed. Coordination by and among states may facilitate the release of statutory deposits to the domiciliary state for use in satisfying the claims of policyholders and other creditors.

8. Replenishment of capital and surplus of the insurer to acceptable levels for all jurisdictions where the insurer is licensed. This will expedite the restoration of licenses previously suspended or revoked.

9. Collection of assets which are speculative or illiquid. An objective of the plan should be to reduce as many assets as practicable to cash or cash equivalents. If there are assets which are speculative or illiquid and on which the rehabilitator will realize negative spreads in market values, the rehabilitator should weigh the advantages of holding them for future disposition in the hope of regaining value versus immediate disposition to prevent further deterioration of value. Conversely, assets on which the Rehabilitator will enjoy positive spreads in market values should be liquidated timely.

10. Quantification of liabilities and payment of claims. The Plan should provide for the actuarial justification of liabilities, both on a gross and net basis; reinsurers may pose a credit risk to the insurer, which, in turn, may further erode capital and surplus, or preclude the insurer from meeting obligations as they come due.

    The Plan may include claim moratoria, pending the collection of previously identified asset recoveries, particularly off-balance sheet. At a minimum, the Rehabilitator will want to address the moratorium for the payment of classes below policyholders (Class 3), either temporary or indefinite. The Rehabilitator as a part of the Plan and depending on the sufficiency of assets may wish to petition the Court to continue pay superior creditor (classes 1 through 3), while deferring payments to subordinate creditors (classes 4 through 9), pending the success of the Plan. Typically, subordinate creditors will be subject to a formal claims process including the filing of proofs of claims and a claim filing deadline established by the Court, whereas superior creditors will receive payment of claims from estate assets in the normal course. The Rehabilitator may wish to consider as part of the plan the appointment of court assistants to assist in the timely adjudication of claims and resolution of disputes with regard to class 3 claims.

11. Reinsurance programs. The plan should address the importance of the continuing timely reporting and collection of reinsurance proceeds, resolution of pending disputes and development of commutation plans to abate credit risk and facilitate the release of any excess funds held.

12. Sale or recapitalization of the insurer. If the plan calls for the ultimate transfer of the insurer back to original or successor management, if allowed under state law, the rehabilitator must be aware of all Form A requirements in the domiciliary state. The Form A process will require the formulation of a business plan inclusive of pro forma financial statements. The rehabilitator should work closely with the Department of Insurance to ascertain the viability of the business



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plan as well as the integrity and qualifications of management and proposed recapitalization and proposed assets to accomplish same. In a recapitalization where a Form A may not be required, the rehabilitator will need to consider these issues carefully as a part of the court approval process.

The culmination of the rehabilitation process will be court approval of the plan. IRMA provides that when a plan is filed with the court any party in interest may file objections to the plan; after any hearings the court feels necessary, it may approve or disapprove the plan or modify it and approve it as modified.

The filing should include applicable documents detailing the specifics of the proposed transaction, outlining the history of the plan and its objectives. The plan should also deal with such issues as recapitalization, litigation, final accounting, claims of creditors, tax planning, actuarial analyses, fees and expenses, and the rehabilitator's discharge.

The rehabilitator will want to provide notice to policyholders and creditors of the hearing on the plan and the specifics of the proposed transaction to enable objections and responsive pleadings to be timely filed.

Similarly, the receiver should be prepared to liquidate the insurer if rehabilitation is not feasible or practical. The receiver should organize the assets, books and records of the insurer to ensure an orderly transition to liquidation. Thus, the receiver should incorporate procedures that address the following:

1. Payment of administrative expenses, including staff salaries,
2. Notice to creditors and other interested parties,
3. Coordination of data transfer from the insurer's data processing system to the receiver's system,
4. Coordination for the distribution of claims and policy files and data with the guaranty associations, and with the National Conference of Insurance Guaranty Funds ("NCIGF") and NOLHGA, as necessary, and
5. Evaluation of staffing needs.

5. Insufficient Assets

Sometimes the rehabilitator discovers that the insurer does not have sufficient liquid assets to defray costs incurred during the receivership. In this instance, the rehabilitator may seek an advance for costs that will be incurred during the rehabilitation from the state regulator. Most statutes require that any money so advanced to the rehabilitator be repaid out of the assets of the insurer. § 804 of IRMA, under certain circumstances, allows unclaimed funds of receivership estates to be found by the court to be abandoned and disbursed under several methods, one of which is to fund a general receivership expense account.

6. Agency Force

In a rehabilitation proceeding or when the rehabilitator otherwise contemplates selling or reinsuring the in-force business of the delinquent insurer, it is important to create an atmosphere favorable to the preservation of the business. Public confidence in the insurer may be shaken. The relationship with policyholders should be preserved to the extent possible. Communication with policyholders and agents of the insurer is necessary to maintain the desired book of business. Agents can influence the degree of confidence policyholders have in the receiver and the efforts to rehabilitate the insurer. Policyholders view life insurance, in particular, as a long-term investment. Their natural tendency, when notified that



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their insurer has been placed in receivership, is to withdraw their cash value and purchase insurance from another company at the earliest opportunity.

One way to preserve a book of business and retain the cash values and the premium income in the company is through the agency force. Most life insurance companies have a large and loyal force of agents. These agents may be employees or independent contractors; in either case, they provide a major link to the policyholders. In order to provide for the continued inflow of premium dollars that will facilitate a successful rehabilitation, the rehabilitator may consider continuing the contracts of the agency force and paying their renewal commissions as an incentive for them to continue to work with their policyholders during the rehabilitation.

Neither the Liquidation Model nor IRMA address the treatment of preexisting agent commission arrangements, but in many proceedings rehabilitators have maintained relationships with agents and continued to pay renewal commissions.[9]

The cases that have considered whether renewal commissions are owed to the agent in receiverships are split, and many have turned on the particulars of the agency agreements involved.[10]

7. Terminating the Rehabilitation

The time may come when the rehabilitator determines that rehabilitation of the insurer is not possible or that further attempts to rehabilitate the insurer would substantially increase the risk of loss to creditors, policyholders, cedents or the public. The rehabilitator may then petition the court for an order of liquidation. IRMA§404A requires that there be coordination with guaranty associations and their national organizations to plan for transition to liquidation.

Some states may provide that if policy payment obligations have been suspended for a specified period of time after a rehabilitator's appointment and the rehabilitator has not yet filed an application for approval of the rehabilitation plan, the rehabilitator must petition the court for an order of liquidation on the grounds of insolvency. IRMA allows for a six-month period, after which the rehabilitator must apply for a liquidation order or apply for a longer suspension period (IRMA§404B).

Alternatively, whenever the rehabilitator determines that the causes and conditions that made the rehabilitation proceedings necessary have been removed, the rehabilitator should petition the court for an order terminating the rehabilitation. Under the NAIC Model Acts, officers and directors may also make such an application. Although this order will usually permit the insurer's owners and directors to resume possession and control of the insurer and the conduct of its business, it may require, or the plan of rehabilitation may have imposed, a change of ownership and/or control. Under IRMA §901, a termination order will also require that funds expended by guaranty associations be repaid, or that there be a guaranty association approved plan to repay, prior to resumption of control of the insurer and its assets by shareholders or management.

## E. Liquidation

Liquidation is typically necessary in situations where the insurer's deficiencies cannot be remedied. While liquidation may be sought after a rehabilitation proceeding has been initiated, the regulator is not required

[9] The proceedings involving Executive Life of California and Mutual Benefit Life are recent examples.

[10] Compare e.g., *Cockrell v. Grimes,* 1987 Ok. Civ. App. 28, 740 P.2d 746 (Okl. App. Div. 3 1987); *Wear v. Farmers & Merchants Bank of Las Cruces,* 605 P.2d 27, on rehearing, 606 P.2d 1278 (Alaska 1980); with e.g., *D.R. Mertens, Inc. v. Florida,* 478 So.2d 1132 (Fla. App. 1st Dist., 1985), review denied, 488 So. 2d 829 (1986), and appeal dismissed, 479 U.S. 802, 93 L.Ed. 2d, 107 S.Ct. 43 (1986); *Layton v. Illinois Life Ins. Co.,* 81 F.2d 600 (7th Cir.) cert. denied, *Bachman v. Davis,* 298 U.S. 681, 80 L.Ed. 1401, 56 S.Ct. 949 (1936); *Myers v. Protective Life Ins. Co.,* 342 So.2d 772 (Ala. 1977).


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to attempt to rehabilitate the insurer as a prerequisite to seeking an order of liquidation.[11] In liquidation, the liquidator identifies creditors, marshals and distributes assets in accordance with statutory priorities, and dissolves the insurer.

1. Grounds

State statutes set forth the grounds for liquidation, any one of which is appropriate for the issuance of a liquidation order. The regulator may seek liquidation on the grounds that the insurer is insolvent, is in such a condition that further transaction of business would be hazardous, or on any ground applicable for an order of rehabilitation. If the insurer is in rehabilitation, the regulator may petition the court for an order of liquidation when it believes further attempts to rehabilitate the insurer would substantially increase the risk of loss to the insurer's policyholders, creditors or the public, or if liquidation is in the best interests of the parties.

2. Order of Liquidation

Once the court determines that an insurer should be placed in liquidation, it enters an order of liquidation, which affirms the statutory appointment of the regulator as the liquidator of the insurer and vests him or her with title to all of the insurer's assets, books, records, accounts, property and premises. The order enables the liquidator to control all aspects of the insurer's operations under the general supervision of the court. Where necessary to protect the interests of the estate and its claimants and creditors, affiliates and subsidiaries may be made subject to a receivership order issued by the liquidation court if it can be shown that the insurer, its affiliates and subsidiaries operated as a single business enterprise.[12] Orders of liquidation may be appealed by management and/or shareholders of the insolvent insurer. However, several state appellate courts have refused to reverse an order of liquidation without a clear showing that the regulator abused his or her discretion. The reviewing court's primary focus is whether the regulator properly and reasonably acted to protect the policyholders and the public.

Most state statutes provide that upon issuance of the order, all of the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of liquidation, IRMA § 501. State statutes describe the effect of the order of liquidation upon contracts of the insolvent insurer, IRMA § 114, § 209 B and § 504 A(8).

3. Effect on Policies

   a. Life & Health Policies

   Care should be taken in life and health insurer insolvencies that the filing of a liquidation order does not inadvertently result in the cancellation of policies or contracts that are subject to ongoing guaranty association coverage. Before filing a motion for a liquidation order, the liquidator should consult with guaranty associations to ensure that covered contracts are not canceled, and that the liquidation order serves as an effective trigger for guaranty association obligations. IRMA, § 502 makes specific provisions and distinctions as to cancellations of property/casualty coverages and continuations of life and health coverages.

[11] See In re *Conservation of Alpine Ins. Co.,* 741 N.E.2d 663 (Ill. App. 1st Dist. 2000) (decision whether to rehabilitate or liquidate not mandated by statute, but left to regulator's discretion based on circumstances); *Remco Ins. Co. v. State Ins. Dept.*, 519 A.2d 633 (Del. 1986) (regulator need not first pursue summary remedies).

[12] See e.g., *Brown v. Automotive Cas. Ins. Co.,* 644 So.2d 723 (La. App. 1st Cir. 1994), writ denied, 648 So. 2d 932 (La. 1995); see also *Green v. Champion Ins. Co.*, 577 So. 2d 249 (La. App. 1st Cir.), cert. denied, 580 So. 2d 668 (La. 1991).


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b. Property & Casualty Policies

The cancellation of property and casualty policy obligations raises several legal issues. In general, the courts strictly enforce the statutes providing for the cancellation of insurance policies upon liquidation. Courts are reluctant to rule contrary to the statutes, even when a policyholder does not receive actual notice of the policy cancellation. Several cases have considered the question of whether the policyholder's claim would be accepted when it was filed after the bar date established in the order. These cases involve instances both where the claimant did and did not have notice of the bar date. Courts have held that the order of liquidation effectively cancels outstanding policies and fixes the date for ascertaining debts and claims against the insolvent insurer.

4. Powers and Duties of the Receiver, IRMA, § 504

The liquidator is authorized to:

- Marshal assets;
- Sue a defendant in the insurer's name;
- Sell the insurer's assets;
- Appoint one or more special deputies;
- Employ attorneys, accountants and consultants as necessary;
- Borrow on the security of the insurer's assets;
- Enter into contracts as necessary; and
- Obtain title to all of the insurer's assets.

The liquidator's powers have been challenged in numerous cases. Most jurisdictions hold that the liquidator steps into the shoes of the insolvent insurer and possesses the same rights as the insurer. Several cases have focused on the liquidator's specific duties. These cases have allowed liquidators to compound or sell any uncollectible or doubtful claims owed to the insolvent insurer, to disaffirm the fraudulent sale of mortgages, to act as statutory liquidators of the insolvent insurer's property, to sell the property of the insurer, to conduct business using the assets of the insurer, and to control bonds and mortgages held as collateral security.

5. Litigation

Often when an insurer is placed into receivership, the insurer is involved in litigation. Most state statutes provide for a stay of pending actions in which the insurer is a defendant. In any event, a receivership order should incorporate a provision to stay or enjoin litigation. Some state statutes or receivership orders provide for a temporary stay of litigation involving the insurer's policyholders. A stay or injunction may be enforceable in other states under statutory provisions or case law. If litigation is pending outside the domiciliary state, it may be necessary for the liquidator to petition the court in those jurisdictions for a stay in order to protect the estate and the insurer's policyholders.

Most state statutes provide that an order of receivership vests the right to all causes of action of the insurer in the liquidator. The liquidator is thereby empowered to maintain specific causes of action on behalf of the estate. The liquidator may also be entitled to bring general causes of action belonging to policyholders, claimants and creditors of the estate.[13]

6. Notice

[13] See In re *Rehabilitation of Centaur Insurance Co.,* 238 Ill. App. 3d 292, 606 N.E.2d 291 (Ill. App. 1 Dist. 1992), *aff'd*, 158 Ill. 2d 166, 632 N.E.2d 1015 (Ill. 1994) (holding that receiver may not assert reinsured's claim against parent of insolvent insurer or claims based on fraud and misrepresentation made to creditors).



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Most state statutes set the minimum requirements for notice to creditors and all persons known or reasonably expected to have claims against the insurer. The liquidator should notify the regulator of each jurisdiction in which the insurer does business, the applicable guaranty associations, all agents of the insurer and all policyholders, claimants against policyholders, cedents and reinsurers, creditors, and former employees at their last known address. The liquidator should also give notice by publication in a newspaper of general circulation in the county in which the insurer has its principal place of business. Potential claimants are required to file their claims on or before the date specified in the notice, IRMA § 208 and § 505.

Some liquidators maintain general service lists and notify anyone whose name is on the list of action to be taken in court. Others require persons who want notice to file an appearance in the receivership proceeding and then indicate whether they want notice of all actions or only those directly affecting their interest. IRMA provides that a person shall be placed on the service list to receive notice of matters filed by the liquidator upon that person's written request to the liquidator, § 107 A.

In some circumstances, a liquidator may wish to dispute the "right" of certain persons or entities to participate generally, or receive notice of all actions before the court, in a receivership. For example, a liquidator considering suing the directors and officers of the company may not wish to notify them or a parent company of all actions the liquidator proposes to take. In such circumstances, it may be incumbent upon the party seeking notice to establish their right to receive it.

The liquidator should also follow applicable federal and state statutes and regulations governing notice to relevant federal and state agencies. (See Chapter 5—Claims, section on Notice.)

Notice becomes an issue when the claimant does not receive notice of the liquidation. The cases addressing this issue turn on the specific facts. Courts have allowed late claims where the liquidator should have known of the claimant's existence and provided notice. The liquidator should provide notice to all persons known or reasonably expected to have claims against the insurer. IRMA provides that the liquidator has no duty to locate any persons or entities if no address is found in the insurer's records or if mailings sent to the address shown in the insurer's records are returned. Notice by publication or actual notice is deemed sufficient, § 505 D.

7. The Right to Participate

   a. Necessary Parties

   A necessary party is one whose participation in a lawsuit is required by any of the following reasons: 1) to protect an interest the party has in the subject matter of the controversy that would be materially affected by the party's absence; 2) to reach a decision that will protect the interests of those before the court; and 3) to enable the court to make a complete determination of the controversy. The liquidator should consider the interests of *all* creditors and other persons interested in the insolvency estate. In most circumstances, this includes shareholders.

   b. Intervening Parties

   There are two types of intervention: mandatory and permissive.

   As a general rule, intervention is permitted as of right: 1) when a statute confers an unconditional right to intervene; 2) when representation of the applicant's interest is or may be inadequate and the applicant will or may be bound by an order or judgment in the action; or 3) the applicant is so situated as to be adversely affected by a distribution or other disposition of property in the custody or subject to the control or disposition of the court.

   Permissive intervention generally is permitted when: 1) a statute confers a conditional right to intervene; or 2) an applicant's claim or defense and the main action have a question of law or fact



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in common. In addition, the court must determine whether the intervention will unduly delay or prejudice the adjudication of the right of the original parties.

In either case, the applicant is required to present a petition for intervention, along with the initial pleading or motion he or she proposes to file. IRMA has three alternatives for dealing with right to intervene in § 105 I. All three alternatives prohibit intervention by a person for the purpose of seeking or obtaining payment of any judgment, lien or other claim of any kind. Alternative 1 permits guaranty associations to intervene as parties and participate upon application to and approval by the receivership court if the associations are or may become liable to act as a result of the liquidation proceedings. Alternative 2 permits guaranty association intervention as a matter of right. Similarly, the NAIC's Life and Health GA Model Act has, since 1985, recognized the guaranty associations' right to appear or intervene in receivership proceedings involving an impaired or insolvent insurer for which the association is or may become obligated. See Life Model Act § 8(J). IRMA's Alternative 3 is silent as to guaranty associations.

8. Deadline for Filing Claims

Unless established by statute, the court establishes a deadline or bar date for the filing of claims against an insolvent insurer or its assets. Creditors who do not file a claim by the bar date may be barred from participating in the distribution of the insurer's assets or may be subordinated to a lower distribution priority. Many receivership acts provide that late claims may be treated as if they were timely filed under certain circumstances, and that claims not eligible for such treatment may be subordinated. See IRMA, § 701B and § 801. The liquidator may be permitted to request the court to set a date after which no further claims may be filed. See IRMA, § 701B. Many receivership acts also contain provisions permitting claimants to file unknown, unliquidated or contingent claims. See IRMA, § 704 and § 705.

9. Jurisdiction and Ancillary Receiverships

Many insurers are licensed to do business in several states. States other than the insurer's state of domicile in which the insurer is licensed to do business may have authority to establish an ancillary receivership. However, with the advent of reciprocal receivership statutes and enhanced cooperation among the states, ancillary proceedings have become less common. Generally, it is more efficient for the domiciliary regulator to manage the insolvency for the benefit of all affected regulators.

Liquidation of an insurer is conducted by the receiver in the insurer's state of domicile. Many insurers, however, are licensed to do business in several states. The states in which the insurer is licensed to do business can establish ancillary receiverships, which may be funded by the insurer's assets located in that state.

All states have adopted at least a portion of the Uniform Act or analogous Liquidation Model Act provisions. The Uniform Act was created in an effort to solve some of the interstate problems arising out of the receivership of an insurer conducting business in more than one state. The Uniform Act recognizes the central role of the domiciliary liquidator and the role of the ancillary receiver. Under the Uniform Act, a regulator in a non-domiciliary state may petition a court of competent jurisdiction to appoint an ancillary receiver of an insolvent insurer. The regulator will be appointed as the ancillary receiver if there are sufficient assets located in the state to justify the appointment or if the goal of protecting the policyholders or creditors located in the state mandates the establishment of the ancillary receivership. The ancillary receiver aids the domiciliary receiver in recovering assets of the insurer located in the state, liquidates special deposit claims and secured claims, pays necessary expenses, and remits the balance of the insurer's assets to the domiciliary receiver. In reciprocal states, the domiciliary receiver may perform the same functions without the necessity of establishing an ancillary receivership.

The owners of special deposit claims against an insolvent insurer (Deposit Claimants) receive priority against the deposits. However, if the special deposit is not sufficient to fully discharge the special deposit claims, Deposit Claimants may share in the general assets of the estate only after estate creditors



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who are in the same priority or class have been paid a percentage of their claims equal to the percentage paid to Deposit Claimants from the special deposit.

Some statutes permit a claimant who resides in a reciprocal state to file a claim in either the domiciliary or ancillary proceeding. When that is a possibility, the domiciliary and ancillary receivers should attempt to coordinate bar dates and claims procedures, if possible. The claimant is not allowed to present a claim in a non-domiciliary state unless ancillary proceedings have commenced. Most jurisdictions have held that, in the absence of an ancillary receivership, a claimant must seek recovery in the insolvent insurer's domiciliary state.

The priority of payment becomes an issue in liquidation proceedings involving one or more reciprocal states. In this situation, all of the claims of residents of reciprocal states are given equal priority of payment from the general assets regardless of where the assets are located. Owners of secured claims may also be affected when one or more reciprocal states are involved in the receivership. The owner of the secured claim is entitled to surrender the security and file a claim as an unsecured creditor. Alternatively, the secured creditor generally can liquidate the security to satisfy the claim and have any deficiency in the claim treated as a claim against the insurer's general assets on the same basis as claims of unsecured creditors.

Under §1001 of IRMA, authority for an ancillary receivership has been curtailed. IRMA allows the appointment of an ancillary conservator under limited circumstances. A domiciliary receiver is automatically vested with title to property in any state adopting IRMA, and the test of whether a state is reciprocal has been eliminated. IRMA also clarifies the procedures for handling deposits.

10. Asset Marshaling: Identification and Recovery

One of the liquidator's duties is to marshal and seize all of the insurer's assets. Section 24 of the Liquidation Model Act requires the liquidator to prepare a list of the insurer's assets and liquidate the assets. There is no similar requirement to prepare a list of assets in IRMA. It is also the liquidator's duty to seek to recover assets which are the property of the insurer, but are in the possession of other parties. Illustrations include voidable preferences and fraudulent transfers.

11. Standard of Review

The scope of review to be exercised by the receivership court over the liquidator has been determined by the highest courts of several states. Without exception, those courts have held that the recommendations of a liquidator, in light of the liquidator's legislatively recognized expertise and statutorily delegated responsibility, should be accorded great deference by the receivership court, and rejected only when the liquidator has manifestly abused discretion. For example, in a series of leading receivership cases, the California courts have applied the abuse of discretion standard, according great deference to the liquidator's recommendations.[14] In order to establish an abuse of discretion, the person or entity challenging a liquidator's proposed action must demonstrate that the action is: 1) arbitrary, i.e., unsupported by rational basis; 2) contrary to specific statute; 3) a breach of fiduciary duty; or 4) improperly discriminatory. The Supreme Court of Pennsylvania explained that, given the expertise of that state's insurance commissioner and the legislative recognition thereof in mandating her appointment as liquidator, "[I]t is axiomatic … that judicial discretion is not to be substituted for administrative discretion."[15]

Under §107 of IRMA, where the liquidator's application for proposed action is opposed, the objecting party bears the burden of showing why the receivership court should not authorize the proposed action.

[14] See e.g., Quackenbush *v. Mission Ins. Co.*, 54 Cal.Rptr. 2d 112 (Cal.Ct.App. 1996); *accord Executive Life Ins. Co.*, 38 Cal.Rptr. 2d 453 (Cal.Ct.App. 1995).

[15] *Foster v. Mutual Fire, Marine & Inland Ins. Co.*, 614 A.2d 1086, 1092 (Pa.1992).



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This requirement in effect creates a rebuttable presumption that the liquidator's proposed action is proper under IRMA and in the best interest of the estate and creditors and codifies case law discussed above.

12. Insufficient Assets

Sometimes the liquidator discovers that the insurer does not have sufficient liquid assets to defray costs incurred during the receivership. In this instance, the liquidator may seek an advance for costs that will be incurred during the liquidation from the state regulator. Most statutes require any money so advanced to be repaid out of the first available assets of the insurer. § 804 of IRMA allows some unclaimed funds of receivership estates to be used to create a general receivership expense account which can provide the funds needed to administer low- or no-asset estates.

**F. Substantive Consolidation**

1. Substantive Consolidation in Receivership Proceedings of "Non-Insurer" with "Insurer"

Under the doctrine of substantive consolidation, all of the entities conducting a single insurance enterprise may be made subject to the jurisdiction of the receivership court, and their assets and liabilities may be pooled. The foregoing is effectuated without regard to the technical separateness of such entities or the fact that some of them are not nominally "insurers" subject to the relevant insolvency statutes. Substantive consolidation is a doctrine with a long history in federal bankruptcy cases. Under the bankruptcy doctrine of substantive consolidation, a non-bankruptcy debtor's assets and liabilities may be included in a debtor's bankruptcy case if two requirements are met: (a) sufficient indicia that the entities appeared as, and were treated as, a single business enterprise; and (b) consolidation of the entities will result in equitable treatment of all creditors of the consolidated group. Without specifically alluding to the doctrine of substantive consolidation by name, at least one jurisdiction has applied the doctrine in an insurance insolvency case.[16]

Application of the doctrine of substantive consolidation may benefit the receiver and further the purposes of the insolvency laws in certain insurance insolvency cases. For example, when a single insurance enterprise has been conducted through a corporate group, if the technical separateness of the entities is recognized, not all of the group may qualify as an "insurer" within the meaning of the insurance insolvency laws (i.e., only the nominal "insurance company" may qualify as an "insurer" within the meaning of the statute). If the receiver is directed to operate only the "insurer" in insolvency proceedings, the receiver may face grave difficulties. It may be very difficult or even impossible for the receiver to identify with any certainty which funds and other assets belong to the "insurance company" (as distinguished from other "non-insurer" members of the affiliated group). Moreover, the nominal "insurance company" may have no employees or insufficient property needed for its operation because all or a significant portion of its business has been operated by a non-insurer affiliate. If available, the remedy of substantive consolidation will bring the entire insurance enterprise into the insurance insolvency proceedings. That will give the receiver the tools needed to liquidate and/or operate the enterprise, and will free the receiver from the burden of trying to identify and obtain possession of assets on an entity-by-entity basis. In addition, substantive consolidation may confer certain other advantages upon the receiver, such as making the non-insurer affiliate's transfers vulnerable to preference attack by the receiver.

Assuming the availability of the remedy of substantive consolidation, serious consideration should be given to the decision to invoke it. One risk for the receiver is that the imprudent use of substantive consolidation could completely or substantially eliminate any return for creditors and/or policyholders. That would result if substantial claims against the "non-insurer" constitute senior priority claims under

[16] See e.g., *Green v. Champion Ins. Co.,* 577 So.2d 249 (La. App. 1st Cir.), *cert. denied,* 580 So.2d 668 (La. 1991). For a more comprehensive discussion of the doctrine, see L.M. Weil and H.S. Horwich, *Substantive Consolidation in Insurance Company Insolvency Proceedings,* The Insurance Receiver, Vol. 5. No. 4 (1997).



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applicable law against the consolidated assets. For example, if there is a substantial federal tax claim against the target non-insurer entity, that claim would be allowed as a claim in the consolidated case with priority senior to certain classes of claims. Accordingly, there might be nothing left from the consolidated estate for those classes of claims even if a distribution might have been made to them out of the unconsolidated estate of the nominal "insurance company."

The consequences of substantive consolidation may militate against invocation of the doctrine in some cases. However, in a "single business enterprise" situation (and certain other situations as well), the receiver may still have a need to place the "non-insurer's" assets and business affairs under some form of control, either for operational or collection purposes. In that situation, the receiver might consider instituting involuntary bankruptcy proceedings against the target non-insurer.

2. Substantive Consolidation of Separate Proceedings of Two or More Insurers

Substantive consolidation also may be used to consolidate the pending proceedings of two or more insurers. Substantive consolidation of pending cases is well-established in bankruptcy practice, but is not without limitations in its application.[17] Accordingly, substantive consolidation of pending cases ought to be applicable to insurance insolvency cases as well, in proper circumstances. Similar to consolidation of an insurer with a non-insurer, when insurers are substantively consolidated, the assets and liabilities of the consolidated entities are "pooled" and administered on a pooled basis. As a result, inter-entity obligations are eliminated. Accordingly, a receiver may consider a substantive consolidation of insurers that are parties to complex dealings in order to effectuate the pooling of their assets and liabilities without the complexities of their dealings among themselves.

As discussed above, courts generally limit consolidation of companies in proceedings with companies not in proceedings to situations where the test for "piercing the corporate veil" is met. Although such a showing would also support consolidation of pending insurer insolvency proceedings, there is authority to support the proposition that a lesser showing may be sufficient to substantively consolidate companies when both are in proceedings.[18] Courts generally agree that consolidation of pending proceedings is appropriate if the assets of the relevant entities are so commingled that the costs of segregation threaten creditor recovery in either case.[19] Outside those circumstances, courts differ as to the appropriate standard for consolidation. The majority of courts look to certain characteristics of the entities in receivership.[20] Those courts generally require the proponent of consolidation to prove that the entities operated as a single entity, and that consolidation is necessary to achieve some benefit or to avoid some harm. Other courts focus instead upon creditor behavior rather than on debtor characteristics and require the proponent of substantive consolidation to prove that creditors generally dealt with the entities as if they were one enterprise.[21]

There appear to be three limitations upon the doctrine of substantive consolidation that apply to insurance insolvency proceedings. First, substantive consolidation is limited by the jurisdiction of the receivership court. With certain exceptions not here relevant, the receivership court's jurisdiction is typically limited to insurers domiciled in its state. Accordingly, it can be argued that the court lacks

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[17] See e.g., *Chemical Bank New York Trust Co. v. Kheel*, 369 F. 2d 845 (2d Cir. 1966) (substantive consolidation should be used sparingly).

[18] See In re Alpha *& Omega Realty, Inc*., 36 B.R. 416 (Bankr. D. Idaho 1984); see also In re *United Stairs Corp.*, 176 B.R. 359 (Bankr. D.N.J. 1995); In re *Murray Industries, Inc.,* 119 B.R. 820, 829 (Bankr. M.D. Fla. 1990) (substantive consolidation if benefits estate without betraying debtor and creditor expectations).

[19] See e.g., In re *Gulfco Investment Corp*., 593 F.2d 921, 929-30 (10th Cir. 1979); *Chemical Bank New York Trust Co. v. Kheel*, 369 F.2d at 847.

[20] See e.g., In re *Affiliated Foods, Inc.*, 249 B.R. 770 (Bankr. W.D. Mo. 2000); *Eastgroup Properties v. Southern Motel Assoc. Ltd*., 935 F.2d 245, 249 (11th Cir. 1991); *Drabkin v. Midland-Ross Corp. (*In re *Auto-train Corp.)*, 810 F.2d 270 (D.C. Cir. 1987).

[21] See e.g., In re *Augie/Restivo Baking Co., Ltd*., 860 F.2d 515, 518 (2d Circ. 1988).



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jurisdiction to order substantive consolidation of an insurance company domiciled in another state with a domestic insurance company even if grounds for substantive consolidation otherwise exist.[22]

A second limitation on the doctrine of substantive consolidation protects a creditor that can prove that it relied upon the separate credit of a single entity.[23] Such a creditor is entitled to a recovery based on the assets and liabilities of the entity on which the creditor relied. The third limitation on substantive consolidation is that it will not be used as a device to achieve or preserve an inequity. For example, courts have denied a parent company's attempt to substantively consolidate its subsidiary into the parent's proceedings if the effect would be to eliminate the subsidiary's claims against the parent for fraudulent transfer, breach of fiduciary duty and the like.[24] For that reason, if the insurer has claims against its affiliates for such misconduct, it is unlikely that substantive consolidation of that insurer into the cases of one or more of its affiliates will be imposed over the objection of that insurer's receiver.

3. Placing related entities into bankruptcy

The receiver may also have the ability to place some or all of the other entities into bankruptcy or may have to deal with other affiliates already subject to federal bankruptcy proceedings. In such instances, coordination between the multiple proceedings is essential to bring about an effective resolution. The receiver must file any appropriate bankruptcy claims in a timely manner and communicate with the trustees of the bankrupt parent and/or affiliates to protect the rights of the insolvent insurer.

## G. Important Legal Procedural Issues

In handling the insurer's legal affairs, the receiver should become fully familiar with two legal issues that are of vital interest to the affairs of the insolvent's estate: the primacy of the jurisdiction of the liquidation court and statutes of limitations.

1. Jurisdiction of Liquidation Court and Related Issues

Jurisdiction means the power of a court to resolve a particular dispute or issue in such a way as to bind concerned parties. The ultimate jurisdiction or power to control the liquidation of the insolvent insurer resides in the liquidation court.[25] The liquidation court is the state court of the state where the insurer is domiciled that initially ordered the insolvent insurer into liquidation. A claimant against the estate who files a proof of claim in the liquidation proceeding is generally held to have submitted to the jurisdiction of the liquidation court, at least with respect to matters pertaining to the claim.

In some states, the liquidation court is vested by statute, as interpreted by courts, with the exclusive jurisdiction to determine all claims both for and against the insurer and involving the assets or affairs of the insurer in any way. This means that creditors cannot assert simultaneous or subsequent claims against the estate, arising from an insurer insolvency, in a court other than the liquidation court. A single, integrated administration ensures equitable treatment for creditors and avoids preferences.

However, according to the common law of other states and the decisions of the U.S. Supreme Court, the jurisdiction of a liquidation court in an insurance insolvency is exclusive only regarding in rem matters involving the insolvency, i.e., the liquidation court alone may decide matters involving the control and distribution of estate assets. Otherwise, the liquidation court's jurisdiction is concurrent with all other courts, state and federal, over in personam matters involving the insolvency, i.e., any

[22] See *F.D.I.C. v. Colonial Realty Co*., 966 F.2d 57, 58-59 (2d Cir. 1992) (jurisdictional provisions of Bankruptcy Code limit a bankruptcy court's power to substantively consolidate).

[23] See *Chemical Bank New York Trust Co. v. Kheel*, 369 F.2d 845; In re *Snider Bros., Inc*., 18 B.R. 230 (Bankr. D. Mass. 1982).

[24] See *Flora Mir Candy Corp. V. Dickson*, 432 F.2d 1060 (2d Cir. 1970); *Anaconda Building Materials v. Newland*, 336 F.2d 625 (9th Cir. 1964).

[25] *Dykhouse v.* Corporate *Risk Management Corp.,* 961 F.2d 1576 (Table), 1992 WL 97952 (Text) (6th Cir. 1992) (federal court abstention concerning *Cadillac Ins. Co.*).



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court may decide matters involving the legal rights of the insolvent insurer against debtors of the estate, and the liquidation court must honor the judgment of another court on these rights.[26]

For example, in states that recognize the existence of concurrent jurisdiction, a receiver might file a motion with the liquidation court for a show cause order alleging breach of contract by a reinsurer, and in response, the reinsurer will likely remove the dispute to a federal court. Assuming the federal court renders a judgment in favor of the reinsurer, finding that the insolvent insurer owes the reinsurer money, the reinsurer may file the judgment along with a proof of claim in the estate of the insolvent insurer, and the state liquidation court must accept the judgment as conclusive regarding legal liability. The liquidation court will then decide what priority of distribution the claim receives, and how much of the judgment the estate is able to pay.

Under normal circumstances, the liquidation court has exclusive jurisdiction to fully address the claims of all, and accordingly, has the power to bind such creditors to the court's adjudication of those claims.

a. Relation to Federal Court Jurisdiction

Federal courts have jurisdiction to handle cases involving an issue of federal law and cases in which the parties to a suit are citizens of different states, i.e., there is "diversity of citizenship." However, where federal courts are asked to exercise jurisdiction in a case concerning an insolvent insurer for which a state liquidation court has already exercised jurisdiction over the controversy, federal courts will follow the doctrine of abstention under some circumstances. This means the federal court will "abstain" from exercising jurisdiction, even though it would have the power to do so. If, however, a suit is brought before a federal court based upon claims which are exclusively federal, the abstention doctrine most likely will not apply. The abstention doctrine also will not apply to justify dismissal of a federal action when the relief sought is solely legal in nature, such as for money damages, rather than equitable or discretionary.[27] Even in a suit for money damages, however, a federal court may stay the action to allow the receivership court to decide an important issue of state law.[28] A federal court may also abstain where the relief sought is primarily equitable or discretionary in nature, but monetary damages or other legal relief is a less essential component of the case.[29]

b. Primacy of the Liquidation Court, Withstanding Collateral Attack, and Arbitration

The success of a liquidation effort may be heavily influenced by the degree to which the primacy of the liquidation court is recognized. Unless courts in other states defer to the liquidation proceedings in the insurer's state of domicile, there is no way a receiver can marshal assets, adjudicate claims and wind up the affairs of an insolvent multi-state insurer in an equitable, consistent, expeditious, orderly and cost-effective manner. This is why receivers often find it important to vigorously exercise their statutory and court-granted powers to bring before the

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[26] *Morris v. Jones*, 329 U.S. 545, 549, 91 L.Ed. 488, 67 S.Ct. 451, rehearing denied, 330 U.S. 854, 91 L.Ed. 1296, 67 S.Ct. 858 (1947); *Webster v. Superior Court*, 46 Cal.3d 338, 250 Cal. Rptr. 268, 758 P.2d 596 (Calif. 1988); *Woodside v. Seaboard Mut. Cas. Co.,* 415 Pa. 72, 202 A.2d 42 (Pa. 1964); *Seaway Port Authority of Duluty v. Midland Ins. Co.,* 430 N.W.2d 242 (Minn. App. 1988) *(*citing *Fuhrman v. United America Insurors,* 269 N.W.2d 842 (Minn. 1978)); *Campbell v. Wood,* 811 S.W.2d 753 (Tex. App. Hous. 1st Distr. 1991) (*citing Wheeler v. Williams,* 312 S.W.2d 221 (Tex. 1958)); *Moody v. State,* 487 So.2d 852 (Ala. 1986); *Capo v. Century Life Ins. Co.,* 610 P.2d 1202 (N.M. 1980)); In re *National Heritage Life Ins. Co.,* 656 A.2d 252 (Del. Ch. 1994); *Christian Broadcasting Network, Inc. v. Starr,* 401 So.2d 1152 (Fla. Dist. Ct. App. 1981).

[27] *Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 135 L.Ed.2d 1, 116 S.Ct. 1712 (1996), proceedings on remand, 121 F.3d 1372 (1997); see also *Feige v.* Sechrest, 90 F.3d 846 (3d Cir. 1996) (concerning Corporate Life receivership); but see *Munich American Reinsurance Co. v. Crawford*, 141 F.3d 585 (5th Cir.), cert. denied, *American Re-Insurance Co. v. Crawford*, 525 U.S. 1016, 142 L.Ed. 2d 448, 119 S.Ct. 539 (1998) (while Burford abstention not warranted, Federal Arbitration Act reverse preempted by McCarran-Ferguson Act, indicating that argument not raised in *Quackenbush, supra*.

[28] Id.

[29] See *Prentiss v. Allstate Ins. Co.*, 87 F.Supp. 2d 514 (W.D.N.C. 1999).



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liquidation court all disputes and proceedings that come within the scope of the liquidation court's jurisdiction.

Not all claimants, reinsurers and others with an interest in the insolvent insurer's affairs will agree with the receiver's preference for having decisions made exclusively by the liquidation court[30]. For some, it is a matter of convenience: They prefer to have their disputes heard by a court close to where they are located, rather than traveling to a distant liquidation court. If their suit is already pending in another court, they object to having those judicial proceedings stayed so that the matter can be transferred to the liquidation court. They may also have a preference for federal court over a state court. A reinsurer, for example, may prefer to exercise its contractual right to arbitrate its claim. Finally, some claimants may believe that the liquidation court favors maximizing the assets of the insolvent insurer and may therefore not provide a truly objective forum for all claims, particularly those which, if successful, would diminish the assets and reduce the size of the estate.

There has been a plethora of litigation on the liquidation court's jurisdiction and the ability of litigants to send liquidation-related disputes to other state or federal courts or to arbitration. Several doctrines run through the case law, and the outcome of these disputes often depends upon the nature of the dispute, the relief sought and the exact parameters of local law.

The starting point is whether the state where the dispute is pending is a "reciprocal state" under the Uniform Act, analogous provisions of which are now a part of the Liquidation Model Act. If a claimant files an action in a state court in a reciprocal state, the local court should either dismiss the action or transfer it to the liquidation court.[31] The court should not permit the action to proceed outside an ancillary receivership proceeding.[32]

The next question is whether the local court will honor, on full faith and credit or other grounds, the liquidation court's injunction against outside litigation. Such an injunction is typically entered at the outset of the liquidation proceeding as a part of the order of liquidation. Most local courts have honored such judicial pronouncements from the liquidation court, particularly where the outside litigation seeks to attach or determine rights with respect to the insurer's property.

Arbitration presents different issues. The Federal Arbitration Act,[33] which establishes a federal policy favoring the arbitration of disputes, requires a court to stay an action pending arbitration when the governing contract has an arbitration clause. If a claimant, such as a reinsurer, tries to force the liquidator to arbitrate, based upon an arbitration clause in the claimant's or reinsurer's contract with the insurer, then federal courts have split on whether arbitration is permitted to proceed outside the liquidation court. Some courts have enforced the arbitration clause, saying that federal law favorable to arbitration cannot be ignored.[34] Other courts, particularly in New York,

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[30] For example, six state insurance regulators initiated court proceedings in their own states seeking to stop implementation of the rehabilitation plan for Senior Health Insurance Company of Pennsylvania, which had been approved by the receivership court in Pennsylvania. The Rehabilitator argued that any disputes regarding the rehabilitation plan must be raised in the receivership court in Pennsylvania; the opposing state regulators argued that the rehabilitation plan violated their state laws and jurisdiction was appropriate in their state courts. As of the date of publication of this update, there has not been a final resolution of these issues.

[31] See e.g., Checker *Motor Corp. v. Executive Life Ins. Co.,* No. 122, 615 A.2d 530 (Table), 1992 WL 29806 (Text) (Del. 1992) (dismissing claim against insurer in receivership in California, under Delaware statute which is based on Uniform Act).

[32] See e.g., *State ex rel. Juste v. ALIC Corp.,* 595 So.2d 797 (La. App. 2d Cir. 1992) (claim must be brought in either receivership proceeding or in ancillary receivership proceeding).

[33] 9 U.S.C. §§ 1-16, 201-208 (West 2001).

[34] Costle *v. Fremont Indemnity Co.,* 839 F.Supp. 265 (D. Vt. 1993); *Fabe v. Columbus Ins. Co.,* 587 N.E.2d 966 (Ohio Ct. App. 10th Dist. 1990); *Benjamin v. Pipoly,* 155 Ohio App 3d 171 (2003); *Selcke v. New England Ins. Co.,* 995 F.2d 688 (7th Cir.), mot. to vacate denied, 2 F.3d 790 (7th Cir. 1993); *Garamendi v. Caldwell,* No. CV-91-5912-RSWL, 1992 WL 203827 (U.S.D.C., C.D. Cal., May 4, 1992); *Foster v. Philadelphia Mfrs.,*140 Pa. Cmwlth. 186, 592 A.2d 131, 133 (Pa. Commw. Ct. 1991); *Schacht v. Beacon Ins.Co.,*742 F.2d 386 (7th Cir.



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have said that state insurance liquidation statutes control because of the federal McCarran-Ferguson Act[35] and that a claimant cannot compel arbitration over the liquidator's objection.[36] In some instances, the dispute may be held to be outside the scope of the arbitration clause and, therefore, within the liquidation court's jurisdiction.[37] In the end, the liquidator will need to evaluate the importance to the liquidation effort, from a substantive or a timing standpoint, as well as the decisional climate towards arbitration in the jurisdiction, of keeping the dispute in front of the liquidation court.

c. Class Actions/Policyholder Committees

It can be argued that a class action for all creditors and policyholders of an insolvent insurer is inappropriate in a receivership because the receiver represents the interests and claims of all policyholders and general creditors in an insolvent insurer's liquidation. Where the receiver refuses to bring such an action, the court may then direct certain designated representatives to proceed with the action, although this issue remains unresolved.

The receiver's expertise, coupled with the exclusive supervision of a single court, helps to produce an economical, efficient and orderly liquidation and distribution of the insolvent insurer's assets.

Given the role of the receiver, some courts have ruled that the creation of a policyholders committee would result in the inefficient administration of the estate, increased litigation, depletion of the estate's assets and would have an adverse impact upon the interests of all other creditors.[38] Other receivership courts, however, have allowed policyholders committees to be appointed so as to provide an additional means of protecting the interests of policyholders.[39]

The Liquidation Model Act was amended to provide that the receiver may, with the approval of the court, appoint an advisory committee of creditors.

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1984); *Bennett v.Liberty National Fire Insurance Co.,*968 F.2d 969 (9th Cir. 1992); *Ainsworth v. Allstate Ins. Co.,* 634 F.Supp. 52 (W.D.Mo. 1985); *Bernstein v. Centaur Ins. Co.,* 606 F.Supp. 98, 104 (S.D.N.Y. 1984); *Phillips v. Lincoln Nat'l Health & Cas. Ins. Co.,* 774 F.Supp. 1297 (D. Colo. 1991); *Schacht v. Hartford Fire Ins. Co.,* 1991 U.S. Dist. Lexis 12145, 1991 WL 171377 (N.D. Ill.), reconsideration denied, 1991 WL 247664 (N.D. Ill. 1991); *Curiale v. Amberco Brokers, Ltd.*, 766 F.Supp. 171, 174 (S.D.N.Y. 1991); see *Quackenbush v. Allstate Ins. Co., supra* and *Munich American, supra*.

[35] See *McCarran-Ferguson Act*, 15 U.S.C.A. §§ 1011-1012 (West 2000).

[36] *Agency, Inc. v. Holz,* 173 N.Y.S.2d 602, 4 N.Y.2d 245, 149 N.E.2d 885 (1958); In re *Union Indemnity Insurance Co.,*137 Misc.2d 575, 521 N.Y.S.2d 617 (Sup. Ct. N.Y. County 1987); *Albany Insurance Co. v. Wright (*In re *Delta America Re-Insurance Co.),* Civil A. No. 85-CI-0591 (Ky. Cir. Ct. Fed 4, 1994) *(*relying on *Knickerbocker); Ideal Mut. Ins. Co. v. Phoenix Greek Gen. Ins. Co.,* No. 83 Civ. 4687, 1987 WL 28636 (S.D.N.Y. Dec. 11, 1987); *Corcoran v. Ardra Ins. Co.* 657 F.Supp. 1223 (S.D.N.Y. 1987), app. dismissed, 842 F.2d 31 (2d Cir. 1988), on remand, 156 A.D.2d 70, 553 N.Y.S.2d 695 (N.Y. Supr. App. Div. 1st Dept. 1990, stay denied, 76 N.Y.2d 890, 561 N.Y.S.2d 551, 562 N.E.2d 695 (N.Y. 1990), app. dismissed, 76 N.Y.2d 1006, 564 N.Y.S.2d 716, 565 N.E.2d 1267 (N.Y. 1990), aff'd, 77 N.Y.2d 225, 566 N.Y.S.2d 575, 567 N.E.2d 575 (1990), cert. denied, 500 U.S. 953, 114 L.Ed.2d 712, 111 S.Ct. 2260 (1991) (concerning Bermudian reinsurer and Convention on Recognition and Enforcement of Foreign Arbitral Awards); *Corcoran v. AIG Multi-Line Syndicate, Inc.* 167 A.D.2d 332, 562 N.Y.S.2d 933 (N.Y. App. Div. 1st Dept. 1990*); Michigan Nat'l Bank—Oakland v. American Centennial Ins. Co. (*In re *Union Indemn. Ins. Co. of N.Y.),* 137 Mis. 2d 575, 521 N.Y.S.2d 617 (Sup. Ct. 1987), aff'd on other grounds, 200 A.D.2d 99, 611 N.Y.S.2d 506 (N.Y. App. Div. 1st Dept. 1994); *Corcoran v. Doug Ruedlinger, Inc,* Index No. 5349/87, slip op. (Sup. Ct. N.Y. County Aug. 21, 1987); *Washburn v. Corcoran,* 643 F.Supp. 554, 556 (S.D.N.Y. 1986); *Gerling-Konzern Globale Rueckversicherungs-AG v.* Selcke, No. 93 C 4439, 1993 WL 443404 (N.D. Ill. Oct. 29, 1993), *Stephens v. American International Insurance Co.,* 66 F.3d 41 (2d Cir. 1995). It should be noted that all of the above decisions were rendered prior to the U.S. Supreme Court's decision in *Quackenbush v. Allstate Ins. Co., supra*.

[37] See e.g, *Washburn v. Societe Commerciale de Reassurance*, 831 F.2d 149 (7th Cir. 1987).

[38] See In Re *Liquidation of Integrity Insurance Company,* 231 N.J. Super. 152, 159, 555 A.2d 50 (N.J. Super. Ch. Div. 1988) (court declined to appoint policyholders committee); see also *Minor v. Stephens*, 898 S.W.2d 71 (Ky. 1995) (court declined to appoint official committee for shareholders).

[39] Policyholder committees have been given standing by courts supervising the insolvencies of Mutual Fire, Marine & Inland Insurance Company (Pa. Court), Constellation Reinsurance Company (N.Y. Court) and Penn Treaty Network America Insurance Company/American Network Insurance Company (Pa. Court). See e.g., *Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 132 Pa. Cmwlth., 196 572 A.2d 798 (Pa. Cmwlth. 1990), (balance of subsequent citation history omitted as not pertinent here, but cited elsewhere herein).



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IRMA has no provision specifically addressing policyholder/creditor committees.

d. Court Approval of Receiver's Actions

A receiver, in consultation with counsel, needs to consider the extent to which particular actions taken by the receiver should be submitted to the receivership court for prior approval. The receiver should first determine whether there are particular transactions, which must be approved under the state statutes governing the receivership proceedings. While the statutes often provide that a liquidator's recommendations concerning claims against the estate are addressed to the liquidation court for acceptance, denial or modification, the statutes do not always directly address prior court approval of other receivership matters. The receiver should become familiar with the practice in the receivership court.

Receivers and receivership courts across the country take different approaches to seeking court approval. If the state law does not provide sufficient guidance, a receiver should follow or adopt consistent guidelines within the receiver's own jurisdiction concerning prior court approval of asset sales, settlements of litigation, releases of all future claims, compensation agreements with estate consultants or professional advisers, payment of administrative expenses, reinsurance commutations and other matters. However, as not all estates are alike, exact uniformity may not be possible. The guidelines applicable to a receivership with a small amount of assets may not function appropriately for an estate with a sizable asset portfolio.

The receiver also needs to consider to whom and to what extent notice of an application to the court will be given. For instance, if a receiver fails to give notice of an application to a person or entity the receiver knows will be affected by that application, the court approval may have limited usefulness. The receiver should determine whether notice of a particular application should be given by mail or by publication in a newspaper or other media, including the Internet. Particularly in estates with a large number of creditors, it may be financially impractical to give notice of all court filings to all creditors and other interested parties. The receiver should consult with counsel regarding the law and practice governing such notice and an opportunity to be heard.

IRMA provides some guidance on what actions require court approval in § 504 and to whom notice should be given in § 107. Nonetheless, the receiver should still consult with counsel as described above.

2. Statute of Limitations

Statutes of limitations prohibit persons from asserting rights against another party when the right asserted has become "stale." The key date, for purposes of statutes of limitations, is the date on which a cause of action "accrues," i.e., the date when a party comes into possession of a legally enforceable right that would be recognized by a court. For example, a cause of action for breach of contract may be said to accrue on the date on which the breach occurred. In some cases, the actual date of accrual will be difficult to ascertain, such as where there has been an ongoing relationship between the parties over a course of years. In such circumstances, it may be possible to delay the date on which the statute will begin to run.

A statute of limitations sets forth a period within which a person holding a cause of action must assert that cause of action in legal proceedings. If the person fails to assert a cause of action within the period specified in the relevant statute of limitations, that person can be forever barred from asserting the cause of action. Consequently, the cause of action (and the potential resultant recovery) is lost.

The period within which a cause of action may be asserted under statutes of limitations can vary significantly, depending upon the nature of the cause of action. For example, the statute of limitations for breach of contract may be significantly different from the statute of limitations for tort actions, and special limitations periods may apply to causes of actions against certain professionals. Consultation



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with counsel is essential to ascertain the specific statute of limitations requirements applicable to each potential cause of action.

a. Tolling in General

A related concept of which the receiver should be aware is the concept of "tolling" the statute of limitations. In some circumstances, the statutory time period will not begin to run, or may be modified, even though the cause of action has accrued. This most frequently occurs in cases where a party may not be aware that he or she has a cause of action. Thus, in some cases, the statutory period will not begin to run until the cause of action has accrued and the injured party either knew or should have known of the existence of the cause of action. This type of tolling is most frequently found in situations where the injury is not obvious (e.g., latent illness); where the person with the right of action is, through no fault of his own, not in a position to pursue the cause of action (usually because of age or infirmity but, in some states, an insolvent insurer taken over by regulatory authorities also may qualify); or because the person with the cause of action was prevented from discovering it through fraud committed by the potential defendant. These tolling provisions are sometimes accompanied by an outside limit. For example, a statute may provide that the action may be brought within three years of the date on which the party knew or should have known of the cause of action, but in no event may the cause of action be asserted more than 10 years after the date on which the cause of action has accrued. Again, counsel should be consulted to ascertain the potential impact of tolling provisions.

b. Circumstances Unique to Receivers

Many state statutes provide for the tolling of statutes of limitations for the benefit of receivers. For receivers in states which adopt or in which the delinquency proceedings statute patterns the Liquidation Model Act, the receiver may find direct authority for extending periods of limitation in a particular case. For example, under the Liquidation Model Act, if a limitation period is unexpired as of entry of the liquidation/rehabilitation order, entry of such order tolls, for the benefit of the receiver, the running of such period for two years. IRMA § 109 A. extends the applicable limitation period to the later of the end of the limitation period or four years after entry of the most recent receivership order.

In addition, some courts have held that certain causes of action (such as those against former directors and officers, voidable preferences and RICO actions) are unique to the receiver and, as a result, the statute of limitations does not begin to run until the receivership is commenced.[40] Those cases generally are supported by the following doctrines: 1) the "discovery rule" as adopted by the individual states; 2) the doctrine of adverse domination; 3) analogy to other federal and state code provisions and guidelines which extend limitations; and 4) the premise that the receiver acts as arm of the sovereign.

Under the "discovery rule," periods of limitation in certain cases do not start to run until the date the wrongful act was or (by the exercise of reasonable care and diligence) should have been discovered. The doctrine of adverse domination follows the widely held rule that the limitations statute is tolled when a corporate plaintiff continues under the domination of wrongdoers. Generally, that means that causes of action against former directors and officers of an institution do not accrue while the culpable group of defendants retains control of the corporation. The doctrine

[40] Early case law may also be instructive on whether statutes of limitations begin to run against a court appointed receiver upon the receiver's appointment. See *Hall v. Ballard,* 90 F.2d 939, 946 (4th Cir. 1937) (statute of limitations does not begin to run against receiver until the receiver's appointment); *Irvine v. Bankard,* 181 F. 206, 211 (D. Md. 1910), aff'd, 184 F. 986 (4th Cir. 1911) (in Maryland, statute of limitations does not begin to run against an insolvent estate until there is someone in existence qualified to sue). See also *Pioneer Annuity Life Ins. Co. v. Rich,* 179 Ariz. 462, 465, 880 P.2d 682, 685 (Ct. App. 1994) at n.5 (statute of limitations does not begin to run until a judicial determination of insolvency and appointment of a receiver).



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of adverse domination has also been applied to persons other than corporate officers and directors.[41] Adverse domination is a reliable mechanism for fraud claims. However, some courts have refused to apply the doctrine to negligence claims.[42]

Moreover, an analogy to extending limitations upon the appointment of a receiver also may be found in certain federal statutes. For example, both the U.S. Bankruptcy Code and the Financial Institutions Reform, Recovery and Enforcement Act extend limitations upon the appointment of a receiver, or the equivalent of a receiver.[43] Furthermore, the common law rule of nullum tempus occurrit regi (time does not run against the King), which exempts the state from the statute of limitations, may also apply to the receiver of an insolvent insurance company. A receiver's functions in resolving claims may be found to constitute a government action. Therefore, the receiver, as an instrumentality of the state, may be entitled to assert the status of the sovereign in opposing a statute of limitations defense.[44]

c. Potential Impact upon the Estate

As previously noted, one of the primary duties of the receiver is to marshal the assets of the insurer. This will sometimes require the receiver to assert causes of action on behalf of the insurer against third parties. (See the section in this chapter on Important Legal Procedural Issues.) In administering the affairs of the insurer, therefore, it is essential that the receiver be aware of the statute of limitations so that necessary steps are taken to prevent the loss of potential rights or causes of action.

To some degree, the statute of limitations is also relevant in ascertaining the insurer's liability in that potential claims against the insurer which have been allowed to become stale under the relevant statute may be time barred.

3. Discovery

The general concept of discovery deals with the ability of outside parties to gain access to the insurer's books, records or other internal documents. This issue has vital significance to the receiver to the extent that it is necessary or desirable that the receiver keep certain information confidential. Discovery issues generally arise in one of two contexts: discovery pursuant to litigation and arbitration and requests pursuant to the freedom of information law. Discovery in the federal courts is governed by the Federal

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[41] See e.g., *Bornstein v. Poulas,* 793 F.2d 444, 447-49 (1st Cir. 1986) (doctrine extended to attorney); *Mosesian v. Peat, Marwick, Mitchell & Co.,* 727 F.2d 873, 879 (9th Cir.), cert. denied, 469 U.S. 932 (1984) (auditors); *IIT v. Cornfeld,* 619 F.2d 909, 930 (2d Cir. 1980) (accountants, stockbrokers and underwriters); *FSLIC v. Williams,* 599 F.Supp. 1184 (D.M.D. 1984) (lower level employee).

[42] For a discussion of the various theories of wrongdoer control and levels of culpability required to toll the statute of limitations, see *RTC v. Franz*, 909 F.Supp. 1128 (N.D. Ill. 1995), interlocutory appeal permitted, 1996 WL 166940 (N.D. Ill. 1996); see, e.g., *FDIC v. Dawson,* 4 F.3d 1303 (5th Cir. 1993), cert. denied, 512 U.S. 1205, 129 L.Ed. 2d 809, 114 S.Ct. 2673 (1994) (Texas law); *FDIC v. Henderson*, 61 F.3d 421, 427 n.3 (5th Cir. 1995) (Texas law); *FDIC v. Cocke*, 7 F.3d 396 (4th Cir. 1993), cert. denied, 513 U.S. 807, 130 L.Ed 2d 12, 115 S.Ct. 53 (1994) (Virginia law); *FDIC v. Grant,* 8 F.Supp. 2d 1275 (N.D. Okla. 1998), certified question answered by, *RTC v. Grant*, 1995 OK 68, 901 P.2d 807 (Okla. 1995) (Oklahoma law); *RTC v. Blasdell,* 930 F.Supp. 417 (D. Ariz. 1994) (Arizona law); but see *FDIC v. Jackson*, 133 F.3d 694 (9th Cir. 1998) (adverse domination doctrine may apply to negligence claims under Arizona law); *RTC v. Farmer,* 865 F.Supp. 1143 (E.D. Pa. 1994) (Pennsylvania law). But see *RTC v. Hecht, 833 F.Supp. 529 (D.Md. 1993),* certified questions answered by, *Hecht v. RTC, 333 Md. 324,* 635 A.2d 394 (Md. 1994); *RTC v. Rahn,* 116 F.3d 1142 (6th Cir. 1997); *Clark v. Milam,* 872 F.Supp. 307 (S.D.W.Va. 1994), affirmed, 139 F.3d 888 (4th Cir. 1998), No. 2:92-0935 (S.D. W. Va. June 28, 1994); *RTC v. Fleischer*, 890 F.Supp. 972, 976 n.2 (D.Kan. 1995) (Kansas law); *RTC v. Fiala*, 870 F.Supp. 962, 974 (E.D. Mo. 1994) (Missouri law).

[43] See 11 U.S.C. § 108; 12 U.S.C. §§ 1821(d)14(A), (B), (C).

[44] See *Diamond Benefits Life Ins. Co. v. Resolute Holdings (In re Diamond Benefits Life Insurance Co.)*, 184 Ariz. 94, 907 P.2d 63 (1995) (statutes of limitations do not run against receiver of insolvent entity because receiver acts on behalf of state); *Anne Arundel County v. McCormick,* 323 Md. 688, 594 A.2d 1138 (1991) (statutes of limitations do not run against the state or any of its instrumentalities, provided they are acting in a governmental, rather than a corporate or proprietary capacity); *Mitchell v. Taylor,* 3 Cal.2d 217, 43 P.2d 803 (1935) (California insurance commissioner not a mere private trustee in his capacity as receiver, but instead was a state officer performing duties conferred by statute, and acting on behalf of the entire state); but see *Williams v. Infra Commerc Anstalt*, 131 F.Supp. 2d 451 (S.D.N.Y. 2001) (doctrine inapplicable where state official acting to protect private interests rather than public interests).



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Rules of Civil Procedure. The rules of most state courts are largely patterned after the federal rules. The receiver also may have broad subpoena powers under state insolvency law even in advance of litigation.[45] The commissioner's administrative subpoena powers also may be available.[46]

a. Scope

The scope of discovery generally is broad. Whether information is discoverable will depend upon: 1) whether it is "relevant to the subject matter" involved in the action; and 2) whether it is subject to a legally cognizable privilege. "Relevance" usually is defined broadly as including any information reasonably calculated to lead to the discovery of admissible evidence.[47]

i. Relevance

Whether information is "relevant" will depend upon the issues raised in any particular litigation. For example, if the receiver is suing for payment of reinsurance recoverables, information regarding the payment of claims in the reinsured book of business would obviously be relevant. In other cases, the question of relevance will be less clear. For example, in a suit against an insolvent insurer's former officers and directors, information regarding the payment of claims during the receivership may or may not be relevant depending on the theory of damages adopted by the receiver's attorneys. If the damage theory focuses on the financial condition of the insurer at the time it was taken over by the receiver, subsequent events arguably would not be relevant. Obviously, these are judgments that should be made by the receiver in consultation with the receiver's attorney in any action.

ii. Privilege

Even if the data is relevant, it is not discoverable if it is within the scope of a privilege. The privileges that might commonly be considered are the attorney-client privilege; the attorney work-product privilege; and executive privilege. The scope of these privileges may be defined by state law where the litigation involves state law claims. These privileges also exist, however, as a matter of federal common law and federal rules. It is important to restrict access to data so as to avoid being found to have waived a privilege. It is also important to exercise care with both written and oral communications to prevent a waiver to the degree possible.

- Attorney-Client Privilege

The attorney-client privilege is intended to promote open and honest communication between attorney and client. Preventing forced disclosure of such communications is justified on the ground that full disclosure is necessary to enable the attorney to use sound and informed advice and encourages voluntary compliance with the laws. To be within the scope of the privilege, a communication must be made between privileged persons in confidence for the purpose of seeking, obtaining or providing legal assistance for the client.

The attorney-client privilege may exist both with respect to pre-receivership and post-receivership information. Care should be taken by the receiver to separate (or be able to identify) what information was gathered by the receiver and what information existed before the takeover.

Communications between the former officers of the insurer and their attorneys, copies of which are maintained in the insurer's records, will be subject to the privilege. The receiver

[45] See e.g., Liquidation Model Act, *supra*, note 3, at Section 24.A.(6) and IRMA §504 A. (1).

[46] See e.g., *Angoff v. M&M Management Corp.,* 897 S.W. 2d 649 (Mo.Ct. App. 1995).

[47] Fed. R. Civ. P. 26(b)(1).



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inherits the insurer's right to assert the privilege or to waive the privilege. Care must be taken, however, to determine what rights, if any, the individual former directors have in the preservation of the privilege. Communications between the receiver and the receiver's attorneys likewise would be within the scope of the privilege.

The fact that information is communicated to an attorney to obtain legal advice does not make the information itself privileged. It is the communication, not the information, which is privileged. Therefore, the mere fact that information used by the insurer in its business is communicated to an attorney does not protect that information from discovery. To determine the exact scope of the attorney-client privilege, and any exceptions that may apply, the receiver should consult legal counsel.

- Work-Product Doctrine

A second, more limited privilege which may preclude discovery is the work-product doctrine. This doctrine provides a qualified privilege to materials gathered by counsel and prepared by counsel in the course of preparing for possible litigation. The purpose of the rule is to protect an attorney's ability to properly develop and prepare the case without fear that the attorney's work product could be discovered by the other side and used against his or her client.

The work-product doctrine has been codified in the Federal Rules of Civil Procedure[48] and state rules patterned after the federal rules. It protects from discovery documents and tangible things otherwise discoverable which are prepared in anticipation of litigation or for trial and by or for another party or by or for that other party's representative. This immunity from discovery is only qualified and can be overcome if the party seeking discovery shows substantial need for the materials and an inability to obtain the substantial equivalent of the information without undue hardship. Thus, information specifically gathered and prepared by the receiver at the direction of counsel to assist counsel in conducting liquidation proceedings or other litigation may be protected from discovery by the work-product doctrine. Application of this doctrine depends on the particular circumstances and should be assessed by counsel retained by the receiver.

- Executive Privilege/Deliberative Process

Another privilege that may provide limited protection from discovery is a claim of executive privilege. Typically, the receiver as receiver would not have grounds for asserting this privilege. However, because the receiver is also a regulator for the domiciliary state, litigants often seek discovery of information within the possession of the insurance department. They may assert, for example, that part of the losses were the result of pre-takeover negligence by the commissioner as regulator. Whether regulatory negligence is in fact a partial defense is highly disputed. For discovery purposes, great care should be taken in maintaining the distinction between the commissioner as receiver and the commissioner as regulator, particularly as to the insolvent insurer.

Nonetheless, to the extent that data from the insurance department in its role as regulator is discoverable, a claim of executive privilege might be argued. Such a privilege would be based upon arguments as to the need to maintain confidentiality to enable the regulator to fulfill his regulatory obligations and protect the public interest.

[48] See Fed. R. Civ. P. 26(b) (3).



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A qualified privilege, sometimes called the deliberative process privilege, has also been recognized to protect memoranda containing advice, opinions and recommendations given in the course of deliberations regarding governmental, legal and policy decisions.[49]

- Consultants

Consultants providing day to day assistance to the receiver may be protected by privilege but such consultants should be advised that only the receiver may waive the privilege.

b. Freedom of Information Act

Another route that adverse parties may take to obtain information from the insurance department is to file a request under a state Freedom of Information Act (FOIA). A state FOIA generally permits any person to inspect or copy specified public records maintained by state agencies, including the insurance department. The FOIA has a number of specific exceptions to the requirement that the department allow such inspection or copying. Exceptions typically include matters related to litigation, internal memoranda and records or information compiled for law enforcement purposes. Insurance Codes, particularly laws on examination of insurers, may contain exception to state FOIA's. Receivers who are not a part of the Insurance Department may be exempt from FOIA, and records held by department personnel as receiver need to be looked at carefully as to whether they are covered by FOIA. The receiver should alert insurance department personnel to consult with the receiver before responding to a FOIA request to the department seeking any of the insolvent insurer's records held by the department.

c. Costs

The expense of compliance with discovery should be considered. Although the courts typically require the respondent to bear the cost of producing the information in usable form where the expense of recovery results from the respondent's choice of means for storing the information, courts have also required parties seeking discovery to share in the cost of retrieving data. If the party seeking discovery does not agree to share in such expense, a protective order should be sought. Applicable federal law and state statutes may require the party issuing the subpoena to bear the expense of document production. Some case law even supports the delay of producing documents until the cost of the production is advanced. Finally, counsel should review all documents prior to production to verify that the documents themselves are not protected by confidentiality.

H. Health Insurance and Health Maintenance Organizations (HMOs)

The following legal issues are relevant with respect to health insurer and where noted health maintenance organization (HMO) insolvencies.

1. Hold-Harmless Clause (HMO only)

There are two distinct types of hold-harmless clauses that can apply to providers that contract with HMOs. The first, which is discussed in detail in this section, is the hold-harmless clause that is contained in the contract between an HMO and a provider. The second, which is discussed in more detail below, is a court-ordered hold-harmless clause that will only be triggered by judicial intervention into an insolvency. Generally, state law will require the HMO to protect the enrollee from liability for

[49] See *United States of America v. American Telephone and Telegraph Co.,* 86 F.R.D. 603 (D.D.C. 1979).



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medical costs and expenses beyond the applicable copayments, deductibles or fees for services not covered under the member plan or policy. The HMO, in turn, will include a hold-harmless clause in its provider contracts, prohibiting providers from seeking to recover any amounts from the enrollee that are ultimately the responsibility of the HMO, or amounts that are above and beyond the agreed reimbursement for a given service. These clauses are designed to protect patients not only against overbilling by providers, but also to protect them from the risk that the HMO will go insolvent and fail to pay its providers.

Receivers should seek to have an injunction to enforce hold-harmless clauses against contracted providers (and even non-contracted providers in some instances) included within the petition to rehabilitate or liquidate an HMO. In cases where the receiver has evidence that enrollees have been inappropriately billed, efforts should be made to intercede on behalf of the enrollee and require the return of monies collected by the contracted provider. The receiver should note that claims by an enrollee that represent amounts the enrollee has been inappropriately balance billed by a contracted provider may not be valid claims against the HMO. The amounts that were never the obligation of the HMO should therefore be referred to the offending providers. Many states require hold-harmless clauses in all provider contracts and will deem contracts that do not specifically contain them to do so by operation of law. The significance of the hold-harmless clause comes to light when priority-of-distribution provisions are examined.

2. Federal Regulations

   a. Medicare and Medicaid

The advent of Medicare and Medicaid HMO plans has added new elements to the overall receivership picture. Medicare and Medicaid HMOs offer eligible enrollees services similar to those of a conventional HMO rather than the benefits set out by statute or regulation in the fee-for-service programs. HMOs usually offer enrollees extra benefits that they would not have received under conventional systems, or waiver of co-payments or deductibles that they would have been required to pay. Federal government oversight of the operation, financing, and market conduct of these programs is an important part of their business environment. In addition to the additional regulatory constraints under which these HMO programs operate, the unique characteristics of their enrollee population create both opportunities and challenges for a receiver.

The Centers for Medicare & Medicaid Services (CMS), previously known as the Federal Health Care Financing Administration,[50] guidelines require that non-participating providers with Medicare agreements must accept as full payment the amount that Medicare would have paid. For example, it is possible that a physician (with a participating Medicare agreement) may violate his or her Medicare agreement by accepting payment in excess of the Medicare allowed amount. In addition, at least ninety-five percent of "clean claims" (those properly documented claims having no defects or improprieties) must be paid within thirty days under CMS's prompt payment requirements. Late payments incur interest and civil monetary penalties. Receivers must consider the federal statutes, regulations and guidelines in adjudicating claims involving Medicare made by non-participating providers (including physicians, inpatient hospitals and skilled nursing facilities).

One challenge that arises at the outset of a receivership involving Medicare or Medicaid recipients is moving the subscribers to a solvent plan. In some cases, the federal government can roll all subscribers either to traditional Medicare or to other plans, but the timing of this must be coordinated to avoid a period of time where subscribers are trapped in an insolvent company. CMS will work with state insurance departments to try to avoid any disruption of coverage for recipients and to coordinate a

[50] The Centers for Medicare & Medicaid Services' Web site is www.cms.gov/medlearn.



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relatively smooth transition, but this must be done while the petition for appointment of receiver is pending so that cancellation of coverage can be coordinated.

Another issue that arises with Medicaid receiverships is that typically some funds are held in trust for Medicaid services only, and the use of these funds must be coordinated with appropriate state and federal agencies.

Note that the life and health guaranty associations do not provide coverage for Medicare or Medicaid enrollees of insolvent HMOs.

b. ERISA

Federal regulation also plays a role in most health care programs offered to employee groups. The Employee Retirement Income Security Act (ERISA) is a complex statute that federalizes the law of employee benefits. As a receiver, it is important to understand the relationship between federal and state laws as they apply to ERISA employee benefit plans, since the receiver must operate in compliance with both state and federal laws.

When the HMO is responsible for the payment of employee benefits, it is likely to be acting as a fiduciary. ERISA requires that a plan fiduciary must discharge his/her duties solely in the interests of the plan's beneficiaries. It is important to consult an ERISA specialist to determine if the insolvent insurer, MCO or HMO is also a fiduciary and to understand the nature and scope of the fiduciary obligations.

3. Health Insurance Portability and Accountability Act (HIPAA)

The receiver also needs to be aware of the rights granted to HMO subscribers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A wide-ranging, complicated and often confusing law, HIPAA can affect how a receiver structures a plan. For example, HIPAA's guaranteed renewability requirements limit the ability of a receiver to terminate, or perhaps even to change, coverage under a health plan. HIPAA's guarantee issue requirements also permit covered groups and individuals to move more freely to other plans, thereby reducing the receiver's ability to assure a stable block of business for sale to other insurers. (These rights apply, generally speaking, to broad-based health plans, but not to plans that provide limited benefits such as dental-only plans.)

a. Guaranteed Renewability of Coverage by HMO in Receivership

HIPAA requires guaranteed renewal of all group products. Nonrenewal of group coverage is allowed for nonpayment, fraud or misrepresentation, carrier market exit, failure to meet minimum contribution or participation requirements, and a few other specified reasons. In those states that have adopted HIPAA provisions as part of state law, rather than implement an "alternative mechanism," HIPAA also requires guaranteed renewal, or continuation in force, of all individual products.[51] As with group coverage, nonrenewal is allowed for specified reasons, including carrier market exit.

b. Guaranteed Issue of Coverage by Other Plans

HIPAA requires all carriers serving the small employer market (2 to 50 employees) to accept every small employer that applies for coverage and to accept every eligible individual who applies when they first become eligible (although it should be noted that particularly in the individual market, underwriting requirements, or even the ability of carriers to underwrite at all will vary depending upon whether the state has filed an alternative mechanism or not). Small employers covered by an HMO in receivership will thus be able to move their business to another carrier serving that market without

[51] Arizona, Colorado, Delaware, Hawaii, Maryland, North Carolina, Rhode Island, Tennessee and West Virginia are enforcing the federal fallback provisions. In California and Missouri, CMS is enforcing the federal fallback provisions (as of September 2000).



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risking loss of coverage or gaps in coverage. The same is generally true for individual subscribers. A carrier offering coverage in the individual market may not decline to offer coverage to, or deny enrollment of, an eligible individual, and may not impose preexisting condition exclusions with respect to the coverage. Exceptions are permitted for insufficient network or financial capacity. HIPAA does not require guarantee issue in the large group market (more than 50 employees), although large group insurers and employer-sponsored plans may not establish rules of eligibility for enrollment based on a health status-related factor. Also, large group plans may not require an individual to pay a premium greater than that charged to a similarly situated individual based on a health status-related factor.

c. Documentation Requirements

Plans and carriers are required to provide documentation of coverage to individuals whose coverage is terminated, to include dates of coverage (including COBRA) and waiting periods, if any. The HMO in receivership will be required to issue these certificates of creditable coverage to individuals leaving the plan.

4. The Patient Protection and Affordable Care Act (PPACA)

Enacted on March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) or simply the Affordable Care Act (ACA) expanded HIPAA's guaranteed issue and guaranteed renewability market reforms for the individual and small group markets, and, in some cases, these reforms also extend to the large group market. Beginning with plan year Jan. 1, 2014, the ACA requires carriers to accept every employer and every individual that applies for coverage without imposing any preexisting condition exclusions except a carrier may restrict enrollment based upon open or special enrollment periods. Carriers must also renew coverage or continue coverage in force at the option of the plan sponsor or the individual. As with HIPAA, a receiver must be aware of the rights granted to HMO subscribers under the ACA as outlined above for HIPAA.

## I. The Application of Setoffs in Insurance Receiverships

1. Introduction

Setoffs in insurance receiverships are a controversial subject. Any appreciation of the subject must proceed from an understanding of its practical, legal and political implications. The issue is of particular importance to receivers because setoffs can deprive an estate of funds that otherwise would be used to pay administrative costs and claims of the company's insureds. Setoffs are equally important to creditors (who are also debtors) of the estate eager to minimize losses sustained as a result of the receivership. Given these conflicting interests, receivers must appreciate the fact that applying setoffs in an insurance receivership is an issue not easily resolved.

2. Discussion

To determine when a setoff may be taken in an insurance receivership, the receiver needs to be familiar with the statutory parameters imposed on setoffs in the receiver's jurisdiction.

a. Definition

The right to assert setoff in insurance receiverships in the United States arises by statute, contract and common law. In its simplest form, setoff is the right between two parties to net their respective debts when each party owes the other a mutual obligation. For example, if A owes B $100 and B owed A $75, setoff allows A, under certain conditions, to net the liabilities and pay B only the balance, $25. The general rule is that only mutual debts and credits may be set off. It should be



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noted that statutory obligations, and applicable case law, in the insurance receivership context, may be argued to vary the general rules and impose additional requirements and limitations.

b. Mutuality

Most of the controversy about setoffs arises out of the term "mutual." In general terms, there are two requirements of mutuality that must be satisfied before a setoff will be allowed: mutuality of capacity and mutuality of time.

i. Mutuality of Capacity

Simply stated, the mutuality of capacity requirement means that in order for debts to be set off, the parties between whom the setoff is to be made must stand in the same relationship or capacity to each other. If the debt to be set-off arose between the parties when they were acting in different capacities, the debt will not be considered mutual and no setoff will be allowed. The "capacity" referred to is legal capacity, e.g., principal, agent, trustee, beneficiary. Thus, contracting principals who are debtors and creditors of each other by virtue of entry into a contract have the same legal capacity. See Liquidation Model Act Section 30A.

Mutuality of capacity frequently arises as an issue in determining setoffs between agents or brokers and the company over premium obligations, setoffs between affiliated companies, setoffs when a mutual company is involved and, increasingly, setoffs of salvage and subrogation recoveries.

- Agents and Brokers and Premium Obligations. Traditionally, setoffs between agents or brokers and the company have been denied on mutuality of capacity grounds. The reason is that the agent's role usually is viewed not as that of a party to a contract, but rather as a fiduciary. Thus, the statutes of most states (with few, limited exceptions) provide, and most courts have held, that an agent may not set off its obligation to remit earned or unearned premiums to a company against claims for future commissions or other damages. This prohibition against agent setoffs of premiums generally does not apply to insureds, because there is no mutuality of capacity problem. See Liquidation Model Act Section 33A(1) and IRMA § 613.

- Affiliates. As a general rule, setoffs are permitted only between the parties to a particular contract. Thus, a debtor cannot set off an amount it owes the company against an amount the company owed the debtor's affiliate or subsidiary company. Similarly, an insolvent insurer may not assert a setoff owing to one of its affiliates or subsidiaries. See Liquidation Model Act Section 30B(3),(4) and IRMA § 609B(3),(4). Whether setoffs may be allowed in the case of debtors who have merged depends upon the circumstances of the merger. The general rule is that debts may not be purchased by, or transferred to, another debtor for setoff purposes. See Liquidation Model Act Section 30B(2) and IRMA § 609B(2).

- Assessment and Capital Obligations. In most instances, mutual company policyholders who are liable for assessment for company losses may not set off their losses and unearned premiums against their assessment obligations. Likewise, stockholders may not set off their capital contributions. See Liquidation Model Act Section 30B(5) and IRMA § 609B(5).

- Receivers have unsuccessfully disputed reinsurance setoff where the debts and credits between the insolvent insurer and reinsurer arose from different contracts between the parties. The dispute centers on the mutuality of the debts and credits in issue, and is



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sometimes referred to as a dispute over multiple contract setoff.[52] For example, Insurer One might not only assume or reinsure risks from Insurer Two under one contract, but Insurer Two may also assume some other risks from Insurer One under a second, separate contract. This situation makes each insurer either a cedent or reinsurer, depending upon which contract is at issue. According to the statutes and common law of most states, if one of the insurers in the example becomes insolvent and the state puts it in receivership, the other insurer may assert a right to set off its debts or credits under one of the agreements with the debts or credits of the insolvent under the other agreement.[53]

- Salvage and Subrogation Recoveries. Salvage and subrogation recoveries in the hands of an insured (or reinsured) of the company generally may not be set off because the recoveries may be held in a fiduciary capacity.

ii. Mutuality of Time

In order for debts to be set off in an insurance receivership, the debts must be mutual as to time as well as capacity. This requirement often has been stated in terms of a restriction that hinges upon the "date of fixing of claimants' rights." One of the first steps in any insurance receivership is the establishment of an exact date upon which all rights, obligations and liabilities of the company can be fixed. (See Chapter 5—Claims, section on Establishing a Claims Procedure, The Fixing Date.) The date of fixing of claimants' rights is usually the date the order of rehabilitation or liquidation is entered. The general rule is (assuming all other requirements are met) that post-liquidation debts can only be set off against other post-liquidation debts. In other words, a pre-liquidation debt cannot be set off against a post-liquidation debt. Put another way, the debts and credits to be set off mush be owned contemporaneously.

- Pre- vs. Post-Liquidation Debts. Defining when a debt "arises" for purposes of fixing it as a pre- or post-liquidation debt has been a subject of great controversy. Receivers, therefore, must consult their statutes and the court cases construing their own or other states' similar statutes in order to determine whether a debt should be characterized as having arisen pre- or post-liquidation. At least one court has held that where all the debts in question arose under provisions in the reinsurance contracts that were executed and performed prior to the time of the insolvency, the debts were pre-liquidation obligations.[54]

- Contingent, Unliquidated and Immature Claims. Satisfaction of the mutuality of time requirement often depends upon the relative stage of development of the claims and debts to be set off. The general rule is that only claims that are entitled to share in the estate as of the commencement of proceedings may be set off; contingent claims may not be set off if those claims are not entitled to share in the estate. For a discussion of

[52] A different but related concept is called "recoupment." Recoupment allows a defendant to reduce the amount of a plaintiff's claims by asserting the defense that, while she may owe plaintiff money, plaintiff also owes the defendant money from the same transaction or contract, and the court should reduce the plaintiff's judgment against defendant, if any, by the amount plaintiff owes defendant. *Laventhol & Horwath v. Lawrence J. Rich Co.,* 62 Ohio Misc. 2d 718, 610 N.E. 2d 1214, 1216 (Ohio Mun. Cleveland 1991) *(quoting In re Holford,* 896 F.2d 176, 178 (5th Cir. 1990)). In contrast, setoff usually involves a claim of the defendant against the plaintiff, which arises out of a transaction, which is *different* from that on which the plaintiff's is based. *Id.*

[53] *Prudential Reinsurance Co. v. Superior Court*, 3 Cal. 4th 1118, 842 P.2d 48, 14 Cal. Rptr. 749 (Calif. Super. 1992). *Stamp v. Ins. Co. of N. America*, 908 F.2d 1375 (7th Cir. 1990); see also In re *Liquidation of American Mut. Liability Ins. Co.*, 434 Mass. 272, 747 N.E.2d 1215 (Mass. 2001); *Commr. of Ins. v. Munich American Reinsurance Co.*, 429 Mass. 140, 706 N.E.2d 694 (Mass. 1999).

[54] *Stamp v. Ins. Co. of N. America, supra*.



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the differences between contingent, unliquidated and immature claims, see Chapter 5—Claims, section on Establishing a Claims Procedure, The Fixing Date.

- After-Acquired Setoffs. Closely related to the rule against setoffs among affiliates is the general rule against after-acquired setoffs. The rule is that a party may not acquire after receivership a debt or claim by assignment or otherwise for use as a setoff in the receivership. See Liquidation Model Act Section 30.B.(2) and IRMA § 609B(2). Many states' statutes prohibit such setoffs.

c. Reinsurance Setoff

Some receivers are challenging the notion that insurers and reinsurers may set off their payables against receivables they may have against a company for losses under reinsurance treaties assumed by the company. The issue has been litigated in a number of state and federal courts, and likely will continue to be debated in state legislatures for years to come. The Liquidation Model Act was amended in 1990 to limit such setoffs. (See Insurers Rehabilitation and Liquidation Model Act Section 34B(6), 34D, 34E and 34F). Receivers should review their state's statutes to determine whether this change has been adopted.[55] In addition, some receivers have challenged the public policy assumptions underlying the historical development of setoffs in the common law and state statutes. It is imperative that receivers keep abreast of changes in the law of their jurisdictions.

d. Setoffs Outside Receivership Proceedings or Between Receivers

While the receivership court generally has exclusive jurisdiction over the liquidation and distribution of the assets of the estate, if there is a dispute regarding an estate's claim against a third party, those issues are sometimes addressed outside of the receivership court.[56] In such cases, the person or entity with whom the receiver is litigating may allege claims against the receiver in the same proceedings. The receiver may or may not be successful in requiring that person or entity to pursue those claims in the receivership proceedings and in denying that person a right of setoff in the litigation. Case law is still developing in this area and counsel should be consulted regarding this issue.

A related issue involves claims between two or more receiverships. Virtually all receivership orders have injunctions which preclude a person or entity from bringing claims against a receiver outside of the receivership proceedings. Some receivers have been successful in arguing that even though they are pursing claims in a second receivership proceeding, the injunction provision in their receivership order bars setoffs by another receiver in that receiver's own case. In those instances, the first receiver would pursue that receiver's full claim in the second receivership proceeding and the second receiver would, in turn, pursue that receiver's full claim in the first receivership proceeding. If receivers have mutual claims, the receivers should each consult counsel concerning the appropriate manner to deal with this issue.

e. Other Considerations

Determining how setoffs should be applied in a particular receivership is not dependent solely upon rote application of the foregoing rules. Receivers should be aware that some creditors have raised constitutional challenges to the application of statutory setoff rules. The application of setoff in a rehabilitation as opposed to a liquidation also should be considered where appropriate. Finally,

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[55] At least two courts have found that in the absence of a statute, there is no common law right to set off. See *Bluewater Ins. Ltd. v. Balzano,* 823 P.2d 1365 (Colo. 1992): *Allendale Mutual Ins. Co. v. Melahn,* 773 F.Supp. 1283 (W.D. Mo. 1991); but see *Transit Cas. Co. v. Selective Ins. Co. of the Southeast*, 137 F.3d 540 (8th Cir.), rehearing and suggestion for rehearing en banc denied (1998).

[56] The receivership court may determine that it does not have personal jurisdiction over a non-resident person or entity from whom the receiver is attempting to collect assets. See *In the Matter of Rehabilitation of National Heritage Life Insurance Company*, 656 A.2d 252 (Del. Ch. 1994).



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there is an open issue of the extent to which setoffs may be taken regarding claims against the company by the federal government.

**J. Recoupment**

The equitable doctrine of recoupment has been recognized in insurance and other types of insolvency cases.[57] Unlike setoff, recoupment typically is not provided for by statute. Recoupment generally is defined as the equitable adjustment of amounts owing between two parties arising out of the same transaction. Recoupment is usually limited to matters arising out of or related to a contractual relationship. Like setoff, recoupment does not yield a money judgment in favor of the party asserting it; it is defensive in nature. However, setoff differs from recoupment in that setoff applies to cross-obligations between parties arising out of different transactions.

When the doctrine is recognized, recoupment generally is not deemed to be subject to the setoff requirement of mutuality. Moreover, an otherwise valid assertion (and perhaps even the effectuation) of recoupment may not be subject to the receivership injunction against suits and setoffs, even if the assertion and/or effectuation of setoff would be barred by the injunction. The receiver should consult with counsel when considering the assertion of recoupment or when confronted with another person's assertion of the doctrine.

**K. Retrospective Application of Statutes**

A receiver may desire to apply a statute to events that occurred prior to the enactment of that statute. Whether a court will permit the receiver to do so may depend upon whether the court deems such application of the statute to be "retrospective" and, if so, whether surrounding circumstances are deemed to justify such application.

Application of "remedial" or "procedural" statutes to pre-enactment events generally is not deemed to be retrospective. A remedial or procedural statute is deemed merely to enhance an existing remedy or to change a mere rule of procedure. Generally, unless there is contrary legislative intent, remedial or procedural statutes are applied to all cases pending at the time of enactment, or become pending thereafter. That is without regard to whether the statute is to be applied in respect of pre-enactment events.[58] A statute also will be applied to pre-enactment events if it is deemed to be merely declarative of the law in effect at the time of the relevant events.[59] Generally, such application is deemed not to be retrospective.

By definition, a "substantive" statute adversely affects vested rights if retrospectively applied. Generally, courts will enforce a substantive statute retrospectively only if: 1) there is adequate expression of the legislature's intent that the statute be applied retrospectively;[60] and 2) such application is not inconsistent with applicable constitutional limitations. Applicable constitutional limitations may include the Fourteenth Amendment and the Contracts Clause of the U.S. Constitution, and certain state constitutional provisions.[61]

[57] See, e.g., *Kaiser v. Monitrend Investment Management, Inc.*, 672 A.2d 359 (Pa. Commw. Ct. 1996) (recognizing the doctrine). But see *Albany Ins. Co. v. Stephens*, 926 S.W.2d 460 (Ky. App. 1995) (review denied) (deeming the doctrine to be superseded by statute precluding setoff against premiums).

[58] See *Angoff v. Holland-America Ins. Co. Trust*, 937 S.W. 2d 213 (Mo. App. Ct.), rehearing and/or transfer denied (1996) (claims estimation statute deemed to be procedural and applied to pre-enactment events).

[59] See *Bradley v. State Farm Mutual Automobile Ins. Co*., 212 Cal. App. 3d 404, 260 Cal. Rptr. 470 (Cal. App. Ct.), review denied (1989) (statute held merely declarative of prior law and applied to pre-enactment events).

[60] See *State ex rel Crawford v. Guardian Life Insurance Co. of America*, 1997 OK 10, 954 P. 2d 1235 (Okla. 1998) (contrary legislative intent; setoff restrictions not applied retrospectively).

[61] But see, e.g., *Jenkins v. Jenkins*, 219 Ark. 219, 242 S.W. 2d 124 (Ark. 1951) (state constitutional prohibition against retrospective laws does not inhibit certain laws made in furtherance of the police power of the state).



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Application of the foregoing general rules to any given situation tends to be unpredictable. That is because courts are not always consistent as to what they deem to be "remedial," "procedural" or "substantive," how they interpret legislative intent and how they construe constitutional limitations.

**L. Closing of a Receivership Estate**

Prior to calculating the final distributions in a receivership estate, the receiver should consider:

- The length of time the receiver should maintain insurer and receivership records;
- Statutory requirements that affect the preservation and destruction of records;
- The cost of storage or retention of preserved documents; and
- The disposal of residual funds once the final expenses have been satisfied.

In most states, a receiver applies to the court for an order approving a final distribution of assets, closing the estate and discharging the receiver. The order may set aside funds, to be held in trust by the regulator, for post-estate closing administrative costs, such as those set forth above.

§ 902 of IRMA requires that a closing order be applied for, "when all property justifying the expense of collection and distribution have been collected and distributed."

**M. Destruction of Records**

The receiver should identify the various types of documents in the estate's possession and determine the appropriate length of time that the documents should be preserved. In many cases it may be appropriate to review the documents in different categories, i.e., records that are the official records of the regulator, the insurer's records pre-receivership and those records of the receiver.

Counsel should determine whether the destruction of documents is governed by the state law, specifically concerning the destruction of public or governmental documents or by general state law concerning business documents. In certain situations, state law may require that certain types of records be maintained for a specific period of time and ethical standards, i.e., for attorneys, may require specific retention periods. Certain documents may need to be permanently preserved, perhaps through the state archival process.

Once the specific needs of the receiver, creditors and state law have been reviewed, the receiver should recommend to the court specific retention periods.

§ 904 of IRMA allows the receiver to recommend to the court records for destruction whenever it "appears to the receiver that the records … are no longer useful." It also allows for the retention of records post closing and the reserving of funds as administrative expenses needed to maintain the retained records, and for those records to be maintained by the insurance department.

**N. Escheat**

After the receiver has established a procedure for the retention and destruction of documents, sufficient funds should be preserved to satisfy the costs of that long-term process.

Counsel for the receiver should review state law with respect to the disposal of residual assets once the retention period has been satisfied or payment has been made to an entity in advance to carry out the receiver's procedure. Any remaining assets would be used to pay claims of policyholder, guaranty associations or other creditors that had not yet been paid in full. If assets are remaining after all policyholders, guaranty associations and other creditors have been paid in full, the receiver should consider applicable escheat laws.



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Many state laws provide for the escheat of funds to the state treasury. Procedures governing the escheat process and those responsible for implementing it may need to be established.

§ 804 of IRMA has two alternative approaches for dealing with unclaimed funds. Alternative 2 is to follow the general escheat process in state law. Alternative 1 sets up a procedure requiring the funds to be held for two years after termination of the receivership after which the court can order the funds be deposited in a general receivership expense account, be escheated to the state, or be used to reopen the receivership and distributed to known claimant.

## III. CLAIMS

The focus of this section will be upon legal issues arising out of claims handling by a liquidator of an insolvent insurer rather than by a rehabilitator. A rehabilitator trying to decide whether a rehabilitation plan can be proposed that will avoid liquidation must consider the interests of the various groups of people with a stake in the insurer, including policyholders with current and future claims. Unless required by a rehabilitation plan, the rehabilitation process generally proceeds without a claims filing procedure, such as that used in liquidation, so that as much as possible, the result for the insurer and its policyholders is business as usual.

In the case of a life insurer, a moratorium may be placed on any claims for cash surrenders, dividends or policyholder loans, and the availability of those values may be restructured. This restructuring of the policyholder's accessibility to cash surrender and annuity values can create a larger surrender penalty for a reasonable period while confidence is restored in the life insurance company as it emerges from rehabilitation. If, in fact, some policyholders choose to withdraw cash from the insurer at that time, the substantial penalty for early withdrawal retains a larger portion of the nonforfeiture reserves while the liability of the company diminishes so that the resulting financial position is stronger even though the asset base is reduced. If the surrender penalty, however, is so punitive or so lengthy as to discourage policyholders from any hope of restoration of their account value, policyholders are likely to withdraw the available cash at the earliest possible time and look for other sources to recover their loss. Such a run will place substantial demands on the insurer's liquid assets and may endanger the future of the insurer.

Claim administration is at the heart of the receivership process. The receiver should establish claim procedures to ensure that the receivership will proceed, expeditiously and impartially, within the confines of applicable state statutes. The procedures should be clear and fair so that creditors and reinsurers can be secure that they are being dealt with equitably and that their respective interests are being properly addressed and protected by the receiver.

The issues discussed below represent pitfalls in the claims administration process where receivers have or may encounter legal controversy. There are few reported decisions on receivership claims administration questions. The guidelines in the claims chapter of this handbook are guidelines on how to conduct the claims administration process - for a discussion of claims adjudication issues specific to HMOs).

### A. State Liquidation Statutes and Federal Priority

The administration of claims is principally conducted according to relevant provisions of the applicable state liquidation law and judicial determinations. Federal laws affecting the federal government as claimant, however, may preempt state liquidation law (see Section 9.C.8.). The decisions since 1988 applying the federal superpriority statute[62] to insurance liquidation proceedings are discussed in detail below.

### B. Notice Issues

Notice issues are discussed in section on Section II.F.2.

[62] 31 U.S.C. § 3713.



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## C. Primacy of the Liquidation Court, Withstanding Collateral Attack and Arbitration

Effective claims handling may be heavily influenced by jurisdictional issues discussed in detail in Section II.G. of this chapter.

## D. Cancellation of Policy/Bond Coverage

Issues pertaining to cancellation of policy/bond coverage are discussed in detail in this chapter.

## E. Claim Elements

### 1. In General

Once the order of liquidation is entered and the receiver starts the claims administration process, questions pertaining to claim valuation invariably arise. The receiver's role is to make sure that the claim process is fair to everyone and that no creditor is allowed more than the contractual, statutory or court-imposed rules permit. General principles of claims administration are discussed in detail in Chapter 5—Claims.

Policyholders who are covered by guaranty associations generally are not required to submit proofs of claim. Any discussion of policyholder claims in this section relates to policyholders who are not covered by a guaranty association. Guaranty association claims are handled separately and often are coordinate by NOLHGA or NCIGF.

### 2. Punitive/Extra-Contractual Damages

In some jurisdictions, the insurability of punitive damages is prohibited as a matter of public policy. In these jurisdictions, punitive damages claims should not be recoverable against the estate. In most states, extra-contractual damage claims, such as bad faith, are subordinated and treated as general creditor claims.

Any claim that includes alleged punitive damages should be reviewed carefully under the applicable state law to answer the following questions:

- Are punitive damages insurable under applicable law?
- Is the punitive damage claim the result of alleged bad acts by the insured, by the agent or by the insolvent insurer?
- As to acts by the insured, is any part of the punitive damage claim within policy coverage?
- As to those punitive damage claims alleged to be a result of acts by the insured that are within policy coverage, what are the standards that would be applied by a court in awarding punitive damages and what would be the probable recoverable amount of damages?

Answers to these questions should enable a receiver to evaluate each punitive damage claim because the resolution of a punitive damage claim is fact intensive. Before a receiver recommends the approval of a punitive damage claim to the receivership court, the receiver should be certain that applicable law permits recovery.

§ 802 C(5) excludes punitive damages from the policyholder level (Class 3) unless the policy expressly covers punitive damages and subordinates punitive damages to Class 8.

### 3. Surety/Fidelity Bonds



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The claim element questions in the surety/fidelity bond field usually revolve around the allowability of attorneys' fees, interest and liquidated damages. The case law seems to hold that, unlike punitive damages, if the underlying bond provided for such elements, they may be allowed by the receiver. With respect to coverage, at a minimum, there must have been a default by the bond principal before the cancellation date or, so far as fidelity bonds are concerned, the act or occurrence that caused damage covered by the bond must have taken place before the cancellation date. In addition, issues may arise concerning the return of unearned premiums (since surety premium is normally deemed to be fully earned at inception), whether bonds are cancelable, and what priority class a bond claimant is entitled to assert. IRMA § 801 C places in Class 3 (policyholder class) claims of "…obligees (and, subject to the discretion of the receiver, completion bonds) under surety bonds and surety undertakings (not to include bail bonds, mortgage or financial guaranty or other forms of insurance offering protection against investment risk, or warranties), claims by principals under surety bonds and surety undertakings for wrongful dissipation of collateral by the insurer or its agents …"

4. Contingent Claims

   a. Proofs of Claim—Unstated in Amount

A proof of claim may be unstated in amount. As previously discussed, pursuant to the laws of many states, the failure to state a specific amount due may not necessarily result in its classification as a contingent claim. Approaches vary among receivers. Some state laws may require that the initial proof of claim be specific and cannot be materially amended after the bar date passes. Other receivers may permit proof of claim amendments until the claim is evaluated in the estate and a distribution is made.

One technique for dealing with long-tail claims is estimation of contingent claims if it is determined either that: 1) "liquidation of the claim would unduly delay the administration of the liquidation proceeding"; or 2) "the administrative expense of processing and adjudicating the claim or group of claims of a similar type would be unduly excessive when compared with the property that is estimated to be available for distribution with respect to the claim," valuation of the claim may be made by estimate. See IRMA §705 C (2).

Generally speaking, there are three alternative methods in a liquidation for valuing claims and making them absolute:

i. the traditional run-off method in which the receivership is continued until all or substantially all the claims become absolute, i.e., mature to the point where liability and value are clearly proven;

ii. the cut-off approach in which an estate's liability for any claims that remain contingent or unliquidated are terminated by a specific date or event, e.g., bar date;

iii. an estimation method in which the receiver estimates and, if appropriate, allows (approves for distribution) contingent and unliquidated claims at a net present value.

During a liquidation proceeding, in order to properly value and allow claims, the receiver needs clear-cut evidence that the policyholder has, in fact, sustained a loss: 1) within the coverage of an effective policy; and 2) in a specific or determinable amount. The nature of long-tail claims in a receivership makes it difficult or sometimes impossible to establish such proof because of limitations that may prevent potential claims from developing and maturing into enforceable claims.

For example, § 39 of the Liquidation Model Act and § 701 A of IRMA require claims to be filed "on or before the last day for filing specified," i.e., by a bar date which, depending on the jurisdiction, can be as liberal as a date chosen by the receiver at his discretion or a specific date in



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the statute. IRMA § 701 further specifies that the last day for filing shall not be later than 18 months after entry of the order of liquidation unless extended for good cause. An early bar date could prevent late-maturing or long-tail claims from meeting a receivership's proof requirements and exclude them from any distribution of assets. In any estate where long-tail exposure is significant, this not only causes inequity by eliminating long-tail policyholders' reasonable expectations of recovery but, by precluding the development of such long-tail claims, it also significantly reduces the amount of reinsurance that can be collected by the receiver and used to benefit creditors.

The run-off method, on the other hand, presents a more accurate claims valuation technique, i.e., substantially all claims ultimately become absolute through a natural process, but in a more costly manner. As time passes, there is delay in distribution of assets; increased attrition of knowledgeable and competent staff; and the benefit of any investment income is outweighed by mounting administrative costs resulting in depletion of an estate's assets.

An alternative is to use methodologies and techniques consistent with standards of actuarial practice to estimate the ultimate value of case reserves and to allocate remaining incurred but not reported (IBNR) to individual claims.

One problem inherent in such an estimation method is that, because of the uncertainty in the development of the law regarding environmental, asbestos and product liability claims, an estimate that is accurate at present could be rendered meaningless by a significant change in the law. As a result, it is possible for disparities to exist in individual claims estimates which would not occur in the natural development and maturity of such claims over time. Since it is impossible to project with total accuracy, some claimants will invariably be left out, some will receive too high an estimate, and some will receive too low an estimate.

A second problem facing estimation plans is the likelihood that they will be challenged by reinsurers.[63]

Missouri and Illinois have claims estimation statutes and there are numerous similarities and differences. The Missouri statute allows for both insureds and third parties to file contingent claims. It does not require that the claim be liquidated prior to distribution of estate assets. It does appear to allow for IBNR claims, i.e., claims based on losses that have occurred but which have not been reported to the insurance company, though there are provisions for present-value discounting of the claims.

Illinois' statute authorizes insureds, third parties and cedents to file contingent claims but treats all three somewhat differently. Insureds' contingent claims may be allowed: 1) if they are liquidated by actual payment on or before a bar date set by the court; or 2) by estimation if there is reasonable evidence that a claim exists, except that insureds' claims for IBNR are not allowable. Insureds' contingent claims that are liquidated by the bar date are entitled to the same level of priority as insureds' claims that were fully matured when filed. However, insureds' claims that are allowed by estimation are subject to the next lower priority for distribution. The Illinois statute permits third party claimants to file contingent claims and have their claims determined by estimation. It also expressly addresses cedents' claims and provides that cedents' contingent claims, including claims for IBNR, may be allowed by estimation. Under the Illinois statute, cedents participate at a lower priority than policyholders or third party claimants.

[63] See *Quackenbush v. Mission Insurance Co.*, 46 Cal. App. 4th 458, 54 Cal. Rptr.2d 112 (Rd. Dist. 1996); *In the Matter of Liquidation of Integrity Insurance Company,* 193 N.J. 86, 935 A. 2d 1184 (2007), *Angoff v. Holland-America Ins. Co. Trust,* 937 S.W.2d 213 (Mo. Ct. App. 1996).



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b. Policyholder Protection Claims

Often creditors submit a proof of claim in the estate though they are unaware of any specific claim having occurred. These types of claims have been referred to as policyholder protection claims. Some courts have held that a creditor must know of the existence of a specific claim and submit a proof of that claim prior to the bar date. State law differs as to whether such claims will be recognized at all, and if so, under what circumstances.

§ 704 A of IRMA allows the filing of policyholder protection claims.

5. Policy Defenses

The receiver may assert any defenses that the insurer could have asserted to a claim. Moreover, if there are grounds to rescind the policy or bond, for example, where there were material misrepresentations on the policy/bond application by the proposed insured, the receiver should be able to assert those grounds on behalf of the insurer.

6. Unearned Premiums

Where possible, receivers do not require proofs of claim to be filed to assert unearned premium claims, or may deem a filing to be made if the books and records of the insurer are sufficient to calculate any unearned premium due. In property and casualty cases, the receiver automatically calculates the unearned premium amounts from the insurer's records so that guaranty associations will have the necessary information to make payment directly to the policyholder (See Chapter 6, Section II.D.1.a.) In life and health cases, policies may be continued by the covering guaranty associations for many years, and premium reconciliation for the period after the liquidation date will typically be handled by the guaranty associations.

7. Deemed Filed Claims

As with unearned premium claims, receivers often can obtain authorization from the liquidation court to handle certain routine types of claims without the submission of proofs of claim and the attendant additional paper work. For example, the policyholder or bondholder may have submitted to the company, before its demise, a significant amount of information on the insurer's standard claim forms. If the receiver determines that those insurer forms contain substantially similar information to that on the approved liquidation proof of claim forms, then the receiver may ask the liquidation court to consider the previously filed claims to be deemed filed as liquidation proofs of claim, i.e., to consider the insurer's standard forms to be, in effect, the liquidation proofs of claim. Such a procedure has two administrative benefits. First, it reduces the amount of duplicative claim information to be handled by the receiver. That is particularly true regarding health claims where the volume of physician, hospital and other provider documentation can be sizable, but it is also true with regard to property/casualty losses, including workers' compensation, where substantial documentation typically already exists. The deemed filed procedure can improve the receiver's efficiency considerably. Second, the deemed filed procedure is an aid to policyholders/bondholders that may be confused by the necessity of submitting a liquidation proof of claim in situations where considerable claim information has already been sent to the insurer. By streamlining the process and merely sending the policyholder/bondholder a summary of the claims deemed filed, the receiver cuts down on the possibility that some policyholder/ bondholder will fail to act timely because of confusion over the need to resubmit information that was sent to the insurer before the insolvency proceedings began.

## F. Claims of Ceding and Assuming Companies and Setoffs

Claims of ceding and assuming insurers and right of setoff are discussed in Section IX of this chapter.



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**G. Assets that are not General Assets, Special Deposits and Letters of Credit**

The preceding subsections have dealt with legal issues in connection with claims by people that may be entitled to a share of the insolvent insurer's general assets. "General assets" are defined in § 104 K of IRMA as follows:

K. (1) "General assets" includes all property of the estate that is not:

(a) Subject to a properly perfected secured claim;

(b) Subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons; or

(c) Required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons.

(2) "General assets" includes all property of the estate or its proceeds in excess of the amount necessary to discharge claims described in Paragraph (1) of this subsection.

Discussed below are a few of the legal issues surrounding claims against assets that are restricted in one way or another, such as a "special deposit claim."[63] That term is defined in the Insurers Rehabilitation and Liquidation Model Act as follows:

"Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

If a regulator or a guaranty association in a non-domiciliary state where the insolvent insurer has assets, takes action to assert local statutory rights in the assets for the benefit of local policyholders, either in the receivership court or elsewhere, then it is likely that the receiver will be obligated to permit the local officials to conduct an ancillary receivership in that state with the insurer's local assets. If, however, the regulator or guaranty association does not act, and the rehabilitation/liquidation court makes a final determination as to the special deposit, the regulator or guaranty association will be bound by the court's determination.[64]

1. Special Deposits

Any plan of rehabilitation submitted to the supervising court should include a separate section dealing with special deposits. All state regulators and guaranty associations should be given notice and an opportunity to be heard on that provision and all others in the proposed plan. That will give as much protection as possible under the law from later attempts by state insurance regulators to exercise control over local assets.

In a liquidation, if a regulator in a non-domiciliary state takes action with respect to a special deposit and attempts to initiate an ancillary proceeding, it will be up to the receiver to review the terms and the

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[64] *Underwriters National Assurance Company (UNAC),* 102 S. Ct. 1357 (1982), involved a post-rehabilitation attempt by the state guaranty association in North Carolina to attach a special deposit in North Carolina made by UNAC prior to rehabilitation, even though the state guaranty association had participated actively in the UNAC proceeding in Indiana and had not raised any question about the deposit prior to the approval in 1976 of the plan of rehabilitation by the Indiana rehabilitation court. Justice Marshall writing for the court held that a judgment from one state court must be accorded full faith and credit in other states, even as to questions of jurisdiction, when those questions have been "fully and fairly" litigated and finally decided in the first court. See *Underwriters National,* 102 S. Ct. at 1366. The North Carolina guaranty association's claims were fully and fairly considered by the rehabilitation court, so North Carolina had to give *res judicata* effect to the Indiana decisions. See *id.* at 1367-68. The only place where the North Carolina guaranty association could have advanced its argument that the North Carolina statutory deposit scheme should be followed was in the rehabilitation court, not in a collateral attack in North Carolina. See *id.* at 1371.



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law under which the deposit was placed and to make sure that the foreign jurisdiction is not obligated to return the deposit.

IRMA §104 CC, defines "special deposit" as "…a deposit established pursuant to statutes for the security or benefit of a limited class or classes of persons." § 104 DD defines "special deposit claim" as "any claim secured by a special deposit, but does not include any claim secured by the general assets of the insurer." IRMA § 1002 specifies how deposits are to be administered in various scenarios by specifying what action the IRMA adopting state must take as to special deposits in its state. An IRMA state is required to return all deposits to the domiciliary state upon appointment of the receiver, except deposits where its guaranty association is the only beneficiary. See IRMA § 1002 B.

2. Collateral

The receiver needs to consider all other assets purportedly held by the insolvent insurer in some trust, collateral or other non-general capacity to verify that these assets are, in fact, not general assets of the estate and to ascertain what continuing obligations the receiver may have (i.e., who has rights to the funds and how and to whom the funds should be distributed). The entry of an order of liquidation does not abrogate these special situations and the receiver should take steps to assure that these assets and obligations are separately addressed and the rights of claimants protected.

3. Letters of Credit

There has been some controversy surrounding the rights and obligations of receivers regarding letters of credit (LOCs). LOCs are typically used to support reinsurance and large deductible obligations. Letters of credit issued in connection with reinsurance transactions are discussed in detail in Chapter 7, Section VIII and in connection with large deductible transactions in Chapter 4, Section A.

4. Separate Accounts

Another special form of assets are separate accounts, which are those accounts set up by an insurer to fund specific blocks of insurance or other benefits, such as pension plans and other viable products. Separate accounts are generally created and administered in accordance with specific statutory or regulatory guidelines. Such statutes usually provide that funds properly maintained in the separate accounts of an insurer will not be chargeable with the liabilities arising out of any other business the insurer may conduct, which has been held to include the insurer's receivership.[65] (Refer to the following section III.H. and Exhibit 9-2.)

## H. General Guidance for Receivers in a Future Receivership of a Troubled Insurer that Issued SEC Registered Products

1. Authority

a. Federal Statutes and Rules

<u>Securities Act of 1933 (1933 Act)</u>

Certain annuity and life insurance contracts issued by insurers are subject to the Securities Act of 1933 and must be registered with the U.S. Securities and Exchange Commission (SEC), unless the contract qualifies for an exception. Consequently, an insurer issuing certain types of contracts must comply with the requirements of the 1933 Act as well as with applicable state insurance law before issuing an SEC registered contract.

<u>Investment Company Act of 1940 ("1940 Act")</u>

[65] See, e.g., *Rohm & Haas Co. v. Continental Assurance Company,* 58 Ill. App. 3d 378, 374 N.E.2d 727 (1978)



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Section 2(a)(37) of the 1940 Act defines a separate account as "an account established and maintained by an insurance company pursuant to the laws of any State or territory of the United States, or of Canada or any province thereof, under which income, gains and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company."

Section 2(a)(17) of the 1940 Act defines an insurance company to include "any receiver or similar official or any liquidating agent for such a company, in his capacity as such."

Under longstanding federal court precedent and SEC regulations, an insurer's separate account that supports a variable contract (which provides that separate account investment experience is reflected directly in contract values [Variable Products]) is treated as having a separate legal existence from the insurance company for purposes of the 1940 Act[66], and is subject to the registration and other requirements of the 1940 Act, unless an exception applies.

Securities Exchange Act of 1934 ("1934 Act")

Sections 13 and 15(d) of the 1934 Act require insurance company issuers of certain securities registered under the 1933 Act to file regular, publicly available reports with the SEC. These reports include Form 10-K, Form 10-Q and Form 8-K. Insurers that issue annuity and life insurance contracts registered under the 1933 Act that are not supported by a separate account registered under the 1940 Act are required to file such reports, unless the insurer qualifies for an exemption. For registered Variable Products, there is an alternative and much simpler reporting requirement (a separate account annual report on Form N-SAR).

Code of Federal Regulations

Rule 12h-7 under the 1934 Act generally exempts an insurance company issuer from the duty under Section 15(d) to file reports required by Section 13(a) if: 1) the securities do not constitute an equity interest of the issuer; 2) the insurer files an annual statement of its financial condition with the insurance commissioner of the insurer's domiciliary state; 3) the securities are not listed on any exchange; 4) the insurer takes steps reasonably designed to ensure that a trading market does not develop in the securities; and 5) the prospectus contains a statement stating that the insurer is relying on Rule 12h-7.

Rule 0-1 (e) (2) under the 1940 Act provides that, as a condition to the availability of certain exemptions, a separate account "shall be legally segregated, the assets of the separate account shall, at the time during the year that adjustments in the reserves are made, have a value at least equal to the reserves and other contract liabilities with respect to such account, and at all other times, shall have a value approximately equal to or in excess of such reserves and liabilities; and that portion of such assets having a value equal to, or approximately equal to, such reserves and contract liabilities shall not be chargeable with liabilities arising out of any other business which the insurance company may conduct."

For variable contracts funded by separate accounts that are registered under the 1940 Act, Rule 22c-1 under the 1940 Act requires insurers to calculate accumulation unit values daily and to price any premiums, withdrawals, or transfers of contract value at the accumulation unit value for such contracts that is next computed after the insurer receives the purchase, withdrawal, or transfer request in good order.

[66] This creation of federal common law under the Federal Securities Laws applies even though state law governing the creation of a separate account provides that it is not a legal entity. The result has reportedly resulted in a characterization of the "'ectoplasmic theory' of investment companies . . . ." Jeffrey S. Puretz, *Background Information: A Primer on Insurance Products as Securities*, PLI "Securities Products of Insurance Companies and Evolving Regulatory Reform," 39, note 21 (2012).



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Rule 38a-1 under the 1940 Act requires insurers that sponsor a separate account registered under the 1940 Act: (i) to maintain current written compliance policies and procedures that are reasonably designed to prevent, detect and promptly correct violations of the federal securities laws (broadly defined), and (ii) to designate one individual as a chief compliance officer (CCO) responsible for administering the separate account's compliance policies and procedures. An annual review must be conducted of the adequacy of the written policies and procedures and the effectiveness of their implementation, and an annual written report prepared that addresses the operation of the policies and procedures, any material changes made or recommended and each material compliance matter that has occurred since the date of the last report.

b. State Statutes and Rules

NAIC Variable Contract Model Law (#260)

Model #260 permits a life insurer to establish separate accounts for life insurance or annuities, and allocate amounts to it, provided that:

- Income, gains and losses from assets allocated to a separate account are credited to or charged against the account, without regard to other income, gains or losses of the insurer.

- Amounts allocated to a separate account are owned by the insurer, and the insurer is not a trustee with respect to such amounts. If and to the extent provided under the applicable contracts, the portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business of the company (generally referred to as "asset insulation").

- Transfers of assets between a separate account and other accounts are subject to restrictions. The Commissioner may approve other transfers if they are not found to be inequitable.

- Except as otherwise provided, pertinent insurance law applies to such separate accounts.

NAIC Separate Accounts Funding Guaranteed Minimum Benefits under Group Contracts Model Regulation (#200)

- Applies to group life insurance contracts and group annuity contracts, as described in the rule, which use a separate account.

- Prescribes rules for establishing and maintaining separate accounts that fund guaranteed minimum benefits under group contracts, and the reserve requirements for accounts.

NAIC Variable Annuity Model Regulation (#250)

- Defines a variable annuity as a policy that provides benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer.

- Sets forth reserve and nonforfeiture requirements for variable annuity contracts and provides that the insurer must maintain separate account assets with a value at least equal to the reserves and other contract liabilities with respect to the account, except as may otherwise be approved by the commissioner.

- To the extent provided under the contracts, that portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

NAIC Variable Life Insurance Model Regulation (#270)



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- Defines a variable life insurance policy as an individual policy that provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer.

- Sets forth reserve and nonforfeiture requirements for variable life insurance policies, and provides that the insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for the policies.

- Provides that for incidental insurance benefits, reserve liabilities for all fixed incidental insurance benefits shall be maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to the benefit.

- Every variable life insurance policy shall state that the assets of the separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account.

- The policy shall reflect the investment experience of one or more separate accounts, and the insurer shall demonstrate that the reflection of investment experience in the variable life insurance policy is actuarially sound. The method of computation of cash values and other nonforfeiture benefits shall be in accordance with actuarial procedures that recognize the variable nature of the policy.

<u>NAIC Modified Guaranteed Annuity Regulation (#255)</u>

- A modified guaranteed annuity is defined as a deferred annuity, the values of which are guaranteed if held for specified periods, and the underlying assets of which are held in a separate account. The contract must contain nonforfeiture values that are based upon a market-value adjustment formula if held for periods shorter than the full specified periods of the guarantee.

- At a minimum, the separate account liability will equal the surrender value based upon the market value adjustment formula in the contract. If contract liability is greater than the market value of the assets in the separate account, a transfer of assets must be made into the separate account so that the market value of the assets at least equals that of the liabilities. Any additional reserves needed to cover future guaranteed benefits will be set up by the valuation actuary.

- Provides that the contract shall contain a provision that, to the extent set out in the contract, the portion of the assets of any separate account equal to the reserves and other contract liabilities of the account shall not be chargeable with liabilities arising out of any other business of the company.

<u>Insurers Rehabilitation and Liquidation Model Act (1999) (IRLMA), § 3 (K):</u>

"General assets" includes all property, real, personal or otherwise which is not:

(1) Specifically subject to a perfected security interest as defined in the Uniform Commercial Code or its equivalent in this state.

(2) Specifically mortgaged or otherwise subject to a lien and recorded in accordance with applicable real property law.



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(3) Specifically subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons.

(4) Required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons.

As to an encumbered property, "general assets" includes all property or its proceeds in excess of the amount necessary to discharge, in accordance with the Act, the sum or sums secured thereby. Assets held on deposit pursuant to a state statute for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

Separate Account Exclusion in Distribution Scheme

Several states have a provision in their receivership act's scheme for the distribution of assets that specifies the treatment of assets held in an insulated separate account once an order of receivership has been issued. Such state laws generally provide that, to the extent provided under the applicable contracts, the portion of the assets of any such separate account equal to the reserves and other contract liabilities regarding that account are not chargeable with any liabilities arising out of any other business of the insurance company. See, e.g., Ariz. Stat. § 20-651(D); Cal. Ins. Code § 10506(a); Conn. Gen. Stat. § 38a-433(a); N.J. Stat. § 17B:28-9(c); N.Y. Ins. Law § 4240(a)(12); Tex. Ins. Code § 1152.059.

c. Case Law

SEC v. Variable Annuity Life Ins. Co. of America, 359 U.S. 65 (1959)

Variable annuity contracts are securities that must be registered with the SEC under the 1933 Act. Such contracts are not annuity contracts within the meaning of the exemption provided in Section 3(a)(8) of that Act for annuity and life insurance contracts, or the McCarran-Ferguson Act.

SEC v. United Benefit, 387 U.S. 202 (1967)

A deferred variable annuity that promised to return net premiums at the end of a 10-year term is a security. The Court found that, despite the guaranteed return at the end of the term, the contract owner held too much investment risk, especially when the product's marketing appealed to purchasers with its prospect of "growth" through sound investment management rather than on "the usual insurance basis of stability and security."

Prudential Ins. Co. v. SEC, 326 F.2d 383 (3d Cir. 1964), cert. denied, 377 U.S. 953 (1964)

A separate investment account was established by Prudential for the sole benefit of variable annuity contract holders. The account was the "issuer" of securities for the purposes of the 1940 Act, and was separable from Prudential, so that the exclusion in the 1940 Act for insurance companies did not apply.

Rohm & Haas Co. v. Continental Assurance Co., 374 N.E.2d 727 (Ill. App. 1978)

A declaratory judgment determined that assets held by an insurer in insulated separate accounts equal to the reserves and other contract liabilities regarding such accounts were not subject to the claims of general creditors in the event of liquidation. The Court held that a provision in the Illinois Insurance Code stating that the insulated separate accounts may not be charged with unrelated liabilities was mandatory, and "forbids the invasion of separate accounts by a liquidator for the benefit of general creditors." The opinion did not discuss the receivership act; the case preceded the enactment of an exclusion for separate accounts in the distribution scheme.



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d. Rehabilitation Orders

The following are examples of rehabilitation orders that provided exemptions for separate account assets:

- First Capital Life: In the rehabilitation of First Capital Life Insurance Company, the court froze policyholder withdrawals but exempted "whole or partial surrenders of variable separate account holdings of variable annuity contracts." See Limited Stop Order and Notice of Hearing (May 10, 1991) at Item II.A on Page 2. See also Order Appointing Conservator, Establishing of Procedures and Related Orders (May 14, 1991) at Item 7 on p. 6 ("Further, whole or partial surrenders of variable separate account holdings of variable annuity contracts shall continue to be paid").

- Monarch Life: In the rehabilitation of Monarch Life Insurance Company, the court imposed a temporary moratorium on any loan or cash surrender rights under fixed life or annuity contracts, but not under variable separate account products. See Verified Complaint and Request for Appointment of Temporary Receiver (May 30, 1991) at Item 24 on p. 10.

- Mutual Benefit Life: In the rehabilitation of Mutual Benefit Life Insurance Company, a court order provided that restraints on policy loans and surrenders do not prohibit the payment from separate accounts in connection with variable annuities. See Consent Order to Show Cause With Temporary Restraints (July 16, 1991) at Item 15 on p. 10. See also Order Continuing Rehabilitator's Appointment, Continuing Restraints and Granting Other Relief (August 7, 1991) at Item 2(c) on p. 3 (extending the exemption to cover separate accounts in connection with variable life, as well as variable annuity, products).

- Confederation Life: In the rehabilitation of Confederation Life Insurance and Annuity Company, the court imposed restraints on surrenders, exchanges, transfers and withdrawals, but provided that the restraints shall not prohibit the payment of funds from separate accounts in connection with variable annuity contracts, and surrenders, exchanges, transfers and withdrawals shall be permitted without restriction and without delay. See Order of Rehabilitation (Sept. 12, 1994) at Items 9-10 on p. 7-8.

2. Considerations

a. Variable Products Backed by Separate Accounts Registered Under the 1940 Act:

In the event of a liquidation of an insurance company, a separate account registered under the 1940 Act would be insulated as provided in the 1940 Act and the rules promulgated under the Act.

- The definition of "insurance company" in the 1940 Act includes a receiver, or a similar official or liquidating agent for such a company.

- A separate account is treated as an investment company separate from the insurance company for purposes of the 1940 Act.

- In SEC v. Variable Annuity Life Insurance Co. of America, the 1940 Act was not reverse pre-empted by the McCarran-Ferguson Act.

b. Products (Variable or Fixed) Backed by Separate Accounts NOT Registered under the 1940 Act:

If a separate account has been used by an insurer to back certain kinds of benefits guaranteed by the insurer under certain annuity contracts or life policies, the 1940 Act may not always apply to that separate account. However,



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i. A separate account not governed by the 1940 Act may nevertheless be treated as legally insulated under a state's receivership act:

- If the state variable contract law (and the policy/contract, if necessary) so provide.
- If a state insurance law requires that a separate account be held for the benefit of specified persons, it is not a general asset under an act based on IRMA or IRLMA.
- If the separate account is established as a "valid and existing" express trust for the security or benefit of specified persons as described in the receivership act, it is excluded from the general assets of the receivership under an act based on IRMA or IRLMA.
- If the receivership act's distribution scheme contains a provision that governs the treatment of a separate account, and the account is established as specified by such provision, then claims under the separate account agreement are payable from the account as provided by the provision.

ii. If accounts are established in accordance with any of the requirements described in (a), they should be reflected as restricted assets on the receivership's financial statement. (It should be noted that state statutes or rules may vary from the NAIC models. Not all states have a specific exemption for separate accounts in the distribution scheme, and differences also exist in variable contract laws. At least one state has prohibited the use of insulated separate accounts for non-variable products that do not reflect investment results of the separate account, but have guaranteed rates or returns. See Minnesota Department of Commerce Bulletin 97-6, October 22, 1997.)

iii. If an account is not exempted from the definition of a general asset or excluded from the distribution scheme, the receivership act will typically provide that it is subject to distribution to creditors.

iv. An annuity contract or life policy that imposes certain significant investment risks on the owners, such as a "market value adjustment," or an "index-linked variable annuity," might be required to be registered under the 1933 Act regardless of whether it is funded by a separate account registered under the 1940 Act ("Other SEC Registered Products"):

- Other SEC Registered Products such as registered modified guaranteed annuities and index-linked variable annuities may be funded by a separate account established in accordance with one of the requirements described in B.2.(a), above.
- Whether or not funded by a separate account, the receiver could face compliance issues under the 1933 Act with respect to such Other SEC Registered Products.
- Section 989J of the Dodd-Frank Act contains a provision that limits the ability of the SEC to classify indexed annuities and other insurance products as securities. This provision known as the Harkin Amendment.

v. Transfers between a separate account and other accounts may create issues in a receivership. Under the NAIC Model Variable Contract Law, such transfers are subject to restrictions, and the Commissioner may approve transfers that are not "inequitable." Because the Model Law states that pertinent provisions of insurance law apply to separate accounts, except as otherwise provided, the provisions of a receivership act regarding voidable transfers and preferences may be applicable to such transfers.

3. Guidelines



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The following identifies the issues, documents and material a receiver should focus on immediately if faced with a troubled insurance company (TIC) that issued Variable Products or SEC Registered Products. In addition, a receiver should collaborate with guaranty associations (through NOLHGA in multi-state insolvency) and ensure that they are involved as soon as practical regarding registered products that may be eligible for guaranty association coverage, especially with respect to compliance, operational, and other issues arising from the possible continuation of coverage of such products.

a. Determine the Type(s) of Separate Accounts that Support the Products TIC Issued and Obtain Registration Statements for the SEC Registered Products

- Variable Products Backed by Separate Accounts Registered Under the 1940 Act. There are two types of 1940 Act Separate Accounts that TIC would have been required to register with the SEC. The applicable federal securities laws compliance issues that the receiver/insurance regulator of TIC will face differ somewhat depending on the type of Separate Account:

  - Unit Investment Trust Separate Account (UIT). Most variable products offered today utilize Separate Accounts that fall into this category. It is characterized by a "passive" Separate Account[67] into which premiums are deposited and allocated to "subaccounts," each of which invests in a specified underlying mutual fund, which itself must be registered under the 1940 Act. The underlying mutual fund may or may not be managed by an affiliate of TIC.

  - Managed Separate Account. A Separate Account that invests directly in a portfolios of securities or other investments and, therefore, actively manages the investments at the Separate Account level, and has a board of directors responsible for managing the Separate Account. See Section C (5)(D), below.

- Variable Products Backed by Separate Accounts NOT Registered Under the 1940 Act (Exempt SAs).

  - Separate Accounts supporting Variable Products issued in connection with certain qualified retirement plans as specified in Section 3(a)(2) of the 1933 Act and Section 3(c)(11) of the 1940 Act. Such Separate Accounts are not registered under the 1940 Act and the Variable Products are not registered under the 1933 Act.

  - Separate Accounts supporting private placement (i.e., not registered) Variable Products under Section 4 of the 1933 Act and either Section 3(c)(1) or Section 3(c)(7) of the 1940 Act. Very limited in number and qualification of policyholders. Such Separate Accounts are not registered under the 1940 Act.

  - Even though these insurance products are exempted from SEC registration, they are still deemed to be securities, and are subject to the anti-fraud provisions of the federal securities laws. The offering documents (e.g., private placement memorandums, including financial statements) and marketing materials for these products must not contain any material omissions or misstatements. Once a TIC goes into receivership, the offering documents and marketing materials for such products should be amended to reflect such a material event and to explain the consequences for the contract owner.

- Other SEC Registered Products Backed by Separate Accounts NOT Registered under the 1940 Act. In certain situations, products other than Variable Products may be registered

[67] Under Section 4 (2) (b) of the 1940 Act, a UIT may not have a board of directors.



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under the 1933 Act and may be backed by a separate account that is not registered under the 1940 Act. (See Section B. 2 above.)

- Obtain and Review Available 1933 Act and 1940 Act Reports and Registration Statements. Both UITs and Managed Separate Accounts must file annual reports under the 1940 Act with the SEC on Form N-SAR. Managed Separate Accounts must file additional semi-annual reports with the SEC and send semi-annual reports to shareholders. The issuers of all SEC registered products must file updated registration statements with the SEC each year that contain current audited financial statements for the insurance company (and for the separate account, if the separate account is registered under the 1940 Act)[68], except in limited circumstances[69]. For products registered under the 1933 Act that are not backed by 1940 Act registered separate accounts, there could be filings that must be made with the SEC under Section 15(d) of the 1934 Act (Forms 10-Ks, 10-Qs and 8-Ks). The regulator/receiver should obtain a complete set of all SEC filings, including:

  - All recent SEC registration statements containing audited financial statements.
  - All periodic reports.
  - TIC's "plan of operations" or similar documentation for the operation of the Separate Account(s) (filed with certain state insurance departments).
  - All agreements with reinsurers, distributors, third party credit support providers, guarantors, investment advisors to the underlying mutual funds, custodians and other service providers involved in TIC's maintenance of the Separate Account(s).

- Rule 38a-1 Written Compliance Policies and Procedures and Annual Reports of the Chief Compliance Officer

  Rule 38a-1 under the 1940 Act provides that all separate accounts registered under the 1940 Act must have written compliance policies and procedures that are reasonably designed to prevent violations of the federal securities laws. In addition, Rule 38a-1 requires that the insurer appoint a Chief Compliance Officer ("CCO") for each separate account registered under the 1940 Act, and that an annual review and annual report must be prepared each year documenting the effectiveness of the company's compliance policies and procedures. The receiver should obtain a complete set of the registered separate account's Rule 38a-1 written compliance policies and procedures and the written annual reports previously prepared, and consider how compliance with Rule 38a-1 will be accomplished during the period of the receivership.

b. Determine the Type(s) of Products TIC Issued and TIC's Net Financial Exposure

- Locate and review all Prospectuses TIC filed with the SEC, and all Product Forms TIC Issued. Unless the TIC utilized only Exempt SAs, Variable and Other SEC Registered Products would require the TIC to file a Prospectus and updated audited financial statements with the SEC under the 1933 Act for each Variable and Other SEC Registered

[68] If contract benefits are guaranteed by a third party or supported by a credit support agreement as defined by the federal securities laws, then the audited financial statements of the guarantor or credit support provider must be included in, or incorporated by reference into, the registration statement.

[69] The staff of the SEC has taken a no action position with respect to issuers that do not distribute an updated prospectus to contract owners when the product is no longer being sold in certain limited circumstances. See Great-West Life Insurance and Annuity Company (avail. Oct. 23, 1990). However, even in such cases, current audited financial statements for the insurance company and the registered separate account must be prepared, and in some cases, mailed to contract owners each year.


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Product and keep the Prospectus and financial statements current for as long as the TIC was issuing such Products.

- Section 10(a)(3) of the 1933 Act requires that SEC Registered Product issuers (and underlying funds) making a continuous offering of their securities maintain a current or "evergreen" prospectus. The receiver should obtain and review ALL Prospectuses and ALL Variable Product and SEC Registered Product forms issued by the TIC (which Product Forms should have been filed and approved for issuance by the TIC's insurance regulators).

- The SEC believes that issuers of variable annuities that contemplate a series of purchase payments are under a duty to maintain a current prospectus as long as payments may be accepted from contract owners. The SEC views each premium payment under a Variable Product as the purchase of a new security. Absent the TIC suspending the ability of policyholders to make additional premium payments on Variable Products and SEC Registered Products, the TIC should continue to update its Registration Statements and Prospectuses, unless no-action relief from SEC staff has been obtained.[70]

- Determine all Guaranteed Benefits issued by the TIC. Guaranteed Benefits (on both Variable and fixed products) will include expense charge guarantees and mortality guarantees, but likely will also include some combination of "optional" guaranteed benefits:

  - Guaranteed Living Benefits (GLBs), which may take various forms, including one or more of the following:

    - Guaranteed Minimum Withdrawal Benefits (GMWBs), including Guaranteed Lifetime Withdrawal Benefits (GLWBs).

    - Guaranteed Minimum Accumulation Benefits (GMABs).

    - Guaranteed Minimum Income Benefits (GMIBs).

  - Guaranteed Death Benefits (GDBs).

- <u>Determine standards governing the Guaranteed Benefits</u>. Guaranteed Benefits may be based upon, or determined from, one or more of the following:

  - Guaranteed return of premium.

  - Guaranteed annual interest rate return (roll-up).

  - Highest anniversary (or other periodic value (step-up).

  - Other.

- <u>Determine the TIC's financial risk not supported by a Separate Account.</u> Review all actuarial memoranda and analysis to determine:

  - Amount of premium allocated to fixed investment options provided by TIC under variable and fixed products, which may be:

[70] But see footnote 65.



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    - Fixed products or investment options funded by a separate account.
    - Funds held by the TIC in its general account subject to the TIC's commitment to provide minimum guaranteed interest returns.
  - Amount of the TIC's Exposure on Guaranteed Benefits not fully funded by separate account.
  - The TIC's exposure to increased risk by policyholder behavior (e.g., partial withdrawals and surrenders under dollar-for-dollar guarantees or proportional guarantees, or movement of money within separate account or between separate account and fixed account options).
  - Surrender Charges remaining on Variable Products.
- <u>Determine the TIC's financial hedging transactions to support its Guaranteed Benefits and other obligations under its Variable and SEC Registered Products.</u>

c. Evaluate Options

- <u>Are the TIC's hedging programs adequate?</u>
  - Are the terms of the hedging programs adequate to protect the TIC from further financial loss if economy deteriorates?
  - Are the TIC's hedging program partners willing and financially able to satisfy their obligations under the hedging program agreements?
  - Is there any ability or opportunity to transfer, or to obtain hedging partner consent to transfer, the hedging program to a solvent assuming insurer that might be willing to assumptively reinsure the Variable Products and other SEC Registered Products and take over the Separate Accounts?
- <u>What administrative systems are in place to match daily the value of the Separate Account to each Variable Product?</u>
  - Are the systems adequate and working properly?
  - Who owns the systems? Does TIC own the systems, or does it license the systems or contract with a third party vendor to provide the systems?
- What regulatory or receiver actions might require disclosure to owners of Variable and other SEC Registered Products and/or the SEC under 1933 Act or 1940 Act?
  - Unless supported by Exempt SAs, Variable Products (or the unitized interest in the Separate Account) constitute "redeemable securities" under the 1940 Act. Section 22(e) of the 1940 Act provides that the issuer of a redeemable security registered under the 1940 Act may not suspend the right of redemption and must pay redemption proceeds within seven days. There is no clear legal guidance about whether a court with jurisdiction of TIC (i.e., the insurance company issuer of Variable Products) could order any temporary or partial restrictions (e.g., a temporary moratorium, or a temporary limitation on partial withdrawals or surrenders). A receiver should contact the SEC staff prior to seeking any order from the receivership court restricting withdrawals funded from a 1940 Act registered separate account. This includes partial withdrawals, full surrenders, death benefits, 1035 exchanges and similar transactions.



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  - Suspending acceptance of premiums under Variable and other SEC Registered Products raises disclosure issues under the federal securities laws, that is whether the insurer had adequately disclosed previously to those considering purchasing the contract that it had reserved the right to take that action in the future.

- Cash Out Offer with Waiver of Remaining Surrender Charges?

  - In cases where the economic value to TIC of remaining surrender charges plus ongoing fees on Variable Products are less than the economic burden of TIC's guarantees, offering incentives to owners of Variable Products to surrender by offering a "free" full surrender window should be considered.

  - Such offers should not create any preferences since Separate Account assets can be used only to support obligations under Variable Products. So, other policyholders should not be harmed, unless there could be an exposure to an anti-selection problem created by incentive.

  - Should explore possible 1035 exchange options with other insurers to minimize possible adverse tax impact on owners.

  - Any cash out offers involving Variable Products or SEC Registered Products likely would create disclosure obligations under the 1933 Act, and depending on the facts and circumstances for Variable Products, the possible need for no-action or exemptive relief under the 1940 Act.

- What Guaranty Association coverage for the Variable Products might be available?

  - Guaranty associations exclude from coverage any investment risk or other risks born by the Variable Product owners and/or not guaranteed by an insurer. Nonetheless, as either life insurance or annuities, Variable Products may be eligible for coverage by guaranty associations subject to this nearly uniform exclusion. The regulator or receiver should work with NOLHGA, which will coordinate with its member guaranty associations to evaluate coverage and the possible methods by which the guaranty associations may discharge their statutory obligations Early communications with the guaranty associations through the NOLHGA to help evaluate the possible guaranty association coverage and approaches for delivering that coverage, including with respect to compliance, operational, and other issues arising from the possible continuation of coverage of such products, would be an important piece of the approach.

- Are TIC's Separate Accounts UITs or Managed Separate Accounts or Exempt SAs? If the TIC structured its separate accounts as Managed Separate Accounts (i.e., actively managed and investing directly in securities), then it will be governed by a separate board of directors (sometimes called a board of managers) subject to specified duties and obligations under the 1940 Act.

  - What, if any, authority does the TIC have over the Separate Account Directors or their election or appointment?

  - What limitations exist on the actions of those in control of the Separate Account?

d. Coordination with Other Interested Federal Regulators

Other regulators may be involved with issues concerning the insulation of separate accounts assets, such as federal banking regulators concerning variable contract bank owned life insurance (BOLI)



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funded through the life insurer's separate accounts. Receivers should identify other interested federal regulators and establish lines of communication with them.

e. General Guidance for Receivers in a Future Receivership of a Trouble Insurer that Issued SEC Registered Products

Through discussions with SEC representatives about the national state-based system of insurance financial regulation and its insurance receivership process, the life guaranty system, and issues an insurance receiver might encounter in a rehabilitation or liquidation of a troubled insurer that issued SEC registered products (the insurer), general guidance for receivers was developed. The following guidance covers the SEC's role and identifies areas where receivers should be in communications with the SEC staff, and the receiver's own experienced legal counsel, about registered products and how the receiver might handle the products in the receivership.

i. SEC Staff Contacts

As part of the guidance, organizational points of contact at the SEC were established. Receivers will need to know how to reach the appropriate staff contacts at the SEC when involved in a receivership with insurance products registered as securities. The SEC's website contains contact numbers for SEC offices in Washington and for SEC's regional offices: *www.sec.gov*.

The Division of Investment Management regulates investment companies, variable insurance products, and federally registered investment advisers. Types of investment companies include mutual funds, closed-end funds, unit investment trusts, and exchange-traded funds. Information regarding the Division of Investment Management and how to contact them may be located on the SEC's website at *www.sec.gov/investment*.

ii. SEC's Role

Investor protection is central to the federal securities laws and the rules applicable to securities products, which includes insurance products that have been registered with the SEC as securities. A receiver benefits from understanding the SEC's possible role if the insurer enters receivership with registered insurance products in its product portfolio. The SEC is not a solvency regulator for insurance companies and, of course, is not a receiver. While the state insurance receivership laws of the state where the insurer is domiciled primarily govern the receiver's duties and obligations, any federal securities laws applicable because of the insurer's registered products would impact the receiver. The federal securities laws may require receivers to do certain things in terms of disclosure and compliance with federal securities laws, which may vary depending on the insurance product that is registered.

In addition to insurance products that are registered as securities, there are certain types of insurance products that are securities but are exempt and therefore not registered with the SEC.

iii. Insurer Receivership

In any receivership, it is important for the receiver to understand the nature of the insurer's business and how the insurer's products are administered. The receivership will be very fact specific and circumstance driven, given the particular contracts, the market at the time and the insurer's assets. What securities laws that might apply are based on the products the insurer issued (e.g., variable, fixed, indexed, etc.).

The receiver's team should include legal counsel qualified to provide advice on the federal securities laws the rules under those laws and compliance issues, and on how state receivership laws and federal securities laws might interact in a receivership. The receiver needs to ensure that communication channels are open with the SEC staff and needs to ensure that the



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requirements imposed by the federal securities laws and the rules under those laws are met. The receiver will communicate with the SEC staff during receivership. During rehabilitation and liquidation, the receiver stands in the shoes of the insurer and thus may have responsibility to comply with the federal securities laws applicable to the insurer and its separate accounts. In connection with the liquidation of the insurer, the extent of the guaranty associations' role and responsibilities would need to be analyzed based upon guaranty association triggering and the structure used by the guaranty associations in meeting their statutory obligations. As a practical matter, the structure could be that the guaranty association assumes or guarantees the contracts or transfers the contracts to another commercial insurer or a special purpose vehicle (SPV).

iv. Federal Securities Laws and Considerations Overview

The rules under the federal securities laws require that audited generally accepted accounting principles (GAAP) financial statements for the separate account (GAAP-basis) and the insurance company (GAAP, or statutory accounting principles [SAP], if permitted) be included in registration statements that are filed with the SEC[71]. There are also periodic reporting obligations under the 1934 Act that have to be complied with as well. The federal securities laws and the rules under those laws regulate registered Variable Products by requiring insurance companies to conduct operations in a certain way. The 1933 and 1934 Acts impose disclosure obligations with regard to registered Variable Products and the 1940 Act imposes disclosure and operating requirements on the registered separate accounts that issue those products. The Variable Products that must be registered with the SEC under both the 1933 Act and the 1940 Act are variable annuity (VA) contracts and variable life insurance (VLI) policies (unless there is an applicable exemption). These products must be registered because they are securities and the policy owner receives a pass through of the investment performance of the assets that are held in the separate accounts. The 1933 Act is a disclosure regime that requires a prospectus to be included as a part of the registration statement. The 1940 Act classifies separate accounts that insurance companies create to fund variable products as investment companies and generally requires that they be registered. A separate account is essentially a pool of assets under the control of the insurance company but where policy owners have a beneficial interest in the assets in that pool and in the financial performance of those assets. For that reason, the 1940 Act and the rules under that Act place stringent regulatory requirements on separate accounts. These requirements are similar to the requirements for mutual funds.

There are two types of insulated separate accounts that are used to fund VA and VLI products: 1) the managed separate account; and 2) the unit investment trust. Under a managed separate account, the separate account must have an investment advisor and a board of directors. See Section C (1), above. Under a unit investment trust, the insurer acts as a depositor, and the separate account has no board of directors. The managed separate account was the original VA and VLI funding vehicle; however, registered managed separate accounts are currently out of practice and rare.

In order to sell registered VA and VLI products, the insurer must file a registration statement under both the 1933 Act and the 1940 Act with the SEC. This registration statement includes a prospectus, statement of additional information, audited financial statements for the separate account and the insurer, and other exhibits. Top executives and directors of the depositor insurance company must sign it. The executives and directors who are required to sign the registration statement can be held personally liable for material misstatements or omissions in the registration statement. The statement must be refiled with the SEC at least annually to update the financial statements and any other changes in disclosure. A receiver of the issuer in a receivership would become liable for material misstatements or omissions in the registration

[71] See also footnote 64.



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statement. In a provision of a federal law passed in 1996, states are prohibited from requiring more or different disclosures in the prospectus for registered products than are required under the federal securities laws. The intent was to have uniform disclosure for nationally offered products.

Under the 1940 Act, Variable Products funded by a unit investment trust type of separate account are two-tiered products. The assets of a unit investment trust are unitized, are invested in shares of the underlying insurance-dedicated mutual funds offered in the prospectus for the variable product, and must be valued daily. The separate account is the top-tier investment company and the mutual funds are the bottom-tier investment company. Rule 22c-1 under the 1940 Act requires that daily valuation of the separate account units be done using forward pricing, meaning that the units of the separate account will not be priced until the close of business on the day when a contract owner makes a premium payment or requests a transaction involving separate account assets, or separate account assets are otherwise involved in a permitted transaction. A mortality and expense risk charge is deducted from the daily unit value of the separate account assets. Similar to the daily valuation of units, the 1940 Act has a daily redeemability requirement, which requires that units of the separate account must be redeemed at their value computed at the close of business on the day during which the units are tendered for redemption. Payout must occur within seven days. There is also a requirement for the daily pass-through of the investment performance of the underlying funds in which separate account invests such that each contract owner has a right to their proportional share of the monetized value of the separate account assets. A chief compliance officer must be appointed to ensure adherence to written compliance policies and procedures and to conduct an annual review of these policies and procedures. The SEC has multiple enforcement powers available to it, and a receiver of the issuer in a receivership is included within the purview of the 1940 Act. The separate account assets are recorded in book-entry form and there is no physical separation of assets.

There are other types of registered insurance products, such as: certain fixed annuities (and, potentially, life products) with market value adjustments (MVAs) and certain index-linked variable annuities (ILVAs) that must be registered under the 1933 Act. 1933 Act registration means that the insurance company must file a registration statement with the SEC to register the insurance product; the registration statement includes a prospectus that contains extensive disclosures and the signatures of the executives and directors of the insurance company, subjecting them to anti-fraud liability. The registration statement must contain the audited financial statements for the insurance company (as well as any third party guarantor or credit support provider) and be updated regularly. Registered MVAs, indexed life and annuities products and ILVAs may or may not be funded through a separate account; for these types of products there is no requirement that any separate account be insulated. In order for the separate account not to be registered under the 1940 Act, the separate account's investment experience cannot pass directly through to the contract owners. The separate account's insulation alone does not trigger 1940 Act registration. It is also possible to have aspects of both registered fixed and variable annuities in a single product.[72]

Securities that are exempted from the 1933 and 1940 Acts include certain Variable Products sold in the pension market (qualified products) and certain corporate owned life insurance (COLI) and bank owned life insurance (BOLI) products that otherwise might be deemed to be securities. Private placement VA and VLI products are also exempted, as it is assumed that the owners are highly sophisticated or have the financial wherewithal to sustain losses and retain consultants and/or representatives to help assure that they fully understand the investments. In addition, there is an exclusion in Section 3(a) (8) of the 1933 Act for traditional insurance products under which contract owners do not bear significant investment risk and which are

[72] Unregistered fixed account options are frequently included as an option in registered Variable Products.



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not regarded as securities. It is possible to have combined contracts, which includes annuity or life insurance products that are partially registered and partially excluded.

In regard to receiverships, the federal securities laws provide the SEC staff with several legal tools to protect the insulation of separate accounts. In a receivership situation, a receiver has a responsibility to comply with the requirements of the 1940 Act and 1933 Act. Under the 1940 Act, the receiver should preserve separate account insulation. A receiver should contact the SEC staff prior to seeking any order from the receivership court restricting withdrawals funded from a 1940 Act registered separate account. See Section C (3). If the product is SEC registered, the receiver generally must maintain the registration statement. The receiver generally must update and send prospectuses to investors at least annually,[73] and file updated registration statements meeting the requirements of the 1933 Act, which would include updated audited financial statements (including the consent of the auditing firm), and updated disclosures about a receivership and any contract changes.

An SEC order would be required to de-register a separate account. There can be a provision in the contracts, which reserves the right for the insurer to deregister a separate account, but there is usually nothing beyond that.

v. Rehabilitation

In rehabilitation, the receiver attempts to stabilize and improve the insurer's financial status while the insurer continues to operate. The receiver manages all aspects of insurer's operations and takes action necessary to remedy insurer's financial problems, to protect its assets and to run off its liabilities to avoid liquidation, while protecting its policyholders. Rehabilitation may be used to implement: 1) sale of the insurer; 2) runoff of claims, including a reduction in benefits due, including ratable payments on claims as they come due[74]; and/or 3) a transition to liquidation.

Upon assuming the insurer's management, the receiver will:

- Identify the types of insurance products to be administered during rehabilitation.
- Determine whether or not the products are registered with SEC.
    - Variable Products and Other SEC Registered Products: Receivers need to be aware that there may be products other than Variable Products registered with the SEC on the insurer's books. These other products may present different federal securities law compliance issues and different communications with the SEC
- Determine types of separate accounts supporting the products.
- Obtain copies of all reports filed with the SEC for the separate account and/or insurance products.
- Obtain registration statements and prospectuses, and all current agreements with reinsurers, distributors, credit support providers, guarantors, custodians and other service providers, and investment advisors/managers that are listed as exhibits in the registration statements.

[73] But see footnote 65.

[74] IRMA Section 403 provides that in the case of a life insurer, the rehabilitation plan may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for a period not to exceed one year from the date of entry of the order approving the rehabilitation plan, unless the receivership court, for good cause shown, shall extend the moratorium. As discussed above, a moratorium may not be feasible for variable products supported by a separate account registered under the 1940 Act.



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- Obtain Rule 38a-1 compliance policies and procedures and annual compliance reports for registered separate accounts.
- Obtain copies of any significant SEC orders or other relief applicable to the separate account that modifies the regulatory regime governing the account.
- Determine all guarantees provided with the products, and the standards governing those guarantees.
- Determine amount of the insurer's financial exposure not supported by separate accounts.
- Determine what laws (state, federal, and securities) apply to the SEC registered products and separate accounts, and evaluate options for proceeding in the rehabilitation.
- Review and evaluate the impact of and compliance with the applicable state receivership laws and federal securities laws applicable to the insurer and its registered products and any separate accounts, and evaluate options for proceeding in the rehabilitation.

Once the insurer enters rehabilitation, from an operations standpoint, the receiver should consider maintaining the insurer's infrastructure, compliance program, technology, fund managers, etc., unless there are credibility issues with them. Keeping the existing infrastructure, provided there are no inherent problems in it, is the least disruptive for the policyholders and should assist the receiver with complying with the requirements of the federal securities laws. The receiver will also need to make sure to retain the right people to manage the separate account assets and the SEC filings.

Receivership statutes permit use of a rehabilitation plan excusing certain of the insurer's obligations in order to address causes of the insurer's financial difficulties, but only under certain circumstances consistent with the primary goal of protecting policyholder interests.

- The insurer continues to operate and to pay claims in the ordinary course of business, subject to the possible imposition of a moratorium on policy surrenders and withdrawals and in rare cases on benefit payments (subject to any requirements applicable under the federal securities laws).
- The insurer's contract obligations and assets, and the market at the time, will all bear upon the viability of a rehabilitation plan.

It is envisioned that some of the actions a receiver might take in aid of insurer's rehabilitation—or in liquidation—could include: 1) imposing a moratoriums on contract owner's right to redemption to stabilize the block of business; 2) suspending owners' right of redemption; or 3) transferring the registered product business via an assumption reinsurance transaction. General guidance for receivers regarding these actions is covered in the discussion regarding Redeemability in Section G (4), below, and Possible Resolution of Blocks of Business in Section G (5), below.

vi. Liquidation

In liquidation, the insurer is no longer in business. The receiver will handle the registered products differently as the receiver must liquidate or otherwise dispose of all of the insurer's assets in the liquidation process. In liquidation, there will be no further sales of registered products.

Receivership statutes provide for termination of the insolvent insurer's contracts in liquidation (subject to continuation of the covered portion of contracts by the guaranty



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associations) and for all parties' rights and liabilities to be "fixed" as of a specific date (date of the insurer's liquidation order). Distributions are made according to a priority scheme, and policyholders are paid before other unsecured creditors.

There may be direct tension between the liquidation statutes' termination of the insolvent insurers' contracts and rights fixing, and the ongoing obligations of the receiver under the federal securities laws.

(a) Life Guaranty System Triggered

An order of liquidation with a finding of insolvency triggers protection from the life and health guaranty associations, assuring that at a minimum, covered policies will be honored to guaranty association levels of statutory benefits. National responses to multi-state insolvencies are closely coordinated between the receiver and NOLHGA. The receiver and the guaranty associations will collaborate on issues relating to the registered products business, including the assessment of what securities laws might apply because of registered products and any separate accounts, and evaluate options for proceeding in the liquidation.

Covered policyholders are protected in insurance liquidations: 1) by guaranty associations, discussed more below; 2) by special deposits that are held separately (not as general assets) for the policyholders in states requiring such deposits; and 3) by having an absolute priority status over general and other lower level creditors under the statutory priority scheme for the distribution of general assets contained in all state receivership statutes. Covered policyholders who hold policies that, among other things, required the insurer to hold assets backing some portion of the insurer's policy obligations in a separate account are further protected because the assets in the separate account can be used only to satisfy those insurer obligations under such policies that are supported by the separate account.

Once the guaranty association obligations are "triggered", the guaranty association becomes responsible for continuing insurance contracts and paying claims at least to the lower of: 1) the contract's limit of coverage; or 2) the guaranty association's statutory benefit level set forth in the guaranty association statutes. In the life and health insurance context, guaranty association statutes generally require that guaranty associations "guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured the covered policies of covered persons of the insolvent insurer," or issue substitute or alternative policies to replace the insolvent insurer's covered policies or contracts.

As a general matter, guaranty association statutes cover, subject to applicable maximum statutory benefit levels and other limitations/exclusions, life insurance policies and allocated annuity contracts[75] that are issued by a properly licensed life insurer and owned by residents of their state. Guaranty association statutes generally exclude coverage for that portion of a product not guaranteed by the insurer or where the risk is borne by the contract owner.

Even if a policy or annuity is not covered, either in whole or in part by a guaranty association, the policyholder or contract holder may be protected by the policyholder-level priority status in the liquidation.

[75] Coverage for unallocated annuities varies in accordance with the type of arrangement involved. Unallocated annuities are beyond the scope of this Chapter.


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(b) Assumption Reinsurance Transaction with Solvent Insurer

The existence of the guaranty association safety net and regulatory reforms since the 1990s generally has lessened risks for many policyholders in life insolvencies, including those with an interest in a separate account registered under the 1940 Act. In many cases, the guaranty associations (with respect to the covered policies) have looked for a buyer for the book of business. This would be structured as a sale of the book of business to a solvent insurer through an assumption reinsurance transaction funded by the insurer's estate and the guaranty associations. No-action letter relief would likely be sought from the SEC staff in connection with a transfer of the Variable Products backed by separate accounts registered under the 1940 Act, and also in connection with change in control issues arising from the liquidation.

In some of these transactions, contracts are restructured. Historically, separate accounts registered under the 1940 Act have not presented unique issues in these transactions, either because there were no such accounts or because the products relating to the separate account did not contain substantial general account guarantees, which helped facilitate selling the book of business (including the separate account) to a solvent insurer. This may not be the case in future insolvencies.

Where the insolvency is not entirely resolved through a transaction with a solvent insurer, the guaranty associations (with respect to covered contracts) and the insolvent insurer's estate will fund coverage and/or payments to policyholders through enhancement plans or through the traditional liquidation claims process.

vii. Securities Laws Considerations Post-Receivership

(a) Separate Accounts and General Account Guarantees

Receivers recognize that a properly established, insulated separate account supporting Variable and Other SEC Registered Products must be preserved and that the assets in the separate account are insulated and ear-marked and are thus protected from the claims of general creditors in the insurer's receivership. This is the same in both rehabilitation and liquidation.

There is a distinction between the variable contract holders' entitlement to separate account values (right to the monetized value of their proportionate share of the assets in the separate account) and insurer general account guarantees, which are subject to claims paying ability of the insurer. These guarantees include GMWBs, GMABs, GMIBs and GMDBs.

- Prospectuses should contain disclosure that general account guarantees are subject to the insurer's claims paying ability.

Claims associated with the insurer's guarantee of the Variable Product are claims against the general assets of the insurer. To the extent these claims are not covered/paid by a guaranty association, the claim would be treated as a policyholder-level priority status claim in the insurer liquidation proceeding. State receivership law would control the guarantees.

General guidance: In summary, the receiver needs to identify the types of insurance products to be administered during receivership, and review and evaluate the impact of and compliance with the applicable state receivership laws and federal securities laws applicable to the insurer and its registered products and any separate accounts. The receiver must administer the separate account in the same manner as the insurer pre-receivership, and must preserve the separate account insulation.



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(b) Securities laws require material information that might affect an investor's view of a company to be disclosed. The SEC staff's position has always been that it is up to the issuer to determine what is material and requires disclosure. It is likely that SEC staff would view entering into receivership (rehabilitation or liquidation) as a fact that would be material and require disclosure. Even prior to the state insurance commissioner's action against the insurer, the insurer would normally be in communications with the SEC staff about disclosure requirements.

General guidance: Initiation of receivership proceedings necessitates filings with the SEC and disclosure to owners of the registered products. Specifically:

- Receiver should be in communication with SEC about the receivership.
- Receiver will need to file updated disclosures regarding the receivership.
- Receiver will need to disclose the receivership to owners of the registered products.

In general, other stages of receivership that might be material and require disclosure include: 1) the rehabilitation plan filing; 2) variable contract changes; 3) liquidation; and 4) transfer of book of business to solvent insurer. There may be other points that are material and thus require disclosure.

(c) Registration Statements and Prospectus Disclosure – Supplementation Requirements

Receivers may seek guidance from SEC staff and experienced legal counsel on the need to keep current the Variable Product and Other SEC Registered Product registration statements, prospectuses and 1934 Act reports (if any) at different stages of rehabilitation. It is the responsibility of the receiver to make the determination as to what information is material (e.g., filing rehabilitation plan, etc.) and requires disclosure and a supplement of the prospectus. It is likely that SEC staff would view this information as material and that the supplement is required to be filed with the SEC and mailed to contract owners in order to put the investor on notice of the facts, including the fact that at some point, the reasonable investor needs to make a decision about further investment (premiums), transfers or withdrawals.

(1) Suspension of Sales

In liquidation, the insurer ceases selling and stops accepting premium on all policies and contracts. The SEC staff has previously issued no-action letters in connection with the rehabilitations of Confederation Life and Mutual Benefit Life confirming it would not pursue an enforcement action for violation of the federal securities laws where, among other things, the receiver stopped accepting any new premium under existing Variable Products and stopped filing amendments to the registration statements governing the Variable Products and separate account (e.g., filing updated prospectus) with the SEC after the Rehabilitation Order had been entered in reliance on the prior SEC no-action letter in Great–West Life and Annuity Insurance Company (avail. Oct. 23, 1990). See Aetna Life Insurance and Annuity Company, Confederation Life Insurance and Annuity Company in Rehabilitation (avail. Sept. 15, 1995). A receiver would be well-advised to consult with experienced legal counsel to determine whether the circumstances they face permit reliance on these letters or other applicable relief already provided by SEC staff. If the receiver decides it cannot comply with any federal securities law requirements because any Variable Products and/or Other SEC Registered Products remain registered securities under the 1933 Act and the separate account, if registered, remains registered as an "investment company" under the 1940 Act, the receiver should consult with experienced legal counsel and then SEC staff.



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Note that suspending acceptance of premiums under Variable and other SEC Registered Products raises disclosure issues under the federal securities laws, that is whether the insurer had adequately disclosed previously to those considering purchasing the contract that it had reserved the right to take that action in the future.

General guidance: If the insurer suspends sales, receivers should consult with experienced legal counsel regarding the need to obtain a no action letter from SEC staff regarding not filing updated registration statements and issuing updated prospectuses.

(2) Transferring the Registered Variable Product Business

General guidance: The receiver should be in communication with the SEC staff regarding plans to transfer a book of business to an assuming solvent insurer or plans to restructure the insurer's registered Variable Products, and should seek necessary approvals from the SEC. No action and/or exemptive relief under the 1940 Act should be considered in connection with such a transfer and change in control issues arising from the liquidation.

(3) Continuing to "Evergreen" Prospectuses and File Required Reports

Registration statements and other required reports generally would need to be kept up to date and filed in a timely manner with the SEC if the insurer continues to sell registered products in rehabilitation. Prospectuses would need to be kept up to date and mailed to existing contract owners.

(d) Redeemability

The 1940 Act requirement of redeemability is a primary concern of the SEC for Registered Variable Products. Receivers may potentially request the SEC to grant an exceptive order permitting the receiver to temporarily suspend the daily redeemability requirement and defer the variable contract owners' ability to redeem their contracts using separate account assets. Administrative, technical and/or operational issues preventing the receiver from processing redemptions may necessitate a moratorium on rights of redemption.

Exemptions from the redeemability requirement are rarely granted and are narrowly tailored to address the circumstances presented. Receivers need to be aware that:

- It would be necessary to communicate with the SEC staff and experienced legal counsel regarding potential delays in payments and request an exemptive order.
- Communications with the SEC staff and experienced legal counsel about what is happening and about how it is communicated to contract owners would be required.
- Further, the disclosure requirement may be triggered prior to the event that results in the above issue arising.

General guidance: The receiver should be in communication with the SEC staff and experienced legal counsel about any anticipated disruptions in payments or processing redemptions.

(e) Possible Resolution of Blocks of Business

It may not be possible to arrange a "pre-packaged receivership" that results in the immediate sale/transfer of the registered product business at the time of the insurer's



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liquidation order, due to the nature of products in the marketplace at the time (including guarantees provided with Variable Products). There may be a need to restructure the registered product contracts and cease accepting premiums. Note that ceasing to accept premiums on variable annuities with living benefit guarantees and on variable life insurance policies present challenging issues that are of concern to the SEC (e.g., new premiums may be necessary to achieve the policy owner's expected benefits under living benefit guarantees or to keep variable life policies in force).

Consideration also should be given to offering an exchange of the insurer's registered product contract, or offering to buy back the insurer's registered product contracts (e.g., offer more than the contract holder would get if they surrender but less than they would get if they died).

Determining how to proceed would depend upon the specific facts and circumstances of the company and its risk management policies, and the market at the time.

General guidance: The receiver should be in communication with the SEC staff and experienced legal counsel about any plans to restructure, transfer or exchange the insurer's registered product contracts.

## I. Large Deductibles

The purpose of these large deductible amounts is to reduce premiums for the insured while permitting the insured to meet statutory or regulatory insurance requirements. Large deductible policies are most common in the workers compensation area but may be found in other types of liability insurance.

Typically, a large deductible policy provides that the insurer will pay claims in full and then collect the deductible amount from the insured. Conversely, first party claims against an auto policy with a deductible are paid minus the amount of the deductible. To ensure that the deductible will be paid, most insurers that write this type of policy will require the insured to post some form of security. This can be a letter of credit, securities placed in a trust or escrow account for the benefit of the insurer, or some other form of a third-party commitment to reimburse for claims within the large deductible, such as a bond or large deductible reimbursement insurance policy. When the insurer pays a claim, depending on the agreement with the insured, the insurer may either submit a bill to the insured for the amount of the claim paid within the deductible or collect directly from the collateral.

As long as the insurer and the insured remain solvent, there are seldom any difficulties with large deductible arrangements. If the insured becomes insolvent and stops paying the deductible billings and if the collateral held is insufficient to pay current and future billings, the insurer's ability to collect the amounts due will be adversely affected.

If the insurer becomes insolvent and is placed into liquidation, the property and casualty and workers compensation guaranty associations will be triggered to begin paying claims. Just like the insurer, the guaranty association will be responsible for first dollar coverage of the claims. After the guaranty association pays the claim, the liquidator can then collect the amount of the claim within the deductible from the insured or the collateral. Historically, receivers and the guaranty associations disagreed on the disposition of these proceeds. Some receivers believe that the proceeds are claims based assets, similar to reinsurance recoverables, which should go into the general assets of the estates and be distributed *pro rata* to all claimants. The guaranty associations believe that, to the extent that the claim payment is within the deductible, they are not paying a claim on behalf of the insolvent insurer but rather on behalf of the insured and therefore, they should receive the reimbursement directly. ( See below for the most recent guidance from the NAIC indicating that the reimbursements should be refunded in full to the guaranty associations to the extent of their claim payments and not be treated as general assets of the estates. All enacted state laws on this point conform with this view. See also Chapter 6 of this handbook and *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980).



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The first significant incidence of large deductible policies in a receivership occurred in the administration of the Reliance Insurance Co. Estate. During the early years of this receivership, the guaranty associations paid several hundred million dollars of claims within large deductible limits. After extensive unsuccessful negotiations between the Pennsylvania liquidator and the guaranty associations, a suit was filed in the Commonwealth Court of Pennsylvania asking the Court to determine entitlement to the large deductible recoveries. The suit was rendered moot by passage of Act 46 of 2004 by the Pennsylvania General Assembly. Act 46 provided that the liquidator would collect the deductible reimbursements and deliver them to the guaranty associations that had paid the claims. The Act allows the liquidator to retain part of the reimbursements to offset the expense of collection.

Subsequently, several other states have enacted legislation addressing this issue modeled after the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act (NCIGF Model). On April 14, 2021, the NAIC adopted *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) that also addresses this issue Statutes vary by state, therefore, the receiver for a large deductible insolvency should review the applicable statutes of the domiciliary state and states where the claims will be processed.

- § 712 of IRMA requires the receiver to collect the deductible reimbursements as a general asset of the estate, but the amount collected is to be distributed to the guaranty associations that have paid claims within the deductible amount as early access subject to claw-back if the amount distributed ultimately exceeds the amount to which the receiving guaranty association would be entitled from the final estate distribution.

- Under Guideline #1980 subsection B, "Unless otherwise agreed by the responsible guaranty association, all large deductible claims that are also "covered claims" as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling." Refer to the Guideline subsection B for further discussion of deductible claims paid.

**J. Federal Government Claims**

The federal superpriority statute (31 U.S.C. § 3713) provides:

A claim of the United States Government shall be paid first when:

A. person indebted to the government is insolvent; and

    i. the debtor without enough property to pay all debts makes a voluntary assignment of property;

    ii. the property of the debtor, if absent, is attached; or

    iii. an act of bankruptcy is committed, or

B. the estate of a deceased debtor, in the custody of the executor or administrator, is not enough to pay all debts of the debtor.

This subsection does not apply to a case under Title 11:

- A representative of a person or an estate (except a trustee acting under Title 11) paying any part of a debt of the person or estate before paying a claim of the government is liable to the extent of the payment for unpaid claims of the government."

The statute has been on the books substantially in the above-referenced form since 1789.



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The last 100 years have produced much case law on the meaning of each key phrase in subsection (A) of the statute: how to define insolvent, whether one of the three triggering events has occurred and whether there is a claim owed to the federal government.

Similarly, there are many court decisions dealing with the meaning of subsection (B) which imposes personal liability upon a fiduciary who pays other creditors ahead of the federal government. The courts have adopted a broad definition of those subject to § 3713(b) liability, and a receiver of an insolvent insurer is certainly within the established meaning of the word representative. However, a fiduciary will not be liable under § 3713(b) for ignoring claims of the government unless he or she has actual knowledge of facts as would lead a prudent person to inquire about the existence of such claims. Where a receiver has actual knowledge of facts that indicate the existence of a possible liability to the U.S., the receiver may have sufficient knowledge of possible liabilities to be subject to the provisions of § 3713(b).

It should be noted that tax claims, including interest and penalties, are included in the meaning of debt under § 3713. Thus, a receiver should be aware that such tax claims could present complex questions and would require the assistance of a tax specialist.

As can be seen from the words of § 3713 itself, there is no express exception to the superpriority granted to the U.S. under § 3713. However, the Supreme Court has held that state liquidation priority statutes may give administrative expense priority over a debt due to the U.S.[76] There do not appear to be any reported cases inconsistent with that holding. Obviously, aside from the priority statutes and its effect on estate assets, a receiver has to be able to administer the receivership and bring assets into the estate for the benefit of the federal government and all other creditors. Similarly, the courts have created an exception for prior security interests, saying that the statute grants the federal government superpriority in the sharing of assets held by a debtor at the time that the insolvency described by the statute occurred; property (i.e., a specific perfected lien) transferred by the debtor prior to that time is beyond the reach of the statute.

Until 1993, courts were split on the issue of whether to follow the federal superpriority statute or individual state liquidation statutes which set forth distribution priorities. At issue was whether the federal statute preempted the state priority statutes, or whether the state priority statutes fell within the provisions of the McCarran-Ferguson Act, which provides, inter alia, that "[n]o Act of Congress shall be construed to … supersede any law enacted by any state for the purpose of regulating the business of insurance." In 1993, the U.S. Supreme Court settled the question by ruling that the federal priority statute must yield to a conflicting state statute to the extent the state statute furthers policyholders' interests.[77] However, the Court also held that the state statute was not a law enacted for the purpose of regulating the business of insurance to the extent it was designed to further the interests of creditors other than policyholders.[78] The Court found that the preference given by the Ohio statute to administrative expenses and policyholder claims was reasonably necessary to further the goal of protecting policyholders. The preferences given by the Ohio statute to employees and other general creditors, however, were found to be too tenuously connected to the regulation of insurance, and thus, these claims were held to be preempted by the federal statute.[79] State

[76] *U.S. Dept. of Treasury v. Fabe,* 113 S.Ct. 2202 (1993).

[77] *Id.*

[78] But see, *Ruthardt v. United States of America*, 303 F.3d 375 (1st Cir. 2002) where the court interpreted *Fabe* in deciding whether the federal claim priority statute preempted a state liquidation priority statute giving guaranty fund claims priority over federal claims. The First Circuit Court of Appeals stated, "*Fabe*'s premise was not that priority (over the United States) for policyholders is all right and priority for anyone else is not; *Fabe* itself upheld a priority for administrative expenses of liquidation (and apparently for administrative expenses of guaranty funds, too…) because these reimbursements facilitated payment to policyholders. …the question is one of degree not of kind." *Id. at 382.* See also Section IV of this chapter on Priority of Claims.

[79] In 1995, on remand, the District Court ruled that the Ohio priority statute was not severable and that, therefore, the entire priority statute was invalid because it gave priority to general creditors' claims over claims of the federal government. *Duryee v. U.S. Dept. of Treasury,* 6 F.Supp.2d 700 (1995). Soon after the District Court's decision, the Ohio Legislature enacted a new liquidation priority statute revised to comply with *Fabe*. Pursuant to the new statute, federal government claims have third priority to the assets of an insolvent insurer behind administrative expenses and policyholder claims. The statute was passed as emergency legislation and is intended to apply retroactively to pending insolvencies as well as prospectively.



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insurance liquidation priority statutes that put administrative expenses and policyholder claims ahead of federal government claims should be valid in light of the Supreme Court's ruling.[80]

However, the federal government may attempt to characterize some of its claims as post-receivership administrative expenses. Certain federal taxes, such as those incurred as a result of wages paid by a receiver to receivership employees or on interest income earned post-receivership, are easily seen as administrative expenses. The difficult cases are when income is the result of pre-receivership activity, but is considered to be earned post-receivership. For example, one court has held that although premiums may be paid up front, income resulting from the premiums is considered earned, for tax purposes, over the life of the policy.[81] Thus, although the estate did not receive cash, income was earned on a book basis, and the tax on the income was treated as a post-receivership administrative expense.

There is also case law to support the notion that the federal government is not subject to a state's claim filing deadline for proofs of claim in a liquidation.[82]

**K. Cut-Through Endorsements**

A cut-through endorsement is a contractual exception to the general principal of the reinsurance insolvency clause. It is an endorsement to the reinsurance agreement that redirects proceeds otherwise payable to the cedent's liquidator to the insured or mortgagee, pursuant to the reinsurance agreement's insolvency clause, in the event of the insolvency of the ceding company.

Cut-through endorsements are authorized by statute in many states. IRMA § 611H recognizes cut-throughs under very limited circumstances. Cut-throughs are narrowly construed by most receivers and are limited to situations where there is an express written provision and statutory reinsurance credit has not been taken on the cedent's financial statements. The policy rationale for this position is that it gives a preference in liquidation to such insureds or mortgagees and is thus unfair to other claimants who will receive a lesser portion of their claims when the assets of the estate are distributed. One court has termed the cut-through endorsement an improper preference and held that a reinsurer may not pay losses pursuant to a cut-through endorsement, but must instead pay the reinsurance recoverables to the liquidator.

**L. Equitable Subordination**

The theory of equitable subordination may be available to the receiver. Equitable subordination is a theory whereby the claims of one creditor are subordinated to the claims of other creditors to the extent necessary to redress harm caused by such creditor's inequitable conduct.[83] (A related remedy is to reclassify debt owed to a shareholder as equity. Reclassification is based on the grounds that the shareholder inequitably substituted debt for equity capital.)[84] The effect of equitably subordinating a claim is to postpone distribution on the subordinated claim until all claims in the same class (and higher priority classes) have been paid in full. Accordingly, recovery on the subordinated claim is eliminated or substantially diminished, thus increasing the recovery for other claims in the relevant class or classes.

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[80] Indeed, a state priority statute giving state guaranty associations the same priority as policyholders was also found to further the interests of policyholders. *Boozell v. United States,* 979 F. Supp. 670 (N.D. Ill. 1997). Applying the principles of *Fabe*, the Illinois District Court held that the Illinois priority statute's preference of guaranty association claims over federal claims is not preempted by the federal superpriority statute under the McCarran-Ferguson Act. The United States' appeal of this case was withdrawn. See also *State ex rel. Clark v. Blue Cross Blue Shield, Inc.,* 203 W.Va. 690, 510 S.E. 2d 764 (1998).

[81] *North Carolina, ex. rel. Long as Liquidator of Northwestern Security Life Insurance Co. v. United States*, 139 F.3d 892 (4th Cir. 1998).

[82] *Ruthardt v. United States of America*, 303 F.3d 375, 384 (1st Cir. 2002); *Garcia v. Island Program Designer, Inc.*, 4 F.3d 57 (1st Cir. 1993).
[83] See generally *4 Collier on Bankruptcy* 510.05 (15 ed. rev. 1997).

[84] See e.g., *In re Hyperion Enterprises, Inc*., 158 B.R. 555 (D.R.I. 1993); *In re Diasonics, Inc*., 121 B.R. 626 (Bankr. N.D. Fla. 1990). See also *In re Herby's Foods, Inc*., 2 F.3d 128 (5th Cir. 1993) (equitable subordination on similar theory).



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The doctrine of equitable subordination has long existed as a matter of general equity under the federal bankruptcy laws.[85] Accordingly, the remedy ought to be available in insurance insolvency cases. The standards to obtain equitable subordination differ depending on whether the holder of the claim was a fiduciary with respect to the insolvent company. When the defendant is a fiduciary for the debtor, "the burden is on the [fiduciary] … not only to prove the good faith of the transaction but also to show its inherent fairness from the viewpoint of the corporation and those interested therein."[86] On the other hand, to subordinate the claim of a non-fiduciary, the plaintiff must prove egregious misconduct.[87]

Equitable subordination may be useful as an alternative remedy for fraud, fraudulent transfer, breach of fiduciary duty or the like.[88] In fact, it may be the only remedy available as a practical matter when the target is another insolvent insurance company (or a debtor in a bankruptcy case). In that situation, an action against the target would be subject to the anti-litigation injunction in the target's proceedings. However, unlike other actions, equitable subordination should not be held to violate that injunction because equitable subordination addresses the treatment of a claim filed by the target in the insolvent insurance company's proceedings. The filing of such a claim subjects the target to the jurisdiction of the receivership court and should be held to waive any stay as to the filed claim.

It might be argued that equitable subordination is precluded by § 47 of the Liquidation Model Act which provides: "No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes [of § 47] through the use of equitable remedies," or by § 801 of IRMA which has the same language. That argument should fail. Equitable subordination (as proposed to be used here) is a collective remedy for the insolvent insurer's receiver, not a remedy for a specific shareholder, policyholder or other creditor of such insurer. Prohibiting individual creditors and shareholders from seeking subordination as to one another prevents individuals from delaying a receivership case with inter-creditor or inter-shareholder litigation. The same considerations do not apply to a collective remedy. Moreover, this language does not refer to the insolvent insurer's receiver at all but, rather, its prohibition is limited to certain persons other than the receiver. Accordingly, that provision should not be construed to prohibit the receiver from seeking subordination for the benefit of an entire class (or classes) of creditors.

### M. Inter-Affiliate Pooling Agreements89

In a typical pooling transaction, companies cede all of their premiums and losses to a single member of the group. In return, each of the ceding companies receives a designated percentage of the combined underwriting profits or losses of the group. A pooling agreement that has not been terminated is an executory contract that the receiver may either adopt for the benefit of the insolvency estate (if it is profitable) or abandon (if it is not profitable). When a group of companies have become insolvent, at least one receiver is likely to abandon the pooling agreement, thereby effectively discontinuing the agreement on a prospective basis for all participants.

Such abandonment would constitute a breach of the pooling agreement and would give rise to claims against the abandoning company's estate. These claims would have the same status and priority as general claims such as claims under abandoned reinsurance treaties. Thus, the claims would be junior to administrative expenses and the claims of policyholders. However, the claims may be subject to rights of setoff depending

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[85] See e.g., *Pepper v. Litton*, 308 U.S. 295 (1939); *Taylor v. Standard Gas & Elec. Co*., 306 U.S. 307 (1938).

[86] *In re Mobile Steel Co*., 563 F.2d 692, 701 (5th Cir. 1977). 11 USCS 510(c) may have rendered this requirement moot, see *In re Felt Manufacturing Co.,* 371 B.R. 589 (Bank. D.N.H. 2007).

[87] *In re Giorgio*, 862 F.2d 933 (1st Cir. 1988).

[88] See e.g., *In re Osborne*, 42 B.R. 988 (W.D. Wis. 1984) (remedy for misrepresentation); *In re Crowthers McCall Patterns, Inc*., 120 B.R. 279 (Bankr. S.D.N.Y. 1990) (remedy for fraudulent transfer).

[89] See generally H.S. Horwich and L.M. Weil, *Regulation of Inter-Company Pooling Agreements: An Insolvency Practitioner's Perspective*, Journal of Insurance Regulation, Vol. 16, No. 5 (Fall 1998).



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on state law. As such, if the receiver had a claim against another member of the pool arising under another agreement, that claim may be used to set off against the claim under the pooling agreement.

In cases where the pooling arrangement significantly contributed to the insolvency of the company, abandonment of the agreement could give rise to significant claims by other members of the pool. In such cases, the receiver will look for ways to avoid these claims, and, more importantly, to recover some of the losses that were paid prior to the commencement of insolvency proceedings. There are several remedies that may be available to the receiver: fraudulent transfer; breach of fiduciary duty; substantive consolidation; and equitable subordination. Each of these remedies involves proof that the pooling transaction was unfair to the insolvent company.

Under the Insurance Holding Company System Regulatory Act (Holding Company Act), a pooling transaction cannot be implemented unless the relevant insurance commissioners have determined that the proposed agreement is fair and reasonable.[90] [91]Thus, in an insolvency situation, other members of a pooling group may argue that a receiver is precluded from attacking the fairness of the pooling transaction due to the insurance commissioner's prior determination of fairness as to the insolvent insurer under the Holding Company Act. That contention should fail.

In order for an issue to be precluded in litigation based on a prior determination, the parties to the litigation must be the same. The insurance commissioner acting as regulator is a different party from the insurance commissioner acting as receiver. Thus, one of the requisites for issue preclusion is missing. In addition, for an issue to be precluded in litigation based upon a determination in prior proceedings, the issue decided in the prior proceedings must be the same as the issue to be precluded. A determination of fairness under the Holding Company Act is based on facts and circumstances existing at the inception of the pooling transaction. The losses resulting from a pooling transaction may have been caused by materially different circumstances than those considered at the inception of the transaction. Thus, an after-the-fact fairness determination in insolvency proceedings is not precluded.

Fraudulent transfer law may be available to recover amounts paid under the pooling agreement or to avoid obligations incurred pursuant to the pooling agreement on the basis that the relevant insurer did not receive reasonably equivalent value, fair consideration or the like in exchange for the payment made or obligation incurred and either was insolvent or became insolvent as a result. Fraudulent transfer statutes define a period in which transactions are subject to avoidance. Transactions that occurred prior to that period are not subject to avoidance. Thus, it is critical to determine when the transaction is deemed to have occurred. With respect to transactions under pooling agreements, the outcome of this issue varies by statute and also by jurisdiction. There are cases that hold that each segment of the transaction is to be evaluated separately as it occurs.[92] On the other hand, there are cases that hold that the fairness of an ongoing transaction is to be measured at the time of its inception and not thereafter.[93]

Fraudulent transfer law has special rules for inter-affiliate transfers. First, payments by a parent corporation for the benefit of its subsidiary generally are not deemed to be a fraudulent transfer if the subsidiary is solvent. However, if the subsidiary is insolvent, generally there is a contrary result.[94] Second, when corporate affiliates are operated as if they constitute a single business enterprise, courts recognize that, in

[90] See NAIC Insurance Holding Company System Regulatory Act §§5A(1), 5A(4),

91 Holding5(A)(6).

[91] Holding

[92] See e.g., *Rubin v. Manufacturers Hanover Trust Co*., 661 F.2d 979 (2d Cir. 1981).

[93] See e.g., Uniform Fraudulent Transfer Act §6(5).

[94] Compare *Branch v. F.D.I.C*., 825 F. Supp. 384 (D. Mass. 1993) (solvent subsidiary) with *In re Duque Rodrigue*, 77 B.R. 937 (Bankr. S.D. Fla. 1987) (insolvent subsidiary).



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certain circumstances, all affiliates benefit from the synergistic effort of the grouping.[95] Thus, benefit directly received by one affiliate may produce an indirect benefit or value to other members of the group. Arguably, a pooling arrangement benefits all of the members of the group because it gives them access to the combined financial strength of the group. However, where the pool's performance is poor, that defense is correspondingly weaker. Also, the indirect benefit defense may be unavailable if the insolvent insurer consistently suffered losses that it would not have suffered in the absence of its pool participation.

The law of breach of fiduciary duty also may provide a basis for another claim available to the receiver. Under this theory the receiver may obtain affirmative recoveries and may also avoid claims. The receiver would allege that a member of a pooling group or inter-locking management owed the insolvent company fiduciary duties with respect to the pooling arrangement. The receiver would further allege that those duties had been breached by causing the insolvent insurer to enter into, or remain subject to, the pooling arrangement.

In order to maintain a claim under this theory, the receiver must first establish the existence of a fiduciary duty. Directors of the insolvent company clearly owed fiduciary duties to the company; however, the duties of the pooling companies to each other are less clear. Generally, a parent company owes no fiduciary duty to its wholly-owned subsidiary, and affiliates owe no fiduciary duties to one another.[96] However, courts generally make an exception to that rule that imposes a duty on a parent company to a subsidiary when the subsidiary is insolvent or in a vulnerable financial condition.[97] In that situation, courts generally recognize the existence of a fiduciary duty running from the parent (or controlling affiliate) to the subsidiary and its creditors. Moreover, in some states, when a subsidiary becomes insolvent, its assets are deemed to be a trust fund for its creditors, and its parent owes a fiduciary duty to the insolvent subsidiary's creditors.[98]

Once a fiduciary duty has been established, there are questions as to the applicable level of scrutiny. Self-interested transactions are subject to closer scrutiny than other transactions. A pooling transaction involving a parent company and subsidiaries is a self-interested transaction for the parent. It may not be a self-interested transaction for officers and directors. In order to impose liability on inter-locking officers and directors, it may be necessary to show more than their concurrent presence on the boards of directors of the companies involved. It may be necessary to show that the individual benefited from the transaction personally. A better argument with respect to officers and directors may be that they aided and abetted a breach of the controlling company's fiduciary duties to the insolvent company.[99]

It may also be argued that members of a holding company group should be deemed to be fiduciaries for each other by virtue of the Holding Company Act. As noted above, under the Holding Company Act, all transactions within an insurance holding company system must be fair to the regulated company. As discussed below, that is the obligation that fiduciaries have to their charges. Accordingly, it may be argued that the Holding Company Act imposes liability in the event that the transaction was unfair.

The theory of equitable subordination may be used to subordinate pooling agreement claims of affiliates of the relevant insurers to the claims of general creditors of the insurer such as reinsurers. Equitable subordination may be useful as an alternative remedy to actions for affirmative recovery such as fraud, fraudulent transfer or breach of fiduciary duty. In fact, it may be the only remedy available to the receiver

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[95] See e.g., *Mann v. Hanil Bank*, 920 F. Supp. 944, 953-954 (E.D. Wis. 1996); *In re Miami General Hospital, Inc*. 124 B.R. 383 (Bankr. S.D. Fla. 1991).

[96] See *Anadarko Petroleum Corp. v. Panhandle Eastern Corp*., 545 A.2d 1171 (Del. 1988). It is reasonably well settled that a parent corporation does owe a fiduciary duty to a corporation when less than all of the subsidiary's stock is owned by the parent. See 18A Am. Jr. 2d *Corporations* § 773 (1985).

[97] See *Pioneer Annuity Life Ins. Co. v. National Equity Life Ins. Co*., 765 P.2d 550 (Az. Ct. App. 1988); see also *F.D.I.C. v. Sea Pines Co*., 692 F.2d 973 (4th Cir. 1982). cert. denied, 461 U.S. 928 (1983).

[98] See e.g., *Abraham v. Lake Forest, Inc*. 377 So.2d 465 (La. Ct. App. 1979), writ denied, 380 So.2d 100, writ denied, 380 So.2d 99 (La. 1980).

[99] See *Banco de Desarrollo Agropecuario, S.A. v. Gibbs*, 709 F. Supp. 1302 (S.D.N.Y. 1989).



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if the target affiliate is also in insolvency proceedings. That is so because, unlike suits seeking affirmative recovery, equitable subordination should not be held subject to the anti-litigation injunction in the target company's insolvency proceedings.

Equitable subordination may also be useful in cases where fraudulent transfer is unavailable because of limitations inherent in the statute or case law. For example, an obligation under a pooling agreement may not be avoidable under fraudulent transfer law because the obligation was deemed to be incurred at the time of the agreement and, as a consequence, occurred outside the look-back period. In that situation, an equitable subordination claim may be available based on the creditor company's failure to terminate the agreement once it became unfair to the insolvent company.

A receiver may also consider the use of the doctrine of substantive consolidation. When insolvency proceedings are substantively consolidated, inter-company obligations between the relevant insurers are eliminated. Accordingly, a receiver may consider substantive consolidation of insurers that are parties to a pooling agreement in order to effectuate the pooling of their assets and liabilities without the complexities of the pooling agreement.

## IV. PROPERTY/CASUALTY GUARANTY ASSOCIATIONS

### A. Introduction

This section addresses general legal concepts, highlights, points to be aware of and pitfalls to watch out for when dealing with state guaranty associations. Because guaranty association statutes will vary from jurisdiction to jurisdiction, the information contained here is necessarily general in nature. The NAIC *Property and Casualty Insurance Guaranty Association Model Act* (#540) is used as a base for this analysis as it typifies most guaranty association acts. Factual examples are drawn from cases that have decided important issues in the receiver/guaranty association relationship. When analyzing a specific problem, of course, the law of the jurisdiction should be consulted.

While most state guaranty association statutes essentially parallel the Model #540, there are notable exceptions. To the extent guaranty association do not cover an insured or third party claimant, the claimant may have a claim against the assets of the insolvent estate. Consequently, it is important for receivers to understand what issues arise in determining the extent of coverage, if any, by the state guaranty association system.

It is also important to be aware that a particular state's guaranty association only covers claims against insolvent insurers licensed to do business in that state. Thus, claims against nonadmitted insurers or excess and surplus lines carriers generally are not covered claims. (See Model #540 § 5H, which limits coverage to "an insurer licensed to transact insurance.")

Legal Status of Guaranty Associations

- Jurisdiction

  Jurisdictional issues often arise when a claimant files a lawsuit against a non-resident guaranty association and that court asserts jurisdiction over the non-resident association. An insured with liability coverage seeking indemnification or defense costs in a suit brought against it in one state may hope to obtain coverage from multiple state guaranty associations or from a foreign guaranty association that provides higher limits by bringing one or more foreign guaranty funds into the lawsuit. In this context, the issue is whether a particular state court can exercise jurisdiction over a foreign guaranty association.

  - In Personam Jurisdiction



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In a Florida case, an appellate court found that the trial court was not justified in asserting personal jurisdiction over a South Carolina insurer or the South Carolina Insurance Guaranty Association. The court based its decision on the minimum contacts test that requires that the defendant's contacts with a foreign state be such that the defendant could reasonably expect to be summoned into that state's court. Further, the defendant must purposely avail itself of the privilege of conducting activities within the state. [100]

Jurisdiction also becomes an issue when a suit against a guaranty association is filed in federal court and the court determines the citizenship of the guaranty fund for purposes of diversity jurisdiction. A plaintiff that files a diversity lawsuit in federal court must show that all plaintiffs have a different citizenship from all defendants. Some cases hold that a guaranty association is a citizen of each state in which one of its member insurers is a citizen. Therefore, federal diversity jurisdiction is often defeated and the suit must be dismissed.

Similarly, an unincorporated guaranty fund does not have its own citizenship.[101] Guaranty associations are comprised of all the insurers authorized to write policies in a particular state, and their citizenship is deemed to be the same as that of their members.

**B. Legal Disputes Over Triggering of Guaranty Associations**

An analysis of when guaranty association coverage is triggered should begin by assessing the purpose for which guaranty associations exist.

Generally, guaranty associations exist to protect the insurance consumer from harm caused by an insolvent insurer. The trigger for a guaranty association obligation regarding covered claims varies from state to state. The #540 § 5G states:

"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 transactions 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." This should be updated based on outcome of restructuring transactions revisions now pending at RITF.

, To be insolvent for guaranty fund purposes, the insurer must have been declared insolvent by a court of competent jurisdiction and, typically, have an order of liquidation rendered against it. A small minority of states trigger upon a finding of insolvency only. Liquidation and rehabilitation orders should be crafted such that all guaranty funds involved are triggered simultaneously. (See Chapter 6 of this handbook for more information.)

1. Court of Competent Jurisdiction

Ordinarily the e court of competent jurisdiction does not necessarily mean that only a court in the insurer's domiciliary state may issue the order of liquidation with a finding of insolvency. Generally, any court in any state may issue the order so long as certain requirements are met.[102] Usually, these requirements are: 1) the state has sufficient minimum contacts with the parties or the property to make exercise of its authority reasonable; 2) the state has entrusted exercise of that authority to the court in question; and 3) the state has provided the parties adequate notice and an opportunity to be heard. However, if the order is entered in any state other than the insurer's state of domicile, it will not trigger

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[100] *South Carolina Ins. Guar. Ass'n v. Underwood,* 527 So. 2d 931 (Fla. Dist. Ct. App. 1988); *contra Ruetgers-Neas-Chemical Co. v. Friemers Ins.,* 236 N.J. Super. 473, 566 A.2d. 227 (N.J. App. 1989).

[101] See *Rhulen Agency Inc. v. Alabama Ins. Guar. Ass'n,* 896 F.2d 674 (2d Cir. 1990).

[102] See e.g., *New Jersey Property - Liability Ins. Guar. Ass'n v. Sherran,* 137 N.J. Super. 345, 349 A.2d 92 (1975), cert. denied, 70 N.J. 143, 358 A.2d 190 (1976); *contra Fla. Ins. Guar. Ass'n. v. State,* 400 So.2d 813 (Fla. Ct. App. 1981).



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any guaranty association that has Model #540 language cited above other than the guaranty association in the state where the order is entered and only if there is specific statutory language authorizing the regulator to seek such an order.

a. Minimum Contacts

An insurer may satisfy the minimum contacts test in a number of ways. Some examples are: the insurer is authorized to do business in the forum state; the insurer maintains assets within the borders of the forum state; or the company maintains offices and transacts business within the forum state. Basically, if an insurer derives any benefits from a state or solicits business in that state, the insurer will likely satisfy a minimum contacts test for that state. A court in that state will then have competent jurisdiction over the insurer to declare the insurer insolvent, but not to commence a delinquency proceeding.

b. Exercise of Authority Entrusted to the Court in Question

The issue of whether a state has given a court authority to exercise its jurisdiction in an insolvency is readily answered. If a state statute authorizes the court to determine an insurer's insolvency, the court has been properly authorized.[103]

c. Parties Provided with Adequate Notice and Opportunity to be Heard

State court rules will dictate the requisite notice necessary to apprise an insurer of an insolvency hearing. Court rules also provide the hearing's procedural requirements. Such procedural safeguards rarely are breached and do not commonly affect a receiver's relationship with a guaranty association.

2. Order of Liquidation with a Finding of Insolvency

Guaranty association coverage under Model #540 definition is not triggered unless there is final order of liquidation with a finding of insolvency.[104] A finding of insolvency in a rehabilitation order is not sufficient to trigger guaranty association coverage in most states. However, since there are some states whose guaranty associations are triggered by the finding of insolvency alone, care should be exercised in the preparation of conservation and rehabilitation orders.

Problems may arise in determining when an order of liquidation is final. Generally, an order of liquidation does not become final until all possible appeals have been exhausted.[105] However, if an order of liquidation is not appealed, it is final on the date issued.[106]

3. Timing

Another issue may arise when determining the date of an insurer's insolvency and what obligations are triggered upon a determination of insolvency. Section 8A(1)(a) of Model #540 provides:

The Association shall:

- Be obligated to pay covered claims existing prior to the order of liquidation, arising within 30 days after the order of liquidation, or before the policy expiration date if less than 30 days after the order

[103] See *New Jersey Property,* 137 N.J. Super. at 345, 349 A.2d at 92.

[104] See *Young v. Shull,* 149 Mich. App. 367, 385 N.W.2d 789 (1986). See also *In Re Oil & Gas Ins. Co.,* 9 F.3d 771 (CA 1991) a bankruptcy order is not sufficient to trigger guaranty associations).

[105] Id.

[106] *Id.*



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of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within 30 days of the order of liquidation.

## C. Extent of Coverage of Guaranty Associations

Guaranty associations exist for the protection of first- and third-party covered claimants. This section addresses issues that may arise when determining whether a guaranty association is obligated by law to cover a particular claim. This analysis establishes some working guidelines for receivers to use when interacting with guaranty associations.

1. Model #540—§ 5H

Section 5H-of Model #540 defines a "covered claim" as follows:

(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:

(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



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

2. Covered Claims

a. Unpaid Claims

Under most guaranty association acts, to recover for a claim from a guaranty association the claim must be unpaid.[107] This requirement is primarily to prevent excessive or duplicative claim payments.[108] Though it may seem apparent whether a claim is unpaid, courts have addressed a variety of situations in determining this issue. For example, a claim draft issued by the insolvent insurer which is not honored because of the liquidation order is an unpaid claim and is the obligation of the guaranty association to the extent of the guaranty association's statutory limits.[109]

i. Insured Already Compensated

If a claimant has entered into an agreement with an insolvent insurer's policyholder not to levy execution on the insured's property in return for a guaranty of the unconditional receipt of the judgment amount, the claim may not be unpaid.[110] The agreement may render the claim unrecoverable against a guaranty association because the unconditional receipt effectively pays the claim.

Under the agreement, any amount the plaintiff recovered would benefit the insurer. The statutory scheme which established the guaranty association seeks to avoid shuffling of funds among insurers. Therefore, the association is excused from paying claims if the ultimate beneficiary would be an insurer.

Where other solvent insurers paid the claim and then sought recovery from the guaranty association, the court held the claim was not unpaid.[111]

ii. Insured versus Guaranty Association where Insured has not Satisfied Judgment

A guaranty association may have to indemnify an insured even where the insolvent insurer did not defend its insured's claim and the insured has paid nothing on an adverse judgment. In Missouri, an insurer refused to defend its insured and a judgment was then rendered against the insured.[112] Subsequently, the insurer became insolvent. Though the insured had not paid the judgment, the court granted the insured's indemnity claim against the guaranty association after it found that the judgment was a covered claim.[113] Whether the insured later satisfied the judgment creditors with the insurance policy proceeds was outside the guaranty association's scope.

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[107] See *Florida Ins. Guar. Ass'n v. Dolan,* 355 So. 2d 141, 142 (Fla. Ct. App. 1st Dist.), cert. denied, *Dolan v. Florida Ins. Guar. Ass'n,* 361 So. 2d 831 (Fla. 1978).

[108] See *Ferrari v. Toto,* 9 Mass. App. Ct. 483, 402 N.E.2d 107 (1980); aff'd, 383 Mass. 36, 417 N.E.2d 427 (1981).

[109] *Betancourt v. Ariz. Prop. & Cas. Fund,* 823 P.2d 1304 (Ariz. Ct. App. 1991).

[110] See *Florida Ins. Guar. Ass'n,* 355 So. 2d at 141.

[111] *P.I.E. Mutual Ins. Co. v. Ohio Guar. Ass'n,* 66 Ohio St. 3d 209, 611 N.E.2d 313 (Ohio 1993).

[112] *Qualls v. Missouri Ins. Guar. Ass'n,* 714 S.W.2d 732 (Mo. Ct. App. 1986).

[113] Id.



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b. Within the Coverage

All guaranty association acts require that to be covered, a claim must "arise out of and be within the coverage."[114] This provision requires that a claim meet a policy's coverage requirements before it will be paid.[115]

i. Claims Where Liability is to a Third Party

Generally, liabilities to third parties are considered covered claims. In the Missouri case described above, the guaranty association argued that because an insured had not paid the judgment against him, the insured's claim did not arise out of and was not within the coverage of the insurance policy. The court disagreed and held that the action arose out of the policy because the insured was liable to third parties. The exposure to liability amounted to the insured's suffering a loss arising out of the policy. Thus, covered claims may include an insured's action against a guaranty association for liability to a third-party.

ii. Settlements

Section 8A(6) of Model #540 provides:

The association shall:

(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 insured 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 its 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.

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[114] Model #540, *supra* note 96, at section 5F.

[115] See *Indiana Ins. Guar. Ass'n v. Kiner,* 503 N.E.2d 923 (Ind. Ct. App. 1987); see also *Treffenger v. Ariz. Ins. Guar. Ass'n,* 22 Ariz. App. 153, 524 P.2d 1326 (1974).



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(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.

In another Missouri case, an insured settled a claim with a third-party, and then sought reimbursement from the Missouri Insurance Guaranty Association.[116] The insured argued that the settlement payment constituted a covered claim. The court held that as a general proposition, a third-party claimant's decision to bypass a fund's claim procedure should not deny the insured otherwise available protection.[117]

However, the insured's legal obligation to the third party claimant was never adjudicated because the suit was voluntarily settled. The court reasoned that if the insurer had not become insolvent and since coverage was not an issue, the insured could not have successfully pursued reimbursement claims for settlements the insured voluntarily made. The insured was similarly barred from recovering from the guaranty association. Generally, a guaranty association statute gives an insured no broader rights against the guaranty association than those previously existing against the insurer.[118]

iii. Corporation Satisfies Third-Party Claim against Subsidiary

If a corporation voluntarily satisfies a judgment against its subsidiary where the subsidiary's insurer is insolvent, a guaranty association may not cover the corporation's claim. In an Illinois case, a corporation's subsidiary was found liable for wrongful death.[119] The corporation owned an excess general liability and automobile insurance policy which covered it and its subsidiaries. When the excess insurer became insolvent, the corporation itself satisfied the judgment against its subsidiary. However, because the subsidiary only, and not the parent corporation, was liable for wrongful death, the corporation's satisfaction of the judgment was not a loss arising out of and within the coverage of the insolvent insurer policy.[120]

Generally, "[a] corporation is an entity separate and distinct from its stockholders and from other corporations with which it may be connected."[121] Since shareholders of a corporation that includes other corporations will not ordinarily be liable for the debt and obligations of the corporation, satisfaction of the judgment was voluntary. The party making the claim under the guaranty association's act must be the same entity which suffered the loss arising out of and within the coverage. Thus, the corporation could not recover from the guaranty association.[122]

[116] See *King Louie Bowling v. Missouri Ins. Guar. Ass'n,* 735 S.W.2d 35 (Mo. Ct. App. 1987).

[117] *Id.* at 38.

[118] *Id.*

[119] See *Beatrice Foods Co. v. Illinois Ins. Guar. Fund,* 122 Ill. App. 3d 172, 77 Ill. Dec. 604, 460 N.E.2d 908 (1st Dist. 1984).

[120] *Id.* at 910.

[121] *Id.*

[122] *Id.*



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c. Subject to the Applicable Limits

Like the Model Act, each state provides that the guaranty association's liability shall be "subject to the applicable limits of an insurance policy to which this Act applies."[123] This language explicitly limits a guaranty association's liability to the limits of the policy in question. Most states also have a statutory cap, which ranges from a low of $100,000 to as high as $1 million. The policy limit or the statutory cap, whichever is lower, will apply to each covered claim (see Exhibit 6-1). (Michigan is a notable exception where the claim limit of $5million is tied to a COLA adjustment[1]) This graph should be amended when cyber provisions adopted by NAIC.

[1] Covered claims shall not include that portion of a claim, other than a worker's compensation claim or a claim for personal protection insurance benefits under section 3107, that is in excess of $5,000,000.00. The $5,000,000.00 claim cap shall be adjusted annually to reflect the aggregate annual percentage change in the consumer price index since the previous adjustment, rounded to the nearest $10,000.00. MI ST §500.7925.

- Recovery of Excess Denied

In a Washington case, a claimant appealed a judgment which denied her a recovery against the guaranty association in excess of policy limits.[124] The claimant alleged that because of the bad faith of her insolvent insurer, she should be able to recover the full amount of the bad faith award. The trial court denied the portion of the claim which exceeded the insured's policy limits.

The court found that bad faith claims are not covered claims.[125] The court also discussed the significance of the insured's policy limits. Because Washington's guaranty association statute stated that in no event shall the association pay a claimant an amount in excess of the policy's face amount, as a matter of law the claimant was not entitled to recovery above the policy limits.[126]

d. Unearned Premiums

Most guaranty association acts and the Model #540 specifically allow claims for unearned premiums.[127] Generally, there is a cap and deductible that will apply, and unearned premium recovery is limited to the extent that the insurer would have had to reimburse the insured.

- Assignments Allowed

In a New Jersey action, a claimant bank had financed insurance premiums.[128] The bank's customers had assigned to the bank all rights by which they might recover any unearned premiums from their insurer. After the insurer became insolvent, the bank sought to recover from the guaranty association unearned insurance premiums it had paid the insolvent insurer. The court held that, under certain circumstances, a claim for unearned premiums is a covered claim.[129] While the applicable act distinguished reinsurers' claims from others, it did not distinguish between individual and corporate claimants. Had the legislature intended to

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[123] Model #540, at Section 5H.

[124] See *Vaughn v. Vaughn,* 23 Wash. App. 527 (Wash. Ct. App. 1979), 597 P.2d 932, review denied, 92 Wash. 2d 1023 (1979).

[125] *Id.*

[126] *Id.* at 528.

[127] Model #540, at § 5H.

[128] See *Broadway Bank & Trust Co. v. New Jersey Ins. Ass'n,* 146 N.J. Super. 80, 368 A.2d 983 (1976).

[129] *Id.*



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differentiate between individuals and commercial assignees, it would have expressly done so.[130]

e. Residency and Location of Property

Generally, a guaranty association will limit coverage only to those insureds and third-party claimants who can meet certain residency and property location requirements. The Model #540 provides coverage to insureds or claimants who reside, at the time of the insured event, in the state where the individual seeks guaranty association coverage. If the insured or claimant is an entity other than an individual, the applicable residence is the state where its principal place of business is located at the time of the insured event.[131] A first -party claim for property damage is also covered if the property from which the claim arises is permanently located in the guaranty association's state.

i. Residence of Claimant

An individual, or other entity, must be a resident of the guaranty association's state at the time of the insured event to support a covered claim.[132] Therefore, the claimant must establish that it was a resident when the loss occurred, otherwise the guaranty association will not cover the claim. Disputes have arisen in attempting to determine the parameters of the residency requirements in a particular state.

In a New Jersey case, the court addressed whether a Delaware corporation was a resident for guaranty association purposes when it was authorized to do business in New Jersey and maintained its principal offices in New Jersey.[133] The court held that a corporate claimant need not be a domestic corporation to seek recovery from a guaranty association. Whether a corporation has established residence in a foreign jurisdiction for guaranty association purposes depends upon the aim and context of the statute containing the residency requirement.

The court noted that another important element in deciding residency was the extent and character of the business transacted in the state. The guaranty association act involved did not require the claimant to make contributions, direct or indirect, to the guaranty association. The critical issues were whether the insolvent insurer was licensed to transact insurance business in the state either when the policy was issued or when the insured event occurred. Because the claimant conducted substantially all of its business in New Jersey, the court found it was a New Jersey resident even though domiciled in Delaware.

ii. Location of Property

Guaranty association acts generally require that the property from which the claim arises must be permanently located in the state.[134] The New Jersey case described above also discussed the permanently located requirement. In that case, a sea-going dredge sustained damage covered by the policy.[135] Subsequently, the insurer became insolvent and the insured submitted a claim to the New Jersey Guaranty Association. The guaranty association argued that the dredge did not satisfy the permanently located requirement of the guaranty act. The court disagreed.

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[130] *Id.* at 986.

[131] See also *Kroblin Refrig. Express v. Iowa Ins. Guar. Ass'n.,* 461 N.W.2d 175 (Iowa 1990).

[132] See Model #540, at § 5H(1)(a).

[133] See *Eastern Seaboard Pile Driving Corp. v. New Jersey Property and Liability Guar. Ass'n,* 175 N.J. Super. 589, 421 A.2d 597 (1980).

[134] *Id.* at Section 5G(1)(b)

[135] See *Eastern Seaboard,* 175 N.J. Super. at 589.



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The court held that property is permanently located in a state when it has significant and continuing contacts with the state and no significant and continuing contacts with any other state. Because property can only have one permanent location under the guaranty association act, if it has significant and continuing contacts with more than one state, it will be deemed to have no permanent location.

The property's contact with New Jersey was found to be more significant. New Jersey was the home base of the dredge. The property was retained in New Jersey whenever it was not on a job. All repairs and refitting of the property were performed in New Jersey. Therefore, the property was permanently located in New Jersey within the meaning of the guaranty association act.

3. Non-Covered Claims

Guaranty associations do not cover all claims made against an insolvent insurer. In addition to the restrictions placed on a claimant by the definition of covered claims, are those claims which are specifically excluded by or are outside the scope of a guaranty association act.

a. Excluded Claims

Jurisdictions may differ as to which claims are specifically excluded from guaranty association coverage. Model #540 paraphrased, specifies that covered claims shall not include amounts awarded as punitive or exemplary damages; sought as return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool or underwriting fund as subrogation recoveries, reinsurance recoveries, contribution, indemnity or otherwise.[136]

b. Outside the Scope of Guaranty Association

Also not covered by guaranty associations are those claims that arise from areas deemed to be outside the scope of a guaranty association's obligations. Jurisdictions use different terms when describing which transactions are not covered by a guaranty association. Generally, however, these exclusions are similar. The Model #540, Section 3, provides:

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

A. Life, annuity, health or disability insurance;

B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;

C. Fidelity or surety bonds, or any other bonding obligations;

D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

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

F. Title insurance;

[136] See Model #540, at § 5H(2)(c).



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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 insured) 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.

c. Net Worth Exclusions

Some state guaranty associations exclude coverage for claims made by those who have a net worth greater than a statutorily provided limit. In Georgia, for example, the guaranty association will reject a first party claim if the insured had a net worth in excess of $10 million on Dec. 31 of the year preceding the date the insurer becomes an insolvent insurer; a third-party claim is excluded if the insured had a net worth in excess of $25 million on Dec. 31 of the year preceding the date the insurer becomes an insolvent insurer. However, the exclusion as to the third-party claimant will not apply where the insured is in bankruptcy.[137]

Michigan also has a net worth exclusion. The U.S. Court of Appeals has addressed the constitutionality of Michigan's net worth exclusion.[138] In that case, a plaintiff obtained a personal injury judgment in excess of $1 million against Borman's, a supermarket chain's corporate parent. Because Borman's insurer was insolvent, Borman's had to pay the judgment itself. Borman's then filed a claim against the Michigan Guaranty Association for money it would have received from its insurer.

The association rejected the claim because Borman's net worth exceeded Michigan's statutory limit. At that time, the Michigan Property & Casualty Guaranty Act excluded from its definition of a covered claim, "obligations to ... a person who has a net worth greater than 1/10 of one percent of the aggregate premiums written by member insurers in this state in the preceding calendar year."[139] After Borman's claim was denied, Borman's brought suit in the U.S. District Court seeking declaratory and injunctive relief and challenging the constitutionality of the Michigan statute.

The trial court found that net worth was not rationally related to a company's ability to absorb loss. Therefore, exclusion of certain insureds from guaranty association coverage violated the equal protection clauses of the U.S. and Michigan Constitutions. The court of appeals reversed. On appeal, the insured introduced testimony which suggested that net worth is not a reliable measure of a company's ability to absorb loss. However, because the constitutional test is "not whether the legislative scheme is imperfect, but whether it is wholly irrational,"[140] the court upheld the net worth exclusion.

- Assigned Rights Treated as Separate Claims

A premium financing company may stand in the shoes of a policyholder if there is a valid assignment of rights. In a Georgia case, an insurance premium finance company submitted a

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[137] 1990 Ga. Laws Section 33-36-3(2)(g).

[138] See *Borman's, Inc. v. Michigan Property and Casualty Guar. Ass'n,* 925 F.2d 160 (6th Cir. 1991), *reh'g, en banc,* denied, 1991 U.S. App. LEXIS 5159 (6th Cir. 1991).

[139] 1983 Mich. Pub. Acts Section 500.7925(3). Michigan's current statute has a $25 million net worth exclusion for first and third party claimants which is subject to annual increases based on the consumer price index.

[140] *Borman's,* 925 F.2d at 163.



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claim for the return of unearned insurance premiums on policies canceled due to an insurer's insolvency.[141]

The court reasoned that if each of the 3,127 individual Georgia policyholders had submitted a claim to the guaranty association, the unearned premiums would have been paid to them provided they had a net worth of less than, at that time, $1 million. Because the premium financing company asserted the claim for return of the unearned premiums as the policyholders' assignee and attorney-in-fact, the company stands in the shoes of the insureds.[142] The company was, therefore, entitled to all unearned premiums on the canceled policies to which the policyholders would have been entitled but for the assignments.

The court held that under these circumstances the limitation on net worth did not apply. The premium financing company's claims made pursuant to an assignment of policyholders' rights to recover unearned premiums are treated as separate claims not subject to an aggregate statutory claim recovery limit.

In addition to those states that exclude outright coverage of claims based on net worth are those states that have adopted the Model #540 provision that grants the guaranty association a right to recover from the insured proceeds paid on behalf of those insureds that exceed a statutorily provided net worth amount (see Model #540 § 13B). This type of net worth exclusion sometimes referred to as pay and recover is discussed below in the subrogation section.

## D. Primary Responsibility for Handling a Claim

Coverage Under More Than One Guaranty Association

In certain circumstances, more than one guaranty association may be obligated to cover a claim. Since coordination between state guaranty associations and the receiver is essential, receivers should understand the issues which arise in determining when dual liability attaches. The order of recovery is set forth in § 14B of Model #540as follows:

> 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 any other insurance guaranty association or its equivalent.[143]

## E. Late Claim Filing

Most guaranty association acts mandate that all persons known or reasonably expected to have claims against the insolvent insurer, receive adequate notice of the insolvency. Model #540 Section 8A(5), however, requires notice be sent only upon the Commissioner's request. The primary purpose of the notice requirement is to advise insureds of the claim filing deadline and to provide them with adequate time to file a claim. The insured's claim may be rejected by the guaranty association if it is filed after the deadline. Even though the insured may still seek recovery from the receiver, if no timely proof of claim form has been filed, the claim may be denied or designated to a lower distribution priority. However, if the insured is not provided with adequate notice of the insolvency and the procedure for filing a claim, the insured may

[141] See *United Budget Co. v. Georgia Insurer's Insolvency Pool,* 253 Ga. 435, 321 S.E.2d 333 (Ga. 1984).

[142] *Id.* at 337.

[143] Model #540, at Section 14B.



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be entitled to file a claim after the deadline has passed and may be entitled to benefits from the guaranty association.

Not sure of currency of this case.I

Jurisdictions may vary on specifics of claim notice requirements. The local guaranty association should be consultedThe filing deadline, or bar date, is one of the most important dates in guaranty association law. The Model #540 prohibits guaranty associations from handling any claims filed under the bar date.

Section 8A(1)(b) of the Model #540 sets forth this limitation:

> … Notwithstanding any other provisions of this Act, a covered claim shall not include any 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.[144]

In several state guaranty fund acts there is a "separate" bar date for claims against the fund. State law should be consulted in this regard. Courts have also addressed guaranty associations' obligation to cover late-filed claims. Most courts strictly uphold filing requirements. An Ohio court held that insureds who brought a claim against an insurance guaranty association after the expiration of the filing deadline were precluded from filing a claim against the guaranty association.[145] The court based its decision on an Ohio statute that permitted the court to set discretionary final dates for the filing of claims in liquidation proceedings.

The court found that the statute served a valid legislative purpose by allowing the early liquidation of insolvent insurers. Early liquidation benefited policyholders who would otherwise have to wait until all potential statutes of limitation had run before recovering from the estate. Further, the court reasoned that, even though their claims against the insurance guaranty association were precluded, insureds who brought late claims were still entitled to bring their claims against the estate of the insolvent insurer.

A similar decision was reached in a Michigan case.[146] An insured's untimely claim was accepted by the receiver in the insolvency proceeding. However, the court held that the insured's untimely claim was not a "covered claim" within the meaning of the statute because it was filed after the deadline. The court commented that the trend in other jurisdictions was to strictly preclude recovery for late claims. The allowance of delinquent claims prolonged distribution of an insolvent insurer's assets to the detriment of other claimants and adversely affected guaranty associations.

Conversely, a minority of states will allow a late claim upon a showing of good cause. Florida and Wisconsin may allow late claims where the insured was not aware of the claim's existence and filed it as soon as reasonably possible. California may allow a late claim upon a showing that the receiver was responsible for the late filing.

In some instances, the receiver may accept a late-filed claim as timely filed or as an excused late-filed claim. This determination is not binding and the guaranty association may still properly reject the claim as not timely filed.[147]

- Contingent and Policyholder Protection Claims

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[144] Post-Assessment Model Act, *supra* note 91, at Section 8A(1)(b).

[145] See *Ohio Ins. Guar. Ass'n v. Berea Roll & Bowl, Inc.,* 19 Ohio Misc. 2d 3, 482 N.E.2d 995, 15 Ohio G. 167 (1984).

[146] See *Satellite Bowl v. Michigan Property and Casualty Guar. Ass'n,* 165 Mich. App. 768, 419 N.W.2d 460 (1988), appeal denied, 430 Mich. 888 (1988); *In re Ideal Mutual, Midwest Steel Erection v. Ill. Ins. Guar. Assn.,* 578 N.E.2d 1235 (Ill. Ct. App. 1991).

[147] *In re Ideal Mutual, Midwest Steel Erection v. Ill. Ins. Guar. Fund,* 578 N.E.2d 1235 (Ill. App. Ct. 1991); *Monical Mach. Co. v. Mich. Prop. & Cas. Guar. Ass'n.,* 473 N.W.2d 808 (Mich. Ct. App. 1991).


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Some jurisdictions permit an insured to file a contingent claim in order to protect the right to bring a claim against the guaranty association. Other jurisdictions, however, prohibit policyholder protection claims and require specific claim information in the proof of claim forms. § 704 A of IRMA allows the filing of policyholder protection claims.

In an Illinois case,[148] an insured filed a policyholder protection claim prior to the deadline for filing claims but the insured's actual claims were not filed until after the deadline. The court held that the guaranty association was not obligated to cover the claims, regardless of the insured's ignorance of the loss prior to the deadline. The court reasoned that the statute's requirement that claims be filed on or before the last date fixed for filing of proofs of claim demonstrated a legislative intent to provide a cutoff date after which an insurance guaranty association would not be liable. The court found that the policyholder protection claim did not constitute a valid proof of claim. Thus, the claims brought after the cutoff date were not entitled to guaranty association coverage.

**F. Reinsurance Proceeds**

1. Awarded to Receiver

In the past, some guaranty associations have challenged a receiver's right to reinsurance proceeds. However, courts invariably award reinsurance proceeds to the receiver of the insolvent insurer.[149]

2. State-Created Reinsurance Fund Distinguished

A guaranty association may be entitled to reinsurance proceeds if the proceeds come from a state-created reinsurance fund and not a private reinsurer.[150] In a Massachusetts action,[151] a state-created reinsurance fund was set up to cover high risk policies. Under this scheme, insurers ceded high risk policies to a state-created reinsurer. After a ceding insurer became insolvent, a dispute arose between the insurer's receiver and the state guaranty association as to which was entitled to the reinsurance proceeds.

The court held that the guaranty association had a direct right to the proceeds the state-created reinsurance facility owed the insolvent insurer. The court reasoned that the reinsurance fund was created to benefit the public. To remit these proceeds to the receiver would give the estate, along with preferred creditors, a legislatively unintended windfall. The court held that it was the intent of the legislature for the association to recover the reinsurance proceeds.

3. Subrogation

Guaranty associations have also attempted to collect reinsurance proceeds from a reinsurer through the equitable doctrine of subrogation. Subrogation is the right of a party who has paid an obligation to

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[148] See *Union Gesellschaft Fur Metal Industrie Co. dba Union Frondenberg USA Co. v. Illinois Ins. Guar. Fund,* 190 Ill. App. 3d 696, 158 Ill. Dec. 21, 546 N.E.2d 1076 (5th Dist. 1989*); In Re Liquidations of Reserve Ins. Co., et al.,* 524 N.E.2d 555, 122 Ill. 2d 555 (1988) (claims of ceding insurers entitled to general creditor status, below claims of policyholders); *In Re Liquidation of Security Cas. Co.,* 537 N.E.2d 775, 127 Ill. 2d 434 (1989) (constructive trust and rescission claims of defrauded shareholders denied in view of statutory priority scheme, which provides exclusive remedy thus precluding use of inconsistent equitable remedies); *Morris v. Jones,* 545 U.S. 539 (1947) (full faith and credit clause required Illinois liquidator to recognize judgment entered post-liquidation by Missouri court against insolvent Illinois insurer); *Matter of Ideal Mutual Ins. Co. (Midwest Steel) v. Ill. Ins. Guar. Fund,* 218 Ill. App. 3d 1039, 578 N.E.2d 1235 (1st Dist. 1991) (policyholder protection claim not covered by Ill. Guaranty Fund because claim did not satisfy statutory requirement for timely proof of claim in the estate); *Kent County Mental Health Center v. Cavanaugh,*659 A.2d 120 (R.I. 1995); *A.O. Smith Corp. v. Wisc. Security Fund,* 217 Wis.2d 252, 580 N.W.2d 348 (Wis. Ct. App. 1998).

[149] See *Excess and Casualty Reinsurance Ass'n v. Insurance Comm'r of Cal.,* 656 F.2d 491 (9th Cir. 1981); *American Reinsurance Co. v. Insurance Comm'r of Cal.,* 527 F. Supp. 444 (C.D. Cal. 1981); *Skandia American Reinsurance Corp. v. Barnes,* 458 F. Supp. 13 (D. Colo. 1978*); Skandia American Reinsurance Corp. v. Schenck,* 441 F. Supp. 715 (S.D.N.Y. 1977).

[150] See *Massachusetts Motor Vehicle Reinsurance Facility v. Commissioner of Insurance,* 379 Mass. 527 (Mass. 1980).

[151] *Id.*



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collect money from another party who should have paid the obligation. In the reinsurance proceeds context, subrogation allows a guaranty association to step into the shoes of the insolvent insurer and acquire any right to reinsurance proceeds. However, just as a guaranty association has no right to direct payment of reinsurance proceeds, a guaranty association cannot obtain reinsurance proceeds by way of subrogation.[152]

A guaranty association will not have a right to reinsurance proceeds through subrogation due to the association's position after it pays a claim. A reinsurance contract is between the ceding company and the reinsurer. Courts have uniformly held that individual policyholders have no right to reinsurance proceeds because they are not parties to, or third-party beneficiaries of, the reinsurance contract. After a guaranty association pays a claimant, it is subrogated to the claimant's rights against the estate but not against the reinsurer of the estate. Therefore, because a claimant has no rights against the reinsurer, the guaranty association has no right to reinsurance proceeds.[153]

4. NAIC Proposed Reporting Guidelines

The domiciliary receiver has an important relationship with the reinsurer of an insolvent insurer, which may be complicated by the involvement of one or more guaranty associations. Reinsurers request loss reporting information from receivers, and guaranty associations often are the only repositories for this information. It is the receiver's responsibility to establish requirements for guaranty association reporting to the receiver.

The NAIC strongly encourages receivers to consult with guaranty associations and other receivers when creating reporting requirements. To enhance these relationships and the efficient administration of insolvent estates, the NAIC publishes Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers by Insolvent Property and Casualty Insurers. (See Exhibit 9-1.)

## G. Priority of Claims

Order of Distribution

The Liquidation Model Act sets forth the priority of distribution of claims from the insolvent insurer's estate. However, statutory priorities differ somewhat from state to state. The Liquidation Model Act requires that every claim in a class be paid in full before members of the next class receive any payment on their claims. It also prohibits the establishment of subclasses. Paraphrased, the order of distribution found in the Liquidation Model Act is:

Class 1. Costs of administration;

Class 2. Administrative expenses of guaranty associations;

Class 3. Policyholder, third-party claims and guaranty association claims under policies;

Class 4. Claims of the federal government other than under policies;

Class 5. Limited compensation for employee services;

[152] See *Excess and Casualty Reinsurance, 656 F.2d at 495; American Reinsurance,* 527 F. Supp. at 457.

[153] *Id.*



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Class 6. General creditor claims;[154]

Class 7. Claims of a state or local government for a penalty or forfeiture;

Class 8. Surplus notes or similar obligations;

Class 9. Claims of shareholders or other owners in their capacity as shareholders;

In IRMA, the order of distribution under Alternative 1 is:

Class 1. Costs of administration;

Class 2. Expenses of guaranty associations;

Class 3. Policyholder, third-party claims and guaranty association claims under policies;

Class 4. Claims under financial guaranty and mortgage guaranty insurance policies;

Class 5. Claims of the federal government other than under policies;

Class 6. Limited compensation for employee services;

Class 7. General creditor claims;

Class 8. Claims of a state or local governments, and claims for services and expenses in opposing the delinquency proceeding;

Class 9. Claims for penalties, forfeitures and punitive damages;

Class 10. Late filed claims;

Class 11. Surplus notes or similar obligations;

Class 12. Interest on allowed claims if approved by receivership court;

Class 13. Claims of shareholders or other owners in their capacity as shareholders.

Alternative 2 places defense and cost containment expenses of guaranty funds in Class 3, while remaining expenses of guaranty funds are in Class 2.

Realistically, administrative expenses and guaranty association expenses may exhaust the estate's assets. Therefore, policyholders must rely upon state insurance guaranty funds for the payment of claims and the return of unearned premiums. In addition to having its own statutory priority to the insolvent insurer's assets, a guaranty fund also is subrogated to the rights of the covered claimant against the insolvent insurer's estate.

### H. Early Access

Many states have adopted the early access provision in the Liquidation Model Act. An early access statute enables a guaranty association to obtain liquid assets from an insolvent insurer's estate prior to a final order of distribution. The purpose of the statute is to add to the guaranty association's capacity to pay policyholder

[154] Most states do not expressly refer to cedent's claims. *See In re Liquidation of Security Casualty Co.,* 127 Ill. 2d 434, 537 N.E.2d 775, 130 Ill. Dec. 446 (1989); *Foremost Life Insurance Co. v. Indiana Department of Insurance as Liquidator for Keystone Life Insurance Co.,* 274 Ind. 181, 409 N.E.2d 1092, 78 Ind. Dec. 346 (1980); *Neff v. Cherokee Insurance Co., in Receivership,* 704 S.W.2d 1 (Sup. Ct. Tenn. 1986); *Covington v. Ohio General Ins. Co.,* 99 Ohio St.3d 117, 789 N.E.2d 213 (2003).



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claims and expenses as well as reduce the necessity for assessments against solvent member insurers. § 38 of the Liquidation Model Act requires a receiver to submit to the court a proposal to distribute assets to guaranty associations:

> Within 120 days of a final determination of insolvency of an insurer by a state court of competent jurisdiction, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshaled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency.[155]

North Carolina has addressed the question of which associations will be subject to the early access statute.[156] The court held that the guaranty association was entitled to use funds from a special deposit. Pursuant to state statute, an insurer deposited funds with the state treasurer as a condition of doing business in North Carolina. After the insurer's insolvency, the guaranty association asserted a right to the deposit to cover claims and expenses. A "quick access" statute authorized the guaranty association to expend any insurer deposits. The court reasoned that these deposits were placed in trust for the protection and benefit of policyholders. Therefore, the guaranty association was authorized to expend the deposits to pay covered claims and all its expenses relating to the insolvent insurer.

In another case,[157] the court held that a guaranty fund was entitled to a credit balance held by a reinsurance facility. The court rejected the argument that the credit balance was an asset that the receiver could recover. The guaranty fund was perceived as standing in the shoes of the insolvent insurer since it paid all claims against the insurer. The court reasoned that by giving the money to the guaranty fund, it placed more money in the hands of the member insurers, thus lowering the fund's costs and policyholders' premiums.

IRMA's early access provision is at § 803, and its intent is to spell out all aspects of an early access plan thereby eliminating the need for an early access agreement.

## I. Guaranty Association's Right to Subrogation and Salvage on Claims Paid

1. Subrogation

When a guaranty association pays a claim on behalf of an insolvent insurer, the guaranty association is generally considered to step into the shoes of that insurer. Then, through subrogation, a guaranty association may seek indemnity from a third party as if it were the insolvent insurer.[158] Model #540 Section 8A(2) provides:

- The association shall…
    - be deemed the insurer to the extent of its obligation on the covered claims and to that extent 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.

Courts usually permit a guaranty association to seek subrogation.[159]

[155] Liquidation Model Act, at Section 38; IRMA §803 B.

[156] See *State of North Carolina v. Reserve Ins. Co.,* 303 N.C. 623 (1981).

[157] *North Carolina Reinsurance Facility v. North Carolina Ins. Guar. Ass'n,* 67 N.C. App. 359, 313 S.E.2d 253 (1984).

[158] See Model 540 at Section 8A(2). However, while the guaranty association does provide insolvency insurance, it does not "stand in the shoes" of the insolvent insurer for all purposes. See also *Biggs v. California Ins. Guar. Ass'n,* 126 Cal. App. 3d 641, 179 Cal. Rptr. 16 (2d Dist. 1981).

[159] See generally *Dan Reid Ford, Inc. v. Feldman,* 421 So. 2d 184 (Fla. App. 5th Dist. 1982).



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2. Subrogation Based on "Net Worth" or "Affiliation"

Similar to a net worth exclusion, some states statutorily provide the guaranty association the right to recover funds paid on behalf of persons who have a certain net worth or affiliation. Model #540 provides: for various options for treating claims of high net worth insureds. One option is for the guaranty fund to pay the claim and recover the payment from the high net worth insured. In another option the guaranty fund declines the claim in the first instance with an exception for cases of insureds in bankruptcy proceedings. [1]

[1] See NAIC Model 540 at Section 13.

State net worth provisions vary widely, so it is critical to consult a particular state's law when confronting a possible net worth issue.

## V. LIFE & HEALTH GUARANTY ASSOCIATIONS

This section addresses legal issues that have the potential to impact life and health guaranty associations and receivers. Because guaranty association statutes may vary from jurisdiction to jurisdiction, the information contained here is necessarily general in nature. The NAIC Life and Health Insurance Guaranty Association Model Act (#520) is used as a basis for this discussion, and factual examples are drawn from cases.[160] When analyzing a specific problem, the law of the subject jurisdiction should be consulted.

### A. Jurisdiction

Documents executed jointly by receivers and guaranty associations including Early Access Agreements typically will contain provisions that expressly address jurisdictional issues and often provide that the domiciliary liquidation court has limited jurisdiction over the guaranty association solely for the purpose of resolving disputes under the agreement. When the size of the liquidation or other factors require an enhancement agreement (enhancement of a deficient liquidation estate by means of a multi-state implementation of guaranty association statutory obligations, negotiated in concert through NOLHGA), typically the documents establish that jurisdiction regarding the powers and duties of the guaranty associations and the interpretation of their governing statutes is reserved to the state courts of each participating association. In addition, guaranty associations may exercise the right to determine these legal issues locally through declaratory judgment actions.[161]

Similarly, it has been held that personal jurisdiction over a foreign guaranty association could not be successfully asserted by a beneficiary who filed suit in the state of the policyholder's residence.[162]

In addition, attempts to have federal bankruptcy courts assert jurisdiction over insolvent insurers have failed, thus preserving the relationships between receivers and guaranty associations as established under state statutes.[163]

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[160] See NAIC Life and Health Insurance Guaranty Association Model Act [hereinafter Model #520].

[161] See *New Mexico Life Insurance Guaranty Assoc. v. Moore,* 93 N.M. 47, 596 P.2d 260 (1979).

[162] *Pennsylvania Life & Health Ins. Guaranty Ass'n. v. Superior Court,* 22 Cal. App. 4th 477, 27 Cal. Rptr. 2d 507 (Ct. App. 1994).

[163] *In the Matter of Estate of Medcare HMO,* 998 F.2d 436 (7th Cir. 1993); *In re Family Health Services, Inc.,* 143 B.R. 232 (C.D. Cal. 1992); *In re Master Health Plan*, 1997 U.S. Dist. Lexis 22880 (S.D. Ga. 1997).



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**B. Standing**

Courts have held that guaranty associations have standing to appear in any court with jurisdiction over the impaired insurer in order to enable the guaranty association to protect its interests and to address the best interests of the policyholders.[164] Model #520 contains similar language, although it recognizes that guaranty associations have the standing to intervene as well. Under Model #520, a guaranty association's standing to appear or intervene extends to all matters germane to the powers and duties of guaranty associations, including the determination of the policies or contracts and contractual obligations.[165] This provision also specifies that the guaranty association "shall also have the right to appear or intervene before a court or agency in another State with jursidiction over an impaired or insolvent insurer for which the Association is or may become obligated..." See 8(J).

In the context of a court proceeding to approve the settlement of a receiver's recoupment action, it has been held that guaranty associations should have access to the underlying records and should be afforded an opportunity to be heard, although without granting the formal status of standing.[166] A guaranty association that receives a valid assignment of an ERISA fiduciary breach claim can have derivative standing to bring such a claim. But on the facts of the case, the court held that ERISA preempts a state statute purporting to assign such claims by operation of law. Applying federal law, the court determined that the assignment was invalid because the fiduciary breach claims were not expressly and knowingly assigned to the guaranty association.[167]

**C. Abstention**

Some federal courts have declined to exercise jurisdiction over guaranty associations for the purpose of interpreting the provisions of the state guaranty association act, citing the principles of the Burford abstention doctrine.[168]

**D. Triggering of Guaranty Associations**

Guaranty associations primarily act after the entry of an order of liquidationwith a finding of insolvency. Some statutes give guaranty associations discretion to act in cases of an impaired insurer. However, this authority has never been exercised in the case of a multistate insolvency and rarely has been exercised in single-state insolvencies. (As noted earlier in this Chapter, IRMA 901 requires that guaranty associations be repaid in full for all amounts expended before a company can be released from a proceeding and allowed to continue as a going concern.) Some statutes empower guaranty associations to act only after the liquidation order becomes final.[169] In order to facilitate this, it is important that the receiver work with the guaranty associations at the earliest possible moment.

**E. Continuation of Coverage**

A primary concern with life insurance companies is continuance of a company's contractual obligations, which are generally long-term in nature. The state guaranty associations are required by the life and health

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[164] See *Maryland Life and Health Insurance Guaranty Association v. Perrott,* 301 Md. 78, 482 A.2d 9 (1984).

[165] See Model #520, at Section 8J.

[166] *In the Matter of the Liquidation of American Mutual Liability Insurance Co.,* 417 Mass. 724, 632 N.E.2d 1209 (Mass. 1994).

[167] *Texas Life, Accident, Health & Hospital Service Insurance Guaranty Association v. Gaylord Entertainment Co.,* 105 F.3d 210 (5th Cir. 1997).

[168] See *Metropolitan Life Insurance Co., et al. v. Wisconsin Insurance Security Fund,* 572 F. Supp. 460 (W.D. Wis. 1983); *Clark v. Fitzgibbons,* 105 F.3d 1049 (5th Cir. 1997), and *Feige v. Sechrest,* 90 F.3d 846 (3rd Cir. 1996). See also *Quackenbush v. Allstate,* 517 U.S. 706 (1996).

[169] See Model #520, *supra* note 147, at Section 8A.



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insurance guaranty association acts (many of which are patterned on Model #520) to ensure the continued payment of benefits similar to the benefits that would have been payable under the policies of the insolvent insurer subject to statutory limits. The basic purpose of this approach is stated in a comment to the Model #520, "Unlike the property and liability lines of business, life and annuity contracts in particular are long term arrangements for security. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar coverage from other insurers. The payment of cash values alone does not adequately meet such needs. Thus, it is essential that coverage be continued."[170] Similarly, the continuation of coverage is necessary in health and long-term care liquidations to avoid disruption in medical care, treatment and pharmacy services, and insureds may be unable to replace long term care coverage or certain limited or specialty health insurance products. Some guaranty associations may offer substitute coverage either by reissuing terminated coverage or issuing alternative policies.

**F. Assumption Reinsurance**

Whenever feasible, guaranty associations will attempt to find a company that will guarantee, assume or reinsure the covered policies and contracts of the insolvent insurer. Through early planning and coordination, the guaranty associations can evaluate options for transferring blocks of covered business and, in some cases, have one or more assumption reinsurance agreements in place to transfer blocks of business as of the effective date of liquidation. Life insurance insolvencies often involve many states because most life companies offer their products in multiple states. Coordination among the affected guaranty associations will be facilitated by NOLHGA. (See Chapter 6(III)(A).) In some cases, the liquidator may pursue a transfer of uncovered liabilities as well, to the extent the estate has assets sufficient to support the transfer of those liabilities. In that event, the liquidator and guaranty associations/NOLHGA will work closely together to coordinate the transfer.

Transferring guaranty association covered policy obligations to a solvent insurer, particularly when timed for the seamless transfer to be effective as of the liquidation date, requires negotiation and execution of assumption reinsurance documents and cooperation between the guaranty associations and the receiver on data and information transfer. The assuming carrier may be required to obtain approval of assumption certificates in the states where the insurer did business. NOLHGA may also need to consider a number of particular legal issues including policyholder notice, policyholder consent (if required), contingent liability accounting and preservation of tax losses or other tax benefits.

**G. Residency**

Following Model #520, all guaranty association laws limit their protection generally to policyholders who reside in the state.[171] However, there are exceptions to the resident-only coverage rules. For example, persons who are not eligible for coverage by the guaranty association in their state of residence due to the insurer not being licensed in the state are usually covered by the guaranty association of the domiciliary state of the insolvent insurer.[172] Finally, an emerging legal issue is the coverage eligibility of residents who are not citizens of the U.S.[173] Under Model #520, the situs of coverage for unallocated annuities is the state of the principal place of business of the plan sponsor.[174] The situs of coverage for structured settlement annuities is the residency of the payee.[175]

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[170] See Model #520, *supra* note 147, at, Section 8L.
[171] See Model #520, at Section 3A.

[172] See Model #520, at Section 3A(2)(b).

[173] See Texas Attorney General Opinion No. JM-1223, which determined that an individual need not be a U.S. citizen or a legal alien to qualify as a resident for purposes of guaranty fund protection.

[174] See Model #520, Section 3A(3)(a).

[175] See Model #520, at Section 3A(4)(a).



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### H. Eligibility of Insurer see chapter 6

### I. Exclusions from Coverage see chapter 6

### J. Benefit Limitations see chapter 6

### K. Priority of Claims

The priority of distribution from an insolvent insurer's estate may become the subject of differing legal interpretations, such as in the context of the appropriate priority for life and health administrative claims of various sorts submitted by guaranty associations. This issue also is addressed by the Liquidation Model Act and by IRMA. However, care must be taken to determine which version of the model has been enacted in the domiciliary state. With regard to the relative priority between claims of the federal government and guaranty association claims for both benefits paid and administrative expenses, recent cases appear to have preserved the statutory priority of the guaranty association claims, although there has been no final resolution of the issue to date.[176] This preservation of statutory priority to guaranty association claims over those of the federal government was confirmed in *Ruthardt v. United States of America*.[177] In Ruthardt, the United States Court of Appeals for the 1st Circuit reviewed the holding in *Fabe* and concluded that when the issue is the payment of promised benefits to policyholders or, as here, the funding of such payments, *Fabe* places the priority within the protection of McCarran-Ferguson. The court held that the federal claim priority statute did not preempt the priority accorded to guaranty associations' claims.[178]

### L. Early Access see chapter 6

### M. Enhancement Plans

In certain life insurer insolvencies, receivers working in cooperation with NOLHGA, affected guaranty associations, and in some cases the insurance industry, developed or supported innovative plans to protect policyholders. The most common arrangement involves a healthy company assuming the business of the insolvent insurer, with financial support from the receivership estate and guaranty associations. Other plans have included significant coordination with the insurance industry to protect the account values of uncovered policyholders in some circumstances and even the creation of a new insurance company by NOLHGA and the affected guaranty associations to assume the business of the failed insurer.[179]

Courts have held that these plans are sufficient to discharge the statutory obligations of individual guaranty associations and operate to bind individual policyholders who participate in the plans.[180] Guaranty associations take the position that policyholders who opt out of enhancement plans waive their rights to object to the method chosen by the association to discharge its obligations and have no further rights against the association. Courts accept this position with mixed results.[181]

[176] See *United States Dept. of Treasury v. Fabe,* 508 U.S. 491, 113 S. Ct. 2202 (1993); *Kachanis v. United States, et al.,* 844 F. Supp. 877 (D.C. R.I. 1994); *Boozell v. United States,* 979 F. Supp. 670 (N.D. Ill. 1997); *but see Garcia v. Island Program Designer, Inc.,* 4 F.3d 57 (1st Cir. 1993). Regarding priority in general, see also the Ohio *Duryee* decision discussed in Chapter 5.

[177] *Ruthardt v. United States of America*, 303 F.3d 375 (1st Cir. 2002).

[178] "[P]riorities that indirectly assure that policyholders get what they were promised can also trigger McCarran-Ferguson protection; the question is one of degree, not of kind." *Id. at382.*

[179] See e.g., the Rehabilitation Plans for Executive Life Insurance Company, Mutual Benefit Life Insurance Company, and Guaranty Security Life Insurance Company, and the Agreement of Restructuring for the liquidation of Executive Life Insurance Company of New York.

[180] *Lawrence v. Illinois Life & Health Guar. Assn.,* 688 N.E.2d 675 (Ill. App. Ct. 1997).

[181] Ruling for the association was *McCulloch v. Washington Life & Disability Ins. Guar. Assn.,* King County Super. Ct., Washington, Aug. 4, 1995; ruling the other way was a decision in an Illinois administrative ruling, *BW/IP International v. Illinois Life & Health Guar. Assn.,* Jan. 18, 1996.


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### N. Constitutional Issues

The constitutionality of the general guaranty association mechanism and assessment process was established by the Supreme Court of the State of Washington in a 1974 decision.[182]

A number of specific constitutional issues have been addressed by decisions involving property and casualty guaranty associations, some of which may be applicable to all guaranty funds. Virtually all courts addressing the issue have found that the application of a guaranty association statutory amendment to pre-existing claims does not violate constitutional standards.[183]

## VI. ACCOUNTING AND FINANCIAL ANALYSIS

The goal of the receiver should be directed toward making sure that accountants identify insurer and HMO assets, liabilities, operational needs, obligations (including, but not limited to, reinsurance treaties, excess of loss or stop loss policies and third party administrator agreements), transfers and conveyances so that the receiver can comply with the restrictions, limitations and requirements imposed upon the estate. It is important to identify, as early as possible, accounting issues that may require the employment of outside consultants (e.g., valuation of derivatives, swap agreements and retrospectively rated premiums).[184] The accountants play an integral role in the valuation of assets and liabilities, the determination of operational needs and the implementation or structuring of receivership plans. It is also important that books and records are organized so accounting objectives can be coordinated with the objectives of other sections including claims, auditing, legal and administration. Coordination is designed to preserve the insurer's assets, enhance asset recovery and to limit liability to the greatest extent possible. Tax issues are considered in detail in Chapter 3—Accounting and Financial Analysis, section on Tax Issues.

## VII. DATA PROCESSING

Data regarding an insurer that has been put into receivership is critically important for orderly receivership proceedings. Data can also constitute important evidence in legal proceedings. Typically, claims data is retained in electronic format and relevant records must be available to the guaranty funds at the point where they are obligated to pay covered claims. Chapter 2 of this Handbook provides more detailed information regarding use, handling, and control of electronic data.
. Electronically stored information presents a number of practical problems which may have important ramifications for the receiver's legal position. These practical problems include the following:

- Specialized skills. Retrieving the electronically stored information and presenting it in a meaningful fashion often requires specialized skills.
- Easily altered. The stored information can be modified, manipulated, copied or deleted easily and quickly.
- Portability. Because a large volume of information can be stored electronically in a small space, electronic information is more portable than a comparable volume of hard copy records.

The types of information the insurer may maintain in electronic form is as varied as the information used by the insurer. Often, the term "data processing" is assumed to refer only to the insurer's large system for keeping detailed data on policies, premiums, claims and other high volume transactions. However, other information, such as reinsurance transactions, agency information, accounting information, correspondence, customer lists, telephone

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[182] *Aetna Life Ins. Co. v. Washington Life & Dis. I.G. Ass'n.,* 83 Wash. 2d 523, 520 P.2d 162 (1974).

[183] See e.g., *Honeywell, Inc. et al. v. Minnesota Life and Health Ins. Guar. Ass'n.,* 110 F. 3d 547 (8th Cir. 1997), and *Reinsurance Association of Minn. v. Dunbar Kapple,* Minn. Ct. App. Aug. 1, 1989.

[184] The Insurers Rehabilitation and Liquidation Model Act and IRMA clarify the treatment of swaps and derivatives when an insolvent insurance company has been a party to one of these agreements (see Section 46 and Section 711 respectively). The general intent was to make the insolvency treatment of these instruments, for a failed insurance company, the same as for other financial services institutions.



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logs and even notes maintained by individuals may be maintained in electronic form. As used herein, the term "data" refers to any information maintained in electronic form.

Data will also be generated by the receiver after taking over the insurer. If the insurer is being rehabilitated, the type of data the receiver inputs and maintains will be substantially similar to the insurer's data, though it may be maintained in a different manner. If the insurer is being liquidated, the receiver's data will include additional and different data. Such data could include a claims tracking system to monitor the sending of notices and communications to potential claimants.

This subchapter will examine some of the ways in which electronically stored information may present unique legal issues for the receiver. This subchapter examines how to: 1) take control of data so as to minimize data loss; 2) secure the insurer's data that may be in the possession of uncooperative third parties; 3) examine any evidentiary problems that may arise from the loss of data maintained in a data processing system; and 4) examine the issues surrounding the discovery of data maintained by the insurer or imputed by the receiver.

### A. Taking Control of the Data

Seldom is all of the insurer's data stored in one integrated computer system. Typically, the insurer will have a large system that maintains detailed information, such as policies and claims, while other information, such as reinsurance recoverables, agent balances, investment portfolio and accounting information is maintained on other systems—most frequently personal computers (PCs). PCs are often used for word processing, spreadsheet and small database applications.

Data may not be located on the premises of the insurer. Some insurers still use off-site mainframe computer services on a time-sharing basis. Also, increasingly, the data processing functions for certain books of business are performed by managing general agents (MGAs), third-party administrators (TPAs), or other businesses associated with the insurer. In addition, even if the computer equipment itself is located at the offices of the insurer, persons outside of the insurer may have access to those computers. Information may also be maintained on portable laptop computers that officers of the insurer may easily carry away with them.

Because the data may be located off premises, the court order should direct the receiver to take control of all documents and records of the insurer, wherever situated, including insurer records maintained by agents, brokers, management contractors and third-party administrators with whom the insurer does business. The order should further enjoin any disposition or modification to those documents and records. In this regard, it should be noted that the Federal Rules of Civil Procedure, and state rules that are typically patterned after the Federal Rules, define documents as including "data compilations from which information can be obtained, translated, if necessary, by the respondent through detection devices into reasonably usable form."[185] In § 104V(3) of IRMA, the definition of "property of the insurer" or "property of the estate," includes:

> All records and data that are otherwise the property of the insurer, in whatever form maintained … within the possession, custody or control of a managing general agent, third-party administrator, management company, data processing company, accountant, attorney, affiliate or other person.

See also § 118 A. of IRMA, which requires TPAs, MGAs, agents, attorneys and other representatives of the insurer to release records to the receiver.

Once the order is obtained, the seizure must be executed in such a way as to minimize the likelihood that any valuable information will be inadvertently or deliberately lost. Typically, immediately preceding the seizure, the state's examiners will be focusing on the insurer. During this time, the examiners will obtain an understanding as to how the insurer maintains its data, where such data is located and who has access to modify the data. When fraud by officers or others with access to data is suspected, special efforts should be

[185] Fed. R. Civ. P. 34(a).



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made to execute the seizure in such a way as to preserve that data, especially private notes and communications that may be found on personal computers.

The decision as to whether a computer contains useful data should be made only by a data processing expert. Often, data that would appear to a novice to have been deleted from a computer can in fact be retrieved by a person who is knowledgeable about the computer system. This is especially true of personal computers. When a file is deleted from a personal computer, the file actually remains on the disk, but the computer designates the space occupied by those files as available to be overwritten with new information. A knowledgeable data processing person can recover the original file, which may contain valuable information.

**B. Legal Action Against Others to Obtain Data**

While a court order will permit a receiver to assert control over records of the insurer that are in the hands of third parties, it may be necessary to enforce the order against those parties. If the receiver believes that a third party will not voluntarily comply with the order, or does not trust the third party to properly comply with the order, it may be necessary to enlist the assistance of courts and law enforcement to obtain compliance.

The initial question is whether data in possession of a third party really is a record of the insurer. This question is typically answered by applying state law to the relationship between the third party and the insurer. Agreements between the insurer and agents, especially MGAs, may provide that the records of the agent, including not only policy and claims information, but also customer lists, are the property of the insurer. These agreements may also give the insurer the right to audit the third party and obtain copies of data in possession of that third party. Even without an agreement specifically designating the third party's records as the property of the insurer, applicable state law may impose trust or fiduciary obligations upon the third party deeming the third party's data as records of the insurer. Recent amendments to the NAIC Model Holding Company act also address this issue, calling for the data held by third parties to be considered the property of the receiver. More information about pertinent provisions of the current Model Holding Company Act is available in Chapter 2, Section IV. Recent Financial Examination Guidelines also address data segregation and convertibility to UDS for troubled companies.[1]

[1][1] NAIC Holding Company Act, See also General Examination Guidance, Chapter 3, General Examination Considerations.

Under these circumstances, the court order gives the receiver authority to take control of the records in possession of a third party. If the receiver expects an agent to be uncooperative, the receiver should make arrangements with local law enforcement officers in order to aid the receiver's representatives when executing the seizure order.

If the third party is located outside of the domiciliary state, the receiver will have to determine how to execute the seizure order in a foreign jurisdiction. If possible, the receiver should obtain the cooperation of regulators in the foreign jurisdiction. It may also be necessary to begin legal action in the foreign jurisdiction in order to seek enforcement of the seizure order entered by the court in the domiciliary state. If so, it may be preferable to initiate an ancillary receivership.

Such an order from the foreign jurisdiction's court may be sought *ex parte*, without notice to the third party. The order sought should allow the receiver to take immediate possession of the data processing equipment believed to contain the insurer's information, with adequate provision for safeguarding information that may belong solely to the third party or others. The order should direct that before control of the equipment is returned to the third party, a full back-up of all information in the computers should be made and maintained under the control of the receiver subject to further order from the court.



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The receiver's ability to obtain such an order from the court in another state is subject to many variables. For example, the likelihood of success in obtaining the order of the foreign court depends on how clearly state law recognizes the insurer's property interest in the data.

If the foreign court refuses to issue an order *ex parte*, then receiver's counsel should send the third party a letter. Notice of the suit and a request for a temporary injunction should accompany this letter. The letter should set forth the insurer's position that it has a property right in the data, should demand that the insurer not destroy any back-up copies of the data and should state that the receiver will hold the agency fully accountable for any information that is lost. To the extent that the insurer's contact with the third party gives the insurer the right to audit the third party, that right should immediately be asserted and an audit should immediately follow.

Once the receiver obtains access to the data, persons knowledgeable about the type of equipment and software utilized by the third party should retrieve the data. For customized systems, this may require the assistance of one or more employees of the third party. The receiver should make efforts to recover information which may have been recently modified or deleted by the third party's personnel.

### C. Potential Problems Arising from Loss of Data

Problems that can arise from loss of data are as varied as the types of data used by the insurer or the receiver. The discussion to this point has focused on how the receiver can minimize the loss of data used by the insurer at the time the receiver takes control of the insurer. This section will examine some typical problems which may result from the loss of insurer data. It will also examine problems which may arise from loss of data the receiver inputs after the takeover.

In any action brought by the receiver to recover assets of the insurer, the receiver, as plaintiff, will typically bear the burden of proving that the defendant is liable and the amount for which the defendant is liable. Once liability is established, most states require that the amount of damages need not be proven with mathematical precision, but can be based upon a reasonable estimate. Speculative damages, however, may not be recoverable.

Data typically relates most directly to the amount of damages recoverable in an action by the receiver. What data relates to those damages will depend upon the nature of the action and the receiver's theory of damages. In some cases, the amount recoverable will be calculated in a straight-forward manner from a limited amount of data. For example, a claim for unpaid premiums against an agent requires that the receiver know the amount of premiums due from an agent and the amount actually received. In other cases, including cases against the insurer's directors and officers or outside accountants, the damage theory may base the amount of damages upon the insurer's financial status at different times.

Regardless of the type of case, the amount of damages will be calculated from the data maintained by the insurer. To the extent that the data is impaired, estimates will need to be used. As the need for estimation increases, so does the likelihood that the court may find the ultimate damage figure too speculative to use for an award to the receiver.

The loss of data by the insurer also impairs the receiver's ability to challenge information offered by the opponent. In the minds of most lay people, detailed computer output carries a great aura of accuracy. However, computer data may easily be manipulated. Furthermore, in the final analysis, the computer output is no more accurate than the information that was put into the computer (garbage in, garbage out). To the extent that the insurer lacks its own independent data from which it can assess the amount owed, the receiver's ability to challenge the data provided by the opponent will be impaired.

In certain cases, the availability of detailed data may influence the basis for the damage calculations. For example, when pursuing the directors and officers on claims of mismanagement or misconduct, counsel typically has a choice of damage theories available. Under one damage theory, the amount of damages may be arrived at by adding up losses sustained on a number of individual transactions or programs claimed to



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have resulted from mismanagement or misconduct. These damages are not easily calculated, however, if the data regarding these transactions or programs has been lost. This may force counsel to select an alternative damage theory, premised on the net shortfall of the insurer at the time it was put in receivership or the net shortfall in satisfying claims during liquidation. Such theories present difficult legal issues, but the amount of damages arrived at under such theories can often be determined from overall financial statement information which is sometimes available without the detailed data.

Data also can be important evidence of liability. If the officers are suspected of fraud, a possible suit by the receiver against them should be anticipated. Such a suit may involve claims under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 USCS §§ 1961, et seq. Those claims may be predicated, in part, upon telephone calls made to further the fraud. Most telephone systems frequently maintain a record of all calls made by the insurer. This data may be important evidence of wire fraud.

Accidental loss of data put into the system by the receiver may also have adverse legal consequences. For example, a claimant may file a claim after the deadline for filing claims has expired, arguing that the receiver never gave proper notice of a claims deadline. Typically, the receiver would rebut such an argument by producing to the court claims tracking data which establishes that the claimant was properly sent a notice of the deadline. Accidental loss of data from the claims tracking system may expose the receiver to a reopening of claims by a claimant who asserts lack of proper notice.

These examples present only some of the potential legal ramifications of data loss. Before destroying data, the receiver should consult with counsel to minimize the risk that any data destroyed will have adverse legal impacts.

**D. Discoverability of Data**

The Federal Rules of Civil Procedure, and the rules of most states which were patterned after the Federal Rules, make clear that the same rules regarding discovery apply to information stored electronically as to any other information maintained by a party to litigation. Rule 34 of the Federal Rules of Civil Procedure permits any party in litigation to request the inspection and copying of any designated documents, and specifically defines "documents" as including "other data compilations from which information can be obtained, translated, if necessary, by the respondent through detection devices into reasonably usable form."

The Advisory Committee Note of 1970 comments on this definition as follows:

> The inclusive description of "documents" is revised to accord with changing technology. It makes clear that Rule 34 applies to electronic data compilations from which information can be obtained only with the use of detection devices, and that when the data can, as a practical matter, be made usable by the discovering party only through respondent's devices, respondent may be required to use his devices to translate the data into usable form. In many instances, this means that respondent will have to supply a printout of computer data. The burden thus placed on respondent will vary from case to case and the courts have ample power under Rule 26(c) to protect respondent against undue burden or expense, either by restricting discovery or requiring that the discovering party pay costs. Similarly, if the discovering party needs to check the electronic source itself, the court may protect respondent with respect to preservation of his records, confidentiality of nondiscoverable matter and costs.

Analysis of whether data is discoverable is analytically the same as discovery of other documents or tangible items. The Discovery section of this chapter discusses, in detail, general issues with respect to discovery.

When discovery of data is sought, the respondent must provide that data in reasonably usable form. What that means will depend upon the nature of the data sought. Typically, it is interpreted as requiring the respondent to produce computer printouts. Such printouts may not disclose tampering with the data before it is printed out. Printouts may also provide parties seeking discovery with less information than a copy of the computer data in computer readable form. For example, a computerized printout of accounting information may not communicate underlying relationships between the data which would be disclosed by



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viewing the underlying formulas. If the information is provided in computer readable form, the underlying formulas may also be disclosed, unless the respondent copying the data takes certain precautions. The medium in which the information will be provided should be considered whenever data is requested from the receiver or by the receiver in litigation.

## VIII. INVESTIGATION AND ASSET RECOVERY

### A. Introduction

The purpose of this section is to introduce and discuss various fundamental legal issues that have been or may be raised in receiver lawsuits seeking recovery from those who may be liable to the insolvent insurer's estate in connection with an insurer's insolvency. The legal matters reviewed herein are by no means conclusively established; consultation with counsel is essential.

Jurisdictional issues discussed in detail in this chapter in section II(H)—Important Legal Procedural Issues, should be considered in connection with matters discussed in this section.

1. Receiver's Authority to Sue

The authority of the receiver to assert a cause of action is established by relevant state statute and the receivership court's order, see also § 402 and § 504 of IRMA.

2. Receiver's Standing

It is now well established throughout the U.S. that the breadth of a receiver's standing is defined by the language of its statutory authorization. Statutes that vest the receiver with "title to all property, contracts and rights of action of the company" are typically construed to authorize the receiver to bring any suit the company could have brought, but no others.[186] One state has held that only a statute that specifically authorizes the receiver to sue on behalf of third persons creates standing for the receiver to sue on claims that the company could not itself have pursued.[187]

Even where a receiver's authorization is limited to suits on behalf of the company, there are many types of claims that may be pursued. For example, various courts have upheld a receiver's standing to assert claims against an insurer's shareholders, directors and officers for breaches of fiduciary duty and corporate waste, against a controlling stockholder of the insurer for federal securities fraud and breach of fiduciary duties, to enforce an insolvent insurer's creditors' rights against a title company, to set aside fraudulent transfers and to bring an action on behalf of the insurer's policyholders and creditors against a director-majority shareholder for mismanagement and breach of fiduciary duties. Courts have found that both rehabilitators and liquidators enjoy this standing.[188]

One important potential limitation on the standing of a receiver to assert a claim on behalf of the insolvent insurer's creditors may arise from the nature of the creditors' claim. If the claim is one in favor of creditors, in general, arising out of injury to the insolvent insurer and, therefore, injury to creditors of the insurer, the receiver will ordinarily have standing to assert the claim. If, however, the claim is one for special damage done to one group of creditors not common to other creditors, then the

[186] E.g., *Schacht v. Brown,* 711 F.2d 1343, 1346 n.3, (7th Cir.), *cert. denied,* 464 U.S. 1002 (1983).

[187] See *Frank J. Delmont Agency, Inc. v. Graff,* 55 F.R.D. 266 (D. Minn. 1972) for a discussion of such a statute. The Minnesota statute construed as authorizing the receiver to assert a creditor's claim, is Minn. Statutes § 60B.25, which provides: "Subject to the court's control, the liquidator may… (13) Prosecute any action which may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer, or any other person."

[188] See, e.g., *University of Maryland v. Peat Marwick Main & Co.,* 923 F.2d 265 (3d Cir. 1991); *Grode v. The Mutual Fire, Marine and Inland Ins. Co.,* 1991 U.S. Dist. LEXIS 16850 (E.D. Pa. 1991); *Commissioner of Ins. v. Arcilio,* 221 Mich. App. 54, 65-66, 561 N.W. 2d 412 (Mich. App. Ct. 1997); *Foster v. Peat Marwick Main & Co.,* 587 A.2d 382 (Pa. Commw. 1991).



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action may be found to be personal to the injured creditors and the receiver may not have standing to bring the action.[189]

While it is well established that the receiver has standing to bring suit, states are divided on the question of whether that standing is exclusive. That is whether the fact that the receiver had standing to assert a claim on behalf of a creditor or policyholder of the insolvent insurer precludes that creditor or policyholder from asserting that same claim on his or her own. Some states have said that the receiver's right must be paramount and exclusive so as to avoid disorder and confusion in the administration of the insolvent insurer's affairs. § 504 A(10) of IRMA provides in relevant part:

> The liquidator shall have the power: …. To prosecute or assert with exclusive standing any action that may exist on behalf of creditors, members, policyholders or shareholders of the insurer or the public against any person, except to the extent that the claim is personal to a specific creditor, member, policyholder or shareholder and recovery on the claim would not inure to the benefit of the estate…

Courts in other states have ruled, however, that while the receiver clearly has standing to represent injured policyholders and creditors of an insolvent insurer, standing is non-exclusive. The receiver should consult counsel to determine whether the receiver's standing is exclusive or non-exclusive in the applicable jurisdiction.

**B. Audit/Investigation of Financial Statements**

The question of the accurate preparation of financial statements is at the core of the management's duty to the insurer, and thus, at the heart of the receiver's analysis of the insolvent estate. The following is a discussion of potential claims against third parties for their willful and/or negligent damage to the insurer through their acts leading to the misrepresentation of the insurer's financial condition. It must be stressed, however, that any potential claim and/or suit must be evaluated by the receiver's attorneys to determine the utility and the cost-effectiveness of bringing the claim and/or suit.

1. Claims Against Accountants and Actuaries

   a. Misrepresentation of Solvency

   The outside accountants of an insurer owe a duty to the insurer to perform their audits in adherence with professional standards required by the American Institute of Certified Public Accountants (AICPA), applicable state statutes and common law. The outside accountants may be liable for failure to adhere to these standards. Increasingly, insurers employ actuaries to certify loss reserves. Those actuaries are also held to a standard of professionalism when they render a loss reserve certification. A serious deviation from good accounting and/or actuarial practices may render the actuaries and accountants liable for damages. If the accountants and/or actuaries fail to fulfill their duties with respect to an insurer which subsequently is discovered to be insolvent, such failure may give rise to liability to the estate, as well as to policyholders, cedents, reinsurers and other interested third parties.

   Accountants render opinions when they audit financial statements. An unconditional opinion is generally considered to be a sign of good financial health by industry, investors and the public. The refusal to render an audit opinion or an audit opinion without conditions is an indication that the accountants have reservations about the financial condition of the insurer. Actuaries certify the adequacy of loss reserves.

[189] See e.g., *In Re Liquidation of Integrity Insurance Company,* 240 N.J. Super. 480, 573 A.2d 928 (1990); *Selcke v. Hartford Fire Ins. Co.,* 238 Ill.App.3d 292, 606 N.E.2d 291 (1992), aff'd, sub. nom. *In Re Rehabilitation of Centaur Ins. Co.*, 158 Ill. 2d 166, 632 N.E.2d 1015 (1994).



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b. Malpractice

Accountants may be found liable for failing to adhere to professional standards with respect to detecting errors or otherwise failing to adhere to professional standards. Accountants remain responsible for errors when preparing financial statements and performing audits. However, to be responsible for the errors, the accountant must truly be the source of the errors and not the recipient of erroneous information passed on by management. Therefore, the receiver should know the scope of the engagement of the accountant and the quality of management's records.

c. Statute of Limitations

Statutes of limitations are discussed in detail in Section IIH2. In considering action against an accountant or actuary, the receiver should note that in many states, a separate statute of limitations applies to professional liability actions. This statute of limitations is often shorter than that for actions on contracts. The receiver should exercise care and consult with counsel to verify that a statute of limitations will not bar the receiver's contemplated action.

d. Damages

The degree of an insurer's insolvency and damages suffered by those who dealt with the insurer may have been substantially increased over the years if the delayed reporting of the insurer's poor financial position caused the insurer to continue to operate for a period of years before it was placed in receivership. Policyholders and ceding insurers may have renewed coverage and other parties may have dealt with the insurer based on the lack of indication of the insurer's true financial position. This in turn, may give rise to claims that would not have otherwise arisen.[190]

2. Claims Against Former Management

Potential claims against former management may be based upon many theories and fact patterns. Management may have been inexperienced, unprofessional, unwise or dishonest. If it becomes apparent that former management failed to fulfill its obligations to the insurer, the receiver should consult legal counsel to ascertain whether a cause of action is available.

a. Misrepresentation of Solvency

Management, like accountants, has a clear duty to accurately report the financial condition of the insurer to the public, to policyholders, to shareholders and to insurance regulators. For example, annual statements are required to be certified by management, under oath, as representing an accurate presentation of the finances of the insurer. If management had reason to know that the annual statement did not accurately reflect the true financial condition of the insurer but nevertheless certified the statement, a cause of action may be available to the receiver acting as the insurer's representative. The receiver should also check whether there had been a recent change in management. This may be an indication that prior management was not effective.

b. Loss Reserve Certification

Qualified actuaries are employed to certify loss reserves. Presumably, there is a right to rely on the loss reserve certification by an expert. If this certification is in error, then the receiver may have a cause of action against the actuary. Obviously, this is a question of expert opinion and besides conferring with an attorney, the receiver must also seek the opinion of an independent qualified actuary. Generally speaking, management is also required to have sound reserves based on its

[190] An appellate court reinstated a jury verdict that held the company's auditors liable for damages occasioned by the 13-month delay in instituting rehabilitation proceedings where the auditor's malpractice induced the insurance department to settle with management. *Curiale v. Peat, Marwick, Mitchell & Co.,* 630 N.Y.S. 2d 996 (N.Y. App. 1995).



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sworn oath in the jurat of the annual statement. It may be prudent to ask whether adequate controls were installed to ensure that reserving and other financial practices were sound.

c. Insurance Law Violations

Management may have violated insurance laws in a variety of ways to deplete the assets of the insurer before insolvency. There is no exhaustive list of violations, but the following is typical. For example, management may have inadequately supervised MGAs to verify that they kept trust funds or remitted funds to the insurer. The insurer may have charged inadequate rates, which could make their business unprofitable. The management may have demanded insufficient LOCs or used unsuitable reinsurers. The insurer might have engaged in unusual reinsurance transactions where transfer of risk is questionable. Unless the contract contains this essential element of risk transfer, the ceding company may not account for it as reinsurance recoverable. Investments may have been made as a result of self-dealing and conflict of interest and not for their investment value. Holding company transactions may have been entered into, which favored non-insurer members of the holding company over the insurer. All the above transactions have the same characteristic. They were not made in the best interests of the insurer, its shareholders and policyholders.

d. Business Judgment Rule

The business judgment rule has different formulations in different states. Generally, the rule holds that if management or directors acted in an informed basis in good faith and in the honest belief that they were acting in the best interest of the company, they may not be held liable for their actions unless it can be demonstrated objectively that they had reason to know of the detrimental impact of their actions on the insurer. The business judgment rule upholds the subjective view of the intent of the board of directors and the management, and allows the court to presume their good faith. This presumption is subject to rebuttal if the receiver shows that there is persuasive evidence that the best interests of the insurer were not pursued or that the board of directors and management did not act in good faith. Obviously, with the benefit the business judgment rule defense provides the directors and management, the receiver must seek to develop evidence of the intent of their actions in order to rebut the presumption.

3. Discovery

The best advice for a receiver taking over an insolvent insurer is to review every material transaction and every party's involvement in it in order to determine the bona fides of the transaction. The following is a list of the primary sources of that information:

- Audit review
    - The work papers of the accounting firm and the work papers of the insurer relating to internal audits of the insurer's operations are invaluable. The work papers of the loss reserve certification specialist should also be examined.
- Management's reports
    - Board of directors committee meetings reports and board of directors reviews should be examined. Claims and underwriting audits should be reviewed. Personnel files are also helpful.



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- Reinsurance audits
  - Some reinsurers audit the books of businesses that they reinsure and their examination may be invaluable. It may be troublesome to obtain copies from the reinsurers, but it is probably well worth the effort.
- Other sources
  - Prospective purchasers of the insurer may have performed surveys and studies which will illuminate the problems the insurer encountered. State insurance departments' market conduct and financial examinations are invaluable. The U.S. Treasury Department (Treasury) certifies certain insurers for writing surety bonds for the federal government. The Treasury's examination is valuable. Security analysts may also have written on the insurer and its prospects. In addition, the receiver may review the files of the insurer's attorneys, its internal audit reports, its bankers' loan files, its consultants, 'managing general agents' and reinsurance intermediaries' files, as well as the file of Insurance Department officials who regulated or examined the company prior to insolvency.

## C. Voidable Preferences

1. Terms of Specific Statute Govern

A receiver is authorized to reclaim property transferred by the insolvent insurer to another party if the transaction constituted a "voidable preference" as defined by statute. In general, these statutes permit the receiver to recover certain assets which were transferred by the insurer in order to satisfy prior debts and which result in some creditors receiving a greater share of the insurer's assets than other creditors similarly situated. A preferential transfer under IRMA § 604 may be to or for the benefit of a creditor. The statutes in place in various states differ significantly in substance, scope and form. Some states, in fact, do not have a voidable preference statute. A receiver should consult the applicable statutes in the receiver's state to ascertain if there is a voidable preference rule and, if so, to learn the particular requirements of that statute.

2. General Elements of Voidable Preferences

Generally, voidable preference statutes authorize receivers to avoid transactions meeting all of the following requirements:

a. Transfer of Property of the Insurer

The transaction must involve a transfer of the insolvent insurer's property before the receiver may have a right to reclaim the transferred assets. Transfers by third parties, such as bank payments on a letter of credit which was issued at the request of the insolvent insurer, are not voidable by a receiver as a preference. The issuance of collateralized letters of credit, however, may constitute indirect transfers, which may be voidable.

Similarly, receivers cannot recover property held in trust by the insolvent insurer that is transferred to its beneficial owner because the insurer does not hold this property for its own use, but only for the use of the beneficial owner. However, if the insurer's property is transferred into the trust during the preference period, the transaction may be voidable.

b. Transfer During Specified Time Period

Voidable preference statutes only permit receivers to recover transfers which occur within a particular time period immediately preceding the receivership proceedings. This period of time is frequently referred to as the "preference period." Property transferred before the preference period



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generally is not recoverable under voidable preference statutes (although the property may be recoverable under other theories). While this is generally true, some statutes contain an exception to this rule. (See below.)

The preference period may vary from four months to two years depending upon the particular state's law. In addition, many statutes provide longer preference periods for transfers involving directors, officers, substantial shareholders or other persons with significant influence over the affairs of the insolvent insurer than they do for transfers to parties totally unrelated to the insurer. Depending upon the state, the preference period may be measured from the date of the liquidation order, the rehabilitation order, the order declaring the insurer insolvent, or the filing of the liquidation, rehabilitation or conservation proceeding. Again, the receiver must consult state law on this issue.

Receivers should be aware that controversies may arise over the exact timing of a particular transfer if the transfer involves anything more complex than a cash payment. Courts are divided evenly on relatively common transactions, such as check payments. Some courts have ruled that the transfer occurred upon delivery of the check, while others have ruled that the transfer occurred when the bank honored the check.

As an alternative to proving that the transfer occurred during the preference period, some statutes provide that the receiver may void a transaction if the receiver establishes that the insurer was insolvent at the time of the transfer, even though the transfer occurred before the preference period.

c. Transfer Must be Made in Order to Satisfy an Antecedent Debt

Most voidable preference statutes authorize receivers to avoid transactions only when the transactions involve transfers to creditors in satisfaction of an "antecedent debt," that is, transactions which do not constitute substantially contemporaneous exchange. Payments in exchange for contemporaneous transfers of goods or services are generally not voidable by the receiver under these statutes.

Sophisticated and complex transactions may involve controversial determinations of exactly when the insurer incurred the debt (that is, whether the debt is an antecedent debt). Transactions involving contingent liabilities may also be controversial because they involve uncertain liabilities which will be incurred by the insolvent insurer in certain circumstances. It is not clear in what circumstances these contingent liabilities may constitute an antecedent debt. These determinations are highly fact-dependent, and the conclusions may vary from jurisdiction to jurisdiction.[191]

d. Transaction Must Result in Preference

To avoid a transfer, the receiver must also demonstrate that the transfer resulted in a "preference" to the creditor receiving the property. The law of the particular jurisdiction must be consulted. In general, the receiver needs to show that, as a result of the transfer, the creditor obtained payment of a greater percentage of the debt owed that creditor by the insolvent insurer than another creditor of the same class would receive from the estate.

Transfers of property to fully secured creditors do not generally constitute preferences because secured creditors would ordinarily receive the value of the collateral even in the context of a receivership proceeding, and therefore the secured creditors do not receive a disproportionate benefit as a result of the transfer. If, however, the security interest was created during the preference period (for example, by providing collateral for a previously existing debt), then a voidable preference may have occurred. Similarly, payments to some creditors may not result in a preference if the creditors would be entitled (even without the transfer) to set off the payments of the insolvent

[191] See Wilcox c. CSX Corp, *70 P.3d 85*, *473 Utah Adv. Rep. 25, 2003 UT 21(2003).*



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insurer against debts owed by the creditors to the insurer. In these cases, the creditor can either accept the property and later pay the amount owed by the creditor to the insurer's estate or not accept the property and, instead, reduce the amount it pays to the estate by the amount owed to it by the insurer. The creditor is in essentially the same position either way. A receiver should be aware, however, that some courts have suggested that the mere timing of a particular transfer can constitute a preference because of the time value of money, even in cases where the creditor receives the same dollar amount the creditor would have received from the insolvent insurer's estate. In short, this question comes down to whether extra interest earned by the creditor as a result of having the money sooner rather than later constitutes a preference.

e. Intent Requirement

Many voidable preference statutes require the receiver to establish that the creditor receiving the transfer had reasonable cause at the time to believe that the insurer was insolvent or was about to become insolvent. Other statutes may require the receiver to prove that the creditor had reasonable cause to believe that the transfer would result in a preference. Establishing this subjective requirement may prove to be a significant hurdle for the receiver. Not all states, however, require the receiver to show these facts in all cases. Some states only require proof of intent if the receiver is seeking to recover assets transferred before the preference period or if the receiver is seeking to prove that the transfer occurred at a time when the insurer was insolvent.

3. From Whom Can the Receiver Recover the Amount of the Preference?

The most obvious target of a receiver's voidable preference claim is the creditor who receives the preferential transfer. A receiver may also be able to assert a claim against additional parties. Many statutes provide that officers, employees or other "insiders" who participated in granting the preference can be held responsible for return or repayment of the transferred property under the doctrine of joint and several liability. The receiver, therefore, may be able to recover the amount of the preference from the "insider" who authorized the transfer if the insider had reasonable cause to believe that the insurer was or was about to become insolvent. In some cases, this approach may be more efficient than pursuing the creditor, particularly if the creditor is located in another jurisdiction.

Although the law is unsettled, receivers may be able to recover the amount of the transfer from certain "non-insiders" who assisted in the transfer and received a benefit from the transaction. For example, a receiver may wish to consider the role of agents or brokers in the transaction. In addition, a receiver may be able to recover from persons who subsequently purchase the transferred property from the creditor to the extent that these purchasers do not in good faith provide full equivalent value for the property. Local counsel should be consulted as to these issues.

4. Mechanics of Recovery of Preference

The receiver must ordinarily commence suit before the applicable statute of limitations has run in order to recover assets conveyed in a transaction that meets all of the requirements of the applicable voidable preference statute. The receiver should also consult local counsel for all procedural rules.

The receiver can void the entire range of transactions meeting the statute's requirements even if the transaction is otherwise innocent. The applicable voidable preference statute, therefore, can be a valuable tool for augmenting the assets of the estate and assuring that all creditors are treated equally.



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## D. Fraudulent Transfers

### 1. Authority

Receivers typically have the authority to recover assets conveyed by the insurer in transactions that constitute fraudulent transfers. The receiver's authority to recover fraudulent transfers may stem from a specific statute, the Uniform Fraudulent Conveyance Act, to the extent adopted in the particular state, or the common law of fraud. The receiver should consult counsel to ascertain which theories concerning recovery of fraudulent transfers are available to the receiver. § 605 of IRMA addresses fraudulent transfers.

### 2. Elements of Fraudulent Transfer

The fraudulent transfer laws perform a function similar to the purpose of voidable preference statutes. Both laws authorize the receiver to rescind certain transactions and bring previously transferred assets back into the insolvent insurer's estate. The voidable preference statutes, however, address transfers made to satisfy antecedent debts which result in some creditors receiving a greater percentage of their debt than other creditors in the same class (see previous discussion). The fraudulent transfer laws deal with transfers for inadequate consideration and with transfers aimed at obstructing or defrauding other creditors.

Fraudulent transfer laws vary from state to state, but most laws permit the receiver to avoid transactions which meet the following requirements:

#### a. Transfer for Unfair Consideration or with Fraudulent Intent

Many fraudulent transfer laws require the receiver either to demonstrate that the insolvent insurer did not receive "fair consideration" for the transfer or to establish that the transaction was made with the intent to hinder, delay or defraud other creditors in order for the receiver to rescind the transaction as a fraudulent transfer and thereby recover the transferred assets.

#### b. Transfer During Specified Time Period

Fraudulent transfer statutes typically apply only to transfers made within one year prior to a particular stage of the receivership proceedings, such as the filing of a successful petition for receivership. The particular time period, however, varies in different states, and the receiver should consult counsel to determine the rule in the particular jurisdiction. Issues addressed in the voidable preferences section concerning potential disputes as to the timing of a particular transaction are equally relevant in the context of fraudulent transfers. The receiver should consult the previous discussion of voidable preferences for further information on this issue. Simply stated, the exact timing of a particular transfer (and especially a transfer involving a complex commercial transaction) is not always clear and can cause disputes as to the applicability of a fraudulent transfer law to the particular transaction.

#### c. Status of Insurer

Some states may require the receiver to show that the insurer was insolvent or otherwise financially impaired at the time of the transaction (or became insolvent because of the transaction) in order to attempt to recover a fraudulent transfer.

#### d. Distinct Rules for Reinsurance Transactions

Many states impose different standards on reinsurance commutations occurring within the fraudulent transfer period. The receiver may be able to rescind a commutation with a reinsurer if the receiver can prove that the insolvent insurer did not receive the present fair equivalent value of



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its release of the reinsurer from liability. The receiver should consult Chapter 7—Reinsurance for further information on this subject.

3. From Whom Can the Receiver Recover the Amount of the Transfer?

Receivers may recover the value of the fraudulent transfer from the person who received the transfer from the insurer. Receivers also may be able to recover the value of the transfer from other persons who are subsequent holders of the transferred property, although many statutes do not permit recovery from such persons if they provided present fair equivalent value for the property when they procured it. In addition, the receiver may be able to assert a claim against persons who participated in the transfer, such as directors, officers, employees or other "insiders" of the insolvent insurer. The potential liability of such persons is discussed in greater detail under a separate heading in this chapter.

4. Mechanics of Recovery of Fraudulent Transfers

To recover assets conveyed in transactions which constitute fraudulent transfers, the receiver needs to commence suit within the period of the applicable statute of limitations. Counsel should be consulted as to procedural requirements.

5. Typical "Red Flag" Transactions

To the degree practicable, the receiver should examine all transactions which occur during the fraudulent transfer period to see if the transfers may be rescinded. Receivers should pay special attention to extraordinary dividend payments to stockholders, commutation agreements with reinsurers, related party transactions, portfolio transfers, surplus relief reinsurance treaties and any unusual disbursements. While all of these transactions may be entirely innocent, they can also be tainted by fraudulent intent or by unfair consideration which may enable the receiver to rescind the transactions.

**E. Related-Party Transactions**

A common "target" of receivers involves improper or questionable transactions between the insurer and those "related" to it, including parent corporations and shareholders, prior to insolvency.

1. Holding Company Act

The Insurance Holding Company System Regulatory Act (the Holding Company Act) constitutes an extensive statutory scheme regulating among other things, the registration, reporting, examination, acquisition and control by holding companies of an authorized insurer. By statute, "control" is presumed if the holding company owns 10% or more of the voting shares of an insurer. Furthermore, the Holding Company Act requires that all material transactions must first obtain regulatory approval, and that in any event, all transactions between the holding company and the "held" insurer must be "fair and equitable." As such, any transactions between the now insolvent insurer and the controlling party which do not meet the standard (preferences, non-arms-length transactions) may be attacked by the receiver under those statutes.

2. Piercing the Corporate Veil

The ability of a receiver to assert a successful "piercing the corporate veil" claim against the former parent or shareholder of an insolvent insurer will necessarily depend upon the elements of such a claim under the relevant state's laws. Defendants, however, have often attacked such a claim as a matter of law in arguments that closely relate to standing arguments. In essence, defendants have argued that receivers only have standing to sue on behalf of the fallen insurer and, therefore, argue that a corporation



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may never pierce its own veil.[192] Nevertheless, it can be argued that the receiver also represents creditors and policyholders who can clearly assert alter ego claims or piercing the corporate veil claims. In addition, there is a fundamental difference between an "alter-ego" action brought by a receiver and that brought by a viable corporation. When a viable corporate entity sues on its own behalf, it is in essence suing for the benefit of its shareholders. Thus, a suit by a viable corporate entity seeking to pierce its own veil is the equivalent of a suit by a corporation (for the benefit of its shareholders) against its shareholders. As such, many courts have found that such an action must fail. Where, however, the corporate entity is in receivership, the receiver's suit is for the benefit of the insurer's creditors. In such a setting, the interests of the party plaintiff (i.e., the receiver on behalf of the estate, representing among others, the creditors) differs from the defendants (the shareholders).

In addition, the Holding Company Act expressly contemplates actions against holding company systems which own and control an insurer. In fact, one of the provisions typically found in these statutes mandates that officers and directors of a controlled insurer manage the insurer so as to assure its separate operating identity. Violation of that statute, coupled with the express right of action under a separate provision, clearly contemplates an alter ego or piercing the corporate veil claim under insurance laws.

### F. Other Suspect Transactions

Besides the above enumerated transactions which are not exhaustive, it is possible that aspects of or the intent of any transaction may be fraudulent. Therefore, all material transactions should be investigated to see if they indicate fraud, self-dealing, violation of law, conflict of interest, etc. Insolvency may be accompanied by acts which render the management, board of directors or vendors of services liable for damages. Recovery of these damages will increase the assets of the estate and, thus, the amount available for distribution.

### G. Potential Actions Against Unrelated Third Parties

In the examination of the insolvent insurer, the receiver may come across possible causes of action to bring against third parties and present all such findings to counsel. The rights to bring a suit and/or make a claim must be evaluated in terms of the relevant statutes and case law.

1. MGA/Agent/Broker

Although producers share certain characteristics, only agents (including MGAs) represent the insurer and ordinarily owe a duty to the insurer. Nevertheless, in certain states, brokers may owe a duty to the insurer. There are states in which all producers are deemed agents. Consult an attorney to determine the duty owed by the producer. Under the insurance laws, almost all states require producers to maintain trust funds which are held to pay premiums to insurers and for other purposes. MGAs who underwrite business must comply with the legal requirements of the rating law and may not underprice the business so as to make it unprofitable. MGAs may have violated underwriting guidelines or made claim payments in violation of guidelines set up by the insurer. This may make them liable under a breach of contract theory if their agency agreement required adherence to insurer guidelines. In particular, a MGA may have had binding reinsurance authority. Breaches of authority, lack of good faith or other acts may make the MGA liable under a contract or tort theory depending on the acts committed.[193]

It may also be possible to bring an action based upon a tort theory. A common example of facts creating tort liability is where the MGA violated its trust and wrote business solely to earn commissions rather than to obtain a profitable return for the insurer. The MGA may have committed breaches of

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[192] *Selcke v. Hartford Fire Ins. Co.,* 238 Ill. App. 3d 292, 606 N.E.2d 291 (1992), aff'd, sub. nom., *In re Rehabilitation of Centaur Ins. Co.*, 158 Ill. 2d 166, 632 N.E.2d 1015 (1994).

[193] E.g., *Omaha Indemnity Company v. Royal American Managers,* 777 F. Supp. 1488 (W.D. Mo. 1991).



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underwriting or claims authority or failed to document business written so as to render the insurer unable to assemble its records.

A broker owes a duty to the insured. A broker who owns and controls an insurer also owes a fiduciary duty to that insurer. If the broker has failed to fulfill its obligations to the insurer by knowingly placing substandard or underpriced risks with the insurer so as to generate additional commission income for the broker, the receiver may have a cause of action against the broker for the resulting damage to the insolvent insurer.

Many states have statutes that are directed at managing general agents and define these as property and casualty agents with expanded responsibilities that may include underwriting, policy issuance, claims payment and continued policy owner services, as well as the marketing of the insurance products. Life insurers also have marketing contracts that may be labeled "Managing General Agent" (MGA) or "Brokerage General Agent" (BGA) contracts. These contracts, however, pertain to the acquisition of new business and retention of existing policies.

A BGA can differ from a MGA in that a BGA, through special contracts with a number of life insurance companies, provides a variety of products and solutions to an agent that is seeking to solve a client's unique needs. A MGA for a life insurer normally will distribute for a single insurer (or a very limited number of insurance companies) through a group of agents recruited by the MGA, who will focus their selling activity on the products of that insurer.

Some life insurers have attempted to streamline internal operations by sharing their home office functions with large MGA and BGA operations. Because of this, both electronic data as well as physical files are kept by the MGA or BGA for some blocks of business. The MGA or BGA serves as the administrator, while the life company serves as the insurer. Care should be taken not to disenfranchise the field agents when the retention of their services and equipment may be important to the discovery, communication and rehabilitation process.

2. Reinsurance Intermediaries

Reinsurance intermediaries must now be licensed in most states. Under the laws, an intermediary generally must have clear written authorization from its principal and must notify its principal when it has bound reinsurance. If the assuming reinsurer is unauthorized, the reinsurance intermediary must exercise due diligence in researching the financial condition of the unauthorized reinsurer. The intermediary must maintain records for a number of years and maintain a premium trust fund in a fiduciary capacity. These laws generally also require disclosure whether the intermediary controls the ceding insurer or reinsurer, or the ceding insurer or reinsurer controls the intermediary.

It may be possible to base a claim on breach of contract. The reinsurance intermediary may have an engagement or contract with the party it serves and, therefore, if this contract is breached by the reinsurance intermediary, the estate may have a contract claim against the intermediary.

It may also be possible to base a claim on a tort theory. The reinsurance intermediary may be alleged to have violated its duty of reasonable care to the party it represented. It may have encouraged or encountered a conflict of interest or it may have misrepresented the underwriting posture of the ceding insurer or the financial capability of the assuming insurer.

In both the contract and tort actions, one must be aware of the applicable statute of limitations.


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3. Attorneys

Attorneys perform various functions for insurers. Principally, they advise the board of directors and management as to transactions and agreements and the interpretation of insurance law. They also defend claims and may prepare reinsurance agreements. If attorneys have given faulty, negligent or fraudulent advice, the attorneys may be liable to the estate. As stated above, refer such questions to counsel. The receiver should also evaluate current or prior representations of attorneys for conflicts of interest.

4. Recovery from Other Sources

In collecting the assets of the estate, the receiver should remember that other parties may owe the estate reimbursement for their acts, such as ownership of salvage, receipt of the fruits of fraudulent transfers, etc. The following is not an exhaustive list, but an illustrative list of parties which may owe proceeds to the estate.

a. Subrogation and Salvage

Subrogation is an equitable principal by which the wrong-doer who has caused a compensated insurance loss owes indemnity to the insurer. Alternatively, a party may hold property on which the insurer has paid a loss and which thus belongs to the insurer. The property is called salvage. As part of the review of claims procedures, the receiver should check to see that subrogation and salvage were routinely investigated in losses.

Close attention should be paid to the security provided to the company by its reinsurers, including letters of credit and trust accounts. These should be reviewed early to determine whether there is compliance with the obligations under the reinsurance treaties. To assure the reinsurer does nothing to diminish the security as a result of the receivership, it is essential for the receiver to provide notice of the insurer's receivership to all institutions that have issued letters of credit or are acting as the escrow agents. The same parties should also be advised that the receiver must be notified of any transaction that may affect the security. Once it is determined that the security is in place, it is still necessary to continue to monitor the security during the receivership to ensure that it remains in place, including seeing that letters of credit are renewed and that security is increased pursuant to the reinsurance agreement, if appropriate.

b. Fraudulent Transactions

The beneficiary of a fraudulent transaction may, under many state fraud statutes, owe the proceeds back to the insurer. (See the section on Investigation and Asset Recovery in this chapter.)

## H. Dividends and Intercompany Transactions

State insurance codes have strict limitations on how much money can be paid as dividends by insurance companies to their shareholders. All dividends paid by the company should be reviewed to determine compliance with these limitations. The receiver should also examine whether the financial statements were manipulated to make otherwise impermissible dividends appear valid.

As part of this process, intercompany transactions should be reviewed to look for disguised dividends. The company may have entered into cost sharing agreements, tax sharing agreements, marketing agreements and other such transactions with affiliates. These transactions should be reviewed closely. When a company is foreclosed from issuing dividends, it may try to disguise dividends as transactions pursuant to these agreements.

Illegal dividends may be recovered in actions for fraud or breach of fiduciary duty. Additionally, some insurance codes allow the receiver to recover all dividends, whether lawful or unlawful, that were made



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during a stated time period prior to the receivership. Furthermore, the failure of the company's auditors and external accountants to detect unlawful dividends may form the basis of a negligence action.

**I. Directors, Officers and Shareholders**

1. Mismanagement/Negligence

Numerous actions have been filed by receivers throughout the country against former directors and officers of now insolvent insurers for gross negligence and mismanagement that caused the insurers' insolvency. Prior to instituting action, corporate bylaws should be reviewed to determine whether corporate officers will be indemnified for defense costs for actions against them arising from the performance of their corporate duties.

Examples of mismanagement and negligence claims asserted in these actions are failure to exercise due care, breach of fiduciary duties owed by the defendant officers and directors to the corporation and its shareholders, self-dealing and the filing of false and misleading financial reports.

In addition, many of these actions have also alleged fraud and breach of fiduciary duties against an insurer's former directors and officers and the corporation's parent. Possible bases for legal action against an insurer's management or ownership are:

- Operating the insurer as a "loss leader" to enhance other elements of the controlling parties' business at the expense of the insurer;
- Failing to operate the insurer as an independent profit-making corporation;
- Permitting the insurer to violate the insurance laws;
- Managing and operating the insurer without regard to its profitability or solvency and in a manner inconsistent with prudent business practices;
- Operating the insurer to serve the interests of the controlling parties in contravention to the insurer's own interests;
- Forcing the insurer to pay monies to one or more members of the insurer's holding company system when such members performed no services for the insurer;
- Binding the insurer to extremely unprofitable policies;
- Binding the insurer to, or forcing the insurer into, highly disadvantageous arrangements with other members of the holding company system, their clients or others;
- Causing the insurer to make preferential transfers to members of the holding company system and others;
- Causing the insurer to enter into transactions with affiliates that were unfair to the insurer and in violation of the Holding Company Act;
- Failing to investigate, review, scrutinize, monitor, supervise and manage the financial affairs of the insurer to prevent its insolvency;
- Allowing the insurer to maintain inadequate books and records;
- Failing to establish and apply reasonable and prudent underwriting guidelines; or



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- Concealing the insurer's insolvency and misrepresenting the insurer's financial condition through the preparation and issuance of materially false and misleading financial statements filed with regulatory authorities;

2. RICO

Claims under the federal Racketeer Influenced and Corrupt Organizations Act (RICO) 18 USC 1961 et. seq., against former directors and officers of a failed insurer have been sustained against dismissal motions by some courts.[194] RICO claims against the insurer's attorneys, solicitors, reinsurers, agents, brokers and shareholders have also been sustained.[195]

RICO provides remedies, including treble damages and attorneys fees, for activity that meets the following criteria:

- The defendants were "persons" employed by or associated with an "enterprise" (usually, but not always, the insolvent insurer or a related entity);

- The affairs of the enterprise affected interstate commerce;

- The defendants engaged in a "pattern of racketeering activity" (defined in the statute as violations of certain federal and state criminal laws); and

- The defendants conducted or participated, directly or indirectly, in the conduct of the enterprise's affairs through this pattern of racketeering activity.

- The insolvent insurer was injured in its business or property and that the injury was proximately caused by the racketeering activity.[196] In order for a receiver to recover under Section 1962 of RICO, the receiver must show that the defendant participated in the operation or management of the insurance company itself. This "operation or management" test arises from the statute's requirement that a defendant "conduct or participate, directly or indirectly in the conduct of such enterprise's affairs." See Section 1962(c) The U.S. Supreme Court affirmed the dismissal of a RICO claim brought by a bankruptcy trustee against an outside accounting firm on the basis that the accounting firm had not participated in the management of the defunct company.[197]

3. Breach of Fiduciary Duty

It is clear that directors and officers of an insurer owe a fiduciary duty to the corporation. In addition, there is a well-established line of cases holding that dominant or controlling stockholders or a sole shareholder has a fiduciary relationship to the corporation. The same is true of directors and officers of the corporation. In the event of insolvency, the corporation's right to sue for breach of fiduciary duty rests with the receiver.

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[194] However, some courts have held that the RICO claims must be brought on behalf of the insolvent insurer, and have dismissed them when brought on behalf of the insurer's policyholders and creditors. See e.g. *Shapo v. Engle,* 1999 U.S. Dist. Lexis 11231 (N.D.Ill. July 12, 1999), dismissed in part, 1999 U.S. Dist. LEXIS 17966 (N.D. Ill. Nov. 10, 1999).

[195] E.g., *Schacht v. Brown,* 711 F.2d 1343, (7th Cir.), cert. denied*,* 464 U.S. 1002 (1983); *State of North Carolina ex rel. Long v. Alexander & Alexander,* 680 F. Supp. 746 (E.D.N.C. 1988); *Durish v. Uselton,* 763 F. Supp. 192 (N.D. Texas 1990); *Department of Ins. v. Blackburn*, 633 So. 2d 521 (Fla. Dist. Ct. App. 1994).

[196] *Sedima, S.P.R.L. v. Imrex Co.,* 473 U.S. 479, 495 (1985). Some states have enacted parallel state legislation. Local counsel should be consulted.

[197] See *Reeves v. Ernst & Young,* 507 U.S. 170 (1993).


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It is fundamental that damages resulting from a neglect of fiduciary duty are recoverable by the insurer, and this right passes to the receiver.

4. Presumption of Fraud

A severe problem facing all receivers is the frequently disorganized situation the receiver often confronts when first reviewing and investigating the history and cause of a failed insurer. It is not uncommon to find the books and records of the insurer in complete disarray caused by the mismanagement, negligence and sometimes intentional misconduct of former management. Yet, under normal circumstances, the burden of proof is on the receiver to establish his or her claims despite the fact that former management may have intentionally made that burden impossible.

However, there are statutes in some states which, along with the existence of the fiduciary relationships between directors and officers and the corporation (represented by the receiver), provide assistance in shifting that burden. For example, New York Insurance Law Section 1219(b) states:

"The insolvency of an insurance corporation is deemed fraudulent unless its affairs appear upon investigation to have been administered fairly, legally and with the same care and diligence that agents receiving a compensation for their services are bound, by law, to observe."

Hence, upon insolvency and a finding that no investigation has shown that the defunct carrier was administered fairly, legally or competently, it can be argued that director and officer defendants have the burden of disproving the fraudulent insolvency of a carrier.

5. Shareholders

- Holding Company Act

As discussed previously, the Holding Company Act constitutes an extensive statutory scheme regulating, among other things, the registration, reporting, examination, acquisition and control by holding companies of an authorized insurer.

The Holding Company Act expressly contemplates actions against holding company systems and persons that abuse the statutory provisions.

## J. Common Defenses to Receiver Lawsuits

As previously discussed, while it is clear that a receiver has standing to sue on behalf of the defunct insurer, many defendants claim that the receiver has no right to assert claims on behalf of creditors and policyholders. The defendants then argue that because the principal claims asserted in the receiver's complaint against the defendants do not belong to the defunct insurer (but to its creditors and policyholders), the complaint must be dismissed.

As previously noted, the receiver in some states may have, and pursuant to IRMA does have, standing to sue on behalf of policyholders and creditors. In any event, the claims most commonly asserted by a receiver belong to the insurer. For example, a corporation may sue shareholders and directors and officers for breaches of fiduciary duty or corporate waste. Such claims also pass to the receivers of insolvent insurers and may be made against the shareholders of such companies.

The purpose of the liquidation scheme is to preserve and enhance the assets of the insolvent insurer for the benefit of all creditors, policyholders and shareholders. A receiver for an insolvent insurer has a right to maintain the corporation's assets and to recover assets of which the corporation has been wrongfully deprived through fraud. In such a suit, the receiver may be said to sue as the representative of the corporation and its creditors, policyholders and stockholders.



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The one exception noted by any court and contained in IRMA is that the receiver may not have standing to pursue claims that are personal to any one or group of policyholders or creditors and uncommon to all other policyholders, creditors and claimants.[198] IRMA § 112 addresses the issue of defenses, which may be asserted against the receiver.

1. Ratification

Defendants have asserted the defense that no viable action can be brought against them since the Board of Directors ratified the complained of conduct. This defense is generally unsuccessful and considered contrary to public policy.[199]

Only disinterested directors and shareholders can ratify transactions. However, acts which are fraudulent, prohibited by statute or violate public policy cannot be ratified. Such acts are void rather than merely voidable.

Moreover, creditors are not prejudiced by the corporation's acts of ratification. Any ratification, even if effective, would therefore not preclude a receiver's action on behalf of the creditors.

2. Misconduct "Aided" Insurer

Defendants have also asserted the defense that if any misconduct occurred, it only served to place more money in the insurer's coffers by encouraging outsiders to continue doing business with the insurer and/or prolonging the insurer's existence. Courts currently respond to this defense by attempting to distinguish between conduct that injures the corporation and conduct that benefits it.[200]

In a similar line of cases, courts have held that where the insurer is wholly owned by the persons responsible for negligent operation or fraud against outsiders, the misconduct should be "imputed" to the insurer, which defeats a receiver's claim on behalf of the insurer.[201] This defense is inapplicable, however, where the alleged misconduct involves looting from the insurer for the benefit of the owner/director and contrary to the interest of the insurer.[202]

3. Fiduciary Shield Doctrine

The fiduciary shield doctrine holds that the acts of an agent performed in-state for an out-of-state corporation will not form the basis for exercising jurisdiction against the agent as an individual, but may be used to subject the corporation to jurisdiction.

Courts in some states have limited the doctrine, theorizing that it would be inequitable to allow a corporate agent to assert the doctrine where the agent has committed a tort in the state.

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[198] See *Caplin v. Marine Midland Grace Trust Co. of New York,* 406 U.S. 416 (1972); *State of Arizona v. Arizona Pension Planning,* 154 Ariz. 56, 739 P.2d 1373 (1987).

[199] *William M. Fletcher, Fletcher Cyclopedia of the Law of Private Corporations* § 998 (perm. ed. rev. vol. 1994); *Neese v. Brown,* 218 Tenn. 686, 405 S.W.2d 577 (1964); *Coddington v. Canaday,* 157 Ind. 243, 61 N.E. 567 (1901); see also *Foster v. Monsour Medical Found.,* 667 A.2d 18 (Pa. Commw. Ct. 1995) (Defendants unsuccessfully claimed that Insurance Commissioner and Department ratified actions of insolvent insurer through knowledge of, and supervision over insurer's operations).

[200] Compare e.g., *Schacht v. Brown,* 711 F.2d 1343 (7th Cir.), cert. denied, 464 U.S. 1002 (1983), holding that fraudulently prolonging an insolvent insurer's existence "ineluctably" injures the corporation with *Seidman & Seidman v. Gee,* 625 So. 2d 1 (1992), rehearing denied, 1993 Fla. App. LEXIS 8483, holding that prolonging an insolvent insurer's existence allows the insured to be used as an "engine of theft" against outsiders, which benefits the corporation.

[201] E.g., *FDIC. v. Ernst & Young,* 967 F.2d 166 (5th Cir. 1992).

[202] E.g., *Schacht v. Brown, supra* 711 F.2d 1343 (7th Cir.) Other recent decisions applying or rejecting versions of this defense include *FDIC v.O' Melveny & Meyers,* 969 F.2d 744 (9th Cir. 1992), reversed and remanded, 114 S.Ct. 2048 (1994); and *In Re Integrity Insurance Co.,* 573 A.2d 928 (N.J. Super. 1990).



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The doctrine does not generally apply to corporate officers or directors who reside or have offices in the state where the offending acts took place. It should also be pointed out that courts have viewed fairness and equity as the paramount tests of the fiduciary shield's applicability.[203]

4. Counterclaims Against Regulator

A common defense asserted by defendants in receiver lawsuits is a counterclaim alleging that the insurance commissioner as regulator improperly or negligently interfered with the operations of the insurer or negligently failed to place the insurer in receivership sooner.[204]

Preliminarily, it should be noted that an affirmative claim against the receiver may be barred by the liquidation order.[205] There is also a recognized distinction between the regulator and the receiver.[206] Claims (including affirmative defenses) brought against the former cannot be asserted in a receivership action except as to affirmative defenses which assert that the regulator's misconduct constituted an intervening and superseding cause of the insolvency. In other words, the defendants must plead and prove that the conduct of the regulator interrupted the causal nexus between the defendants' negligence and mismanagement and the insolvency, thereby relieving defendants of their liability.[207]

5. Statutes of Limitations

Receivers must be mindful of the relevant state statutes of limitations, particularly regarding negligence and fraud claims. While comfort may be taken in that most states' limitation periods for fraud commence upon discovery (presumptively by the receiver), negligence claims may not have such a savings provision.

In actions against accountants for malpractice, the defendants often claim that such actions are time barred under the relevant state limitation period, which is often three years from the date of issuance of their audit reports. Even if the receiver's action is brought after the three-year period, the receiver may have defenses to a motion to dismiss founded upon:

- A longer statute of limitations period provided for contract actions;
- The Continuous Treatment doctrine which may toll any period of limitations for the entire period that the accountant defendants served as the insurer's certified public accountants; or
- The Adverse Domination doctrine, under which all statutes of limitation are tolled during the period in which persons and entities alleged to have harmed the insurer are in control of its operations.[208]

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[203] E.g., *Rollins v. Ellwood,* 141 Ill.2d 244, 565 N.E.2d 1302 (1990).

[204] See e.g., *Williams v. Standard Chartered Bank*, No. 96-220-CV-ORL-22 (M.D. Fla.), 9-10 *Mealey's Litig. Rep. Ins. Insolv. 6 (1997)s.*

[205] *Id.*

[206] *Foster v. Monsour Medical Found.,* 667 A.2d 18 (Pa. Commw. Ct. 1995) (pre-liquidation regulatory conduct of Insurance Commissioner cannot be raised where commissioner brings actions as statutory liquidator, rather than in regulatory capacity.)

[207] *Meyers v. Moody,* 693 F.2d 1196 (5th Cir. 1982), reh'g denied, 701 F.2d 173 (5th Cir.), cert. denied, 464 U.S. 920, 104 S.Ct. 287, 78 L.Ed. 2d 264 (1983); *Schacht v. Brown,* 711 F.2d 1343 (7th Cir.), cert. denied, 464 U.S. 1002 (1983); *In Re Ideal Mutual Insurance Company,* 140 A.D.2d 62, 532 (N.Y. App. Div. 1988); *Corcoran National Union Fire Insurance Company,* 143 A.D.2d 309 (N.Y. App. Div. 1988); *North Carolina v. Alexander & Alexander,* 711 F. Supp. 257 (E.D.N.C. 1989); *FDIC v. Renda,* 692 F. Supp. 128 (D. Kansas 1988); *FSLIC v. Burdette,* 696 F. Supp. 1183 (E.D. Tenn. 1988); *FDIC v. Niver,* 685 F. Supp. 766 (D. Kansas 1987); *FDIC v. Coble,* 720 F. Supp. 748 (E.D. Mo. 1989); *FDIC v. Glickman,* 450 F.2d 416 (9th Cir. 1971); *Clark v. Milam,* 891 F.Supp 268 (S.D.W.Va. 1995).

[208] E.g., *Clark v. Milam,* 872 F. Supp. 307 (S.D.W.Va. 1994); *Washburn v. Brown,* 1987 U.S. Dist. LEXIS 495, (N.D. Ill. January 23, 1987); *Durish v. Uselton,* 763 F. Supp. 192 (N.D. Texas 1990); *RTC v. Interstate Federal Corp.,* 762 F. Supp. 905 (D. Kan. 1991); *FDIC v. Greenwood,* 739 F. Supp. 450 (D.C. Ill. 1989); *FDIC v. Paul,* 735 F. Supp. 375 (D. Utah 1990); *FDIC v. Howse,* 736 F. Supp. 1437 (S.D.



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6. E&O and D&O Insurance

Many companies purchase Errors and Omissions (E&O) and Directors and Officers (D&O) policies, which may provide coverage for certain types of conduct described above. As part of the investigative examination, all E&O and D&O policies should be found and examined. These policies will almost certainly be claims made policies and should be reviewed to determine the deadline for notifying the carrier concerning possible claims. Additionally, the policies may provide for the purchase of tail coverage to extend the time to file a claim. which may or may not be necessary depending on the circumstances presented. [209]

The presence of insurance can determine which causes of action against officers and directors should be brought. Certain causes of action may be excluded by the language of the policy; it is, therefore, important for counsel to thoroughly review the policies before any suits are filed. One common exclusion that should be considered is a regulatory exclusion, which will likely be present in the policy under review.

7. Failure to Mitigate Damages

Defendants may allege that the receiver has not done everything possible to reduce the damages to the estate. For instance, the defendants may claim that the receiver pursued certain actions, such as entering into reinsurance commutations, that did not benefit the estate or failed to pursue other reinsurance commutations that might have prevented further deterioration of the insurer's financial position.

As a litigation tactic, defendants may attempt to use such a defense to convert the litigation into an examination of the receiver's conduct, rather than a review of defendants' conduct contributing to the insurer's insolvency.

8. Public Policy

Another litigation tactic, particularly where the receiver is suing former officers and directors, is to argue that since the receiver represents the defunct insurer's policyholders and creditors, which may include the officers and directors, a claim against them should not, for public policy reasons, be funded by those policyholders and creditors. Where this tactic has been attempted, the attempt has been universally unsuccessful.[210]

**K. Discovery Issues**

1. Receiver's Right to Preliquidation Documents

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Texas 1990); *FDIC v. Farris,* 738 F. Supp. 444 (W.D. Okla. 1989); *FDIC v. Carlson,* 698 F. Supp. 178 (D. Minn. 1988); *FDIC v. Butcher,* 660 F. Supp. 1274 (E.D. Tenn. 1987); *FDIC v. Buttram,* 590 F. Supp. 251 (N.D. Ala. 1984); *FSLIC v. Williams*, 599 F. Supp. 1184 (D. Md. 1984); *FDIC v. Bird,* 516 F. Supp. 647 (D.P.R. 1981). But see *Mutual Sec. Life Ins. Co. v. Fidelity & Deposit Co.,* 659 N.E.2d 1096 (Ind. Ct. App. 1995) (In action for coverage under fidelity bond issued to insolvent insurer limiting coverage to losses discovered by insurer during bond period, liquidator could not use "adverse domination" to toll discovery period, despite allegation that discovery delay was caused by insurer's officer).

[209] https://ujs.sd.gov/uploads/sc/opinions/29663371697e.pdf. The case holds that the statutory extension on time for the Liquidator to make a claim nullifies an E&O/D&O carrier's claims made deadline.

[210] The defense has been routinely disapproved in cases brought on behalf of failed financial institutions. E.g., *FDIC v. Crosby,* 774 F. Supp. 584 (W.D. Wash. 1991); *FDIC v. Stanley,* 770 F. Supp. 1281 (N.D. Ind. 1991), *aff'd,* 2 F.3d 1424; *FDIC v. Stuart,* 761 F. Supp. 31 (W.D. La. 1991); *FDIC v. Ekert Seamans Cherin & Mellot,* 754 F. Supp. 22 (E.D.N.Y. 1990); *FDIC v. Baker,* 739 F. Supp. 1401 (C.D. Cal. 1990). The few courts considering the defense in cases involving insolvent insurance companies have also disapproved it. See e.g., *Meyers v. Moody,* 475 F. Supp. 232 (N.D. Tex. 1979) *aff'd,* 693 F.2d 1196 (5th Cir. 1982), cert. denied, 464 U.S. 920 (1983); and *Bonhiver v. Graff,* 248 N.W.2d 291 (Minn. 1976).



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As the statutory successor to the insurer, the receiver owns the preliquidation documents of the insurer. If this is challenged, legal counsel should be consulted.

2. Attorney-Client Privilege

The attorney-client privilege may be asserted against the receiver's request to examine documents in the possession of third parties. However, in light of the fact that the receiver becomes the client as successor to the insurer, it is uncertain whether the attorney-client privilege can be asserted against the receiver.

3. Discovery of Regulator for use Against Receiver

This refers to the fact that private third parties may subpoena the domiciliary insurance department in an attempt to discover the regulator's evaluations of the insurer over the years in question in order to use those evaluations as defenses in receiver's actions against the third party. Such requests for information may be controlled by the state's Freedom of Information Act (FOIA) and, where the FOIA controls, these evaluations have generally been found to be subject to discovery by third parties. However, requests for specific documents may not be subject to disclosure, as the documents may be protected by the insurance department laws. Insurance department counsel and receivership counsel should work together in responding to requests for pre-receivership information as to the insurer.

4. Disclosure by Receiver

Forcing disclosure of the receiver's papers has been less successful than forcing disclosure by the regulator. The theory is that the receiver serves in a private capacity and is not subject to FOIA. Be careful to note whether a regulator holds papers in a regulatory or receivership capacity, as the receiver's authority is separate and distinct from the authority of the regulator.

5. Shifting of Burden of Proof

New York Insurance Law Section 1219(b) deems an insurer insolvency to have resulted from fraud. Under a similar statute, it may be possible to argue that the burden of proving that the directors of the insolvent insurer did not engage in fraud is borne by the directors. If such an argument were to succeed, the directors would essentially be required to prove that their actions were not fraudulent or at least culpable. This theory would greatly aid discovery and proof of their acts and is an argument which should be discussed with counsel regarding pursuit of a claim/suit against the directors.

## L. Other Issues

1. Effect of Receiver's Fraud Action Against Directors and Officers Upon Reinsurance Recoverables

Before initiating a fraud action against the management or directors of the insolvent insurer, the receiver should consider possible unintended consequences of the suit. It is possible that the assertion of fraud will provide a basis for the insurer's reinsurers to seek rescission of their reinsurance obligations based upon the same fraud. If so, the receiver may sacrifice the largest asset (reinsurance recoverables) in the estate. This, in fact, happened in a 1996 New York insolvency.[211] IRMA § 112A provides that an allegation of improper or fraudulent conduct by management is not a defense to the receiver's action to enforce a contract unless the other party can prove that the fraud was "materially and substantially related" to the creation of the contract.

[211] See *Matter of Liquidation of Union Indemnity Insurance Co. of New York,* 89 N.Y.2d 94, 674 N.E.2d 313 (N.Y. 1996).



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The ramifications of such a rescission would be far-reaching and dire. The effect would be to deprive the estate of substantial assets, reinsurance recoverables amounting to millions of dollars in most cases, and could severely undermine the receivership proceedings.

A receiver faced with such a demand for rescission may wish to argue that granting rescission fails to take into account the governing principles of law and public policy. Further, rescission contravenes the fundamental purpose of the insurance laws throughout the country, because it would result in a significant preference to reinsurers, as compared to other creditors against the estate, many of whom are innocent policyholders.[212] Under this argument, reinsurers should be accorded the same status as any other creditor and permitted to file a proof of claim in the liquidation proceeding (for fraud) and should not be allowed to absolve themselves of obligations owed to the estate via rescission.

While there is not a great deal of established precedent directly on point, courts have, in some cases, declined to allow rescission based on fraud where to do so would contravene established public policy reflected in a statute. These cases have involved an insolvent health maintenance organization, stockholders' subscriptions, the Federal Deposit Insurance Act, the Security Investor Protection Act (SIPA) and other banking statutes.[213]

Depending upon relevant state statutes, particularly in the area of credit for reinsurance, it may also be possible to construct an argument that allowing rescission in the context of an insurer insolvency is contrary to the legislative purpose and public policy. Such an argument might run as follows: the insurance laws require insurers to satisfy specific capital and surplus requirements. If the capital and surplus requirements are not met, the regulator may revoke the insurer's license to sell insurance in the state. In computing an insurer's capital and surplus requirements, an insurer under certain circumstances is entitled to a credit as an admitted asset (or a deduction from liability) for the amount of its risks and policy liabilities which it has reinsured.

Reinsurance may not be carried as an admitted asset unless the reinsurance proceeds are payable directly either to the insurer, or to the receiver, in the event of the insurer's insolvency, without diminution because of the insolvency of the ceding insurer. These requirements make it clear that the purpose of the regulatory scheme is to protect policyholders and other creditors in the event of an insolvency. The receiver could argue that this legislative purpose cannot be effectuated, however, and will be abrogated, if reinsurers are permitted to rescind ab initio their reinsurance contracts.

Another argument which may be available to the receiver based upon statute and public policy is that the loss of funds coming into the estate as a result of rescission could interfere with the administration of the estate.

Finally, it should be noted that rescission is an equitable remedy and is normally used to restore the parties to a previously existing condition. Some courts have suggested that, when a party enters into a contract with one person knowing that other persons will be affected, such party should not be allowed rescission as to one party without consideration of the consequence to others. Thus, the receiver may wish to argue that rescission ought not be allowed where the reinsurer knew or should have known that the cedent's policyholders would be affected by the reinsurance transaction.

Reinsurers may be expected to counter these arguments by noting that the insolvency clause is designed to prevent refusal of a reinsurer to pay based upon the cedent's insolvency and is not relevant to the separate and distinct question of rescission based upon fraud. Similarly, while state statutes limit

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[212] See *Garamendi v. Abeille-Paix Reassurances,* No. C-683-233, slip. op. (Cal. Super. Ct. L.A. Co. June 25, 1991); but see *Prudential Reinsurance Co. v. Superior Court of Los Angeles County,* 3 Cal. 4th 1118, 842 P. 2d 48 (1996) which arguably rejects the approach taken in *Garamendi*.

[213] See e.g., *Union Indemnity Co. v. Home Trust Co.,* 64 F.2d 906 (8th Cir. 1933); *In re Liquidation of Security Casualty Co.,* 127 Ill. 2d 434, 537 N.E.2d 775 (Ill. 1989) (refused to allow defrauded shareholders to rescind, and thereby increase their priority from Class "F" to constructive trust "super priority.").



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preferences, preferences are not prohibited. For example, secured creditors are ordinarily allowed to convert secured property even though this effectively results in a preference. Further, there is an established body of case law which suggests that parties such as reinsurers who are induced to enter into an agreement by fraud are entitled to attempt to rescind the agreement.

In summary, allegations of fraud could trigger efforts by reinsurers to rescind their reinsurance agreements with the insolvent insurer. While the receiver has available arguments against rescission, the receiver should be aware that the consequences to the estate are potentially severe. Counsel must be consulted and all potential ramifications explored before allegations of fraud are asserted.

2. Receiver's Claim of Proceeds of Directors and Officers Policy

The receiver is the successor in interest to the insurer. Therefore, the receiver has a right to claim against the directors' and officers' liability policy previously provided by the insurer. However, be advised that a claim based on fraud or intentional misrepresentation might provoke a reaction by vendors such as MGAs and reinsurers. They may argue the fraud allegedly prohibited them from rendering proper services to the insurer and, therefore, they are immune from suits and claims as described above. The directors and officers liability insurance policy, if any, may also exclude coverage of claims based upon fraud. The tension and conflict in these two positions should be noted and discussed with the estate's attorney.

## IX. REINSURANCE

### A. Introduction and Goal

The concept of reinsurance is discussed in detail in Chapter 7—Reinsurance. In this section, we will discuss the various legal issues and concepts that may arise in the course of the receivership, both where the insurer was the ceding insurer and where the insurer was the reinsurer.

This is an important area of law as reinsurance recoveries will often be the largest asset of the estate.

### B. Reinsurance Ceded and Assumed

Chapter 7—Reinsurance sets forth a detailed discussion of ceded and assumed reinsurance.

### C. Reinsurance Accounting and Collection Procedures

1. Loss Notifications

Agreements between primary insurers and reinsurers generally contain a provision requiring the insurer to give prompt and adequate notice to the reinsurer in the event of a loss which may trigger the indemnity required under the agreement. Chapter 7—Reinsurance includes a discussion of notice requirements.

- Timeliness

A legal issue often encountered is whether failure to give timely notice of a claim to a reinsurer relieves the reinsurer of the obligation to make a payment based upon the claim.

Case law in this area is far from settled. Some federal and state courts have determined that before a reinsurer can avoid liability due to late notice of loss, the reinsurer must be able to show that it has been prejudiced or suffered damage as a result of the lack of notice.[214] A small number of courts

[214] See *Christiana General Insurance Co. v. Great American Insurance Co.,* 745 F.Supp. 150, 161 (S.D.N.Y. 1990).


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even require that an insurer seeking relief from its obligations based on breach of a notice clause must show "substantial prejudice" to its position in the underlying action resulting from the breach.[215] This is frequently a difficult burden for a reinsurer to meet, but the prudent receiver should expect contentions that late notice has prejudiced reinsurers. Further, other courts have recognized that if a reinsurance contract makes notice a "condition precedent" to payment, then failure to provide this required notice obviates the reinsurer's obligations under the reinsurance agreement regardless of whether prejudice can be demonstrated.[216] The receiver should consult counsel to ascertain the applicable rule in the local jurisdiction.

2. Defenses to Collection Based on Contract

a. Contract Limitations

In addition to the "late notice" defense, several other defenses to payment under reinsurance agreements may emerge. Depending upon the particular facts, reinsurers may assert that a claim arose after the expiration of either the primary coverage or the reinsurance coverage or is otherwise beyond the scope of coverage provided by the underlying insurance or the reinsurance agreement.

b. Exclusions

Both the underlying insurance policies and the reinsurance agreement will typically include descriptions of excluded risks. Before billing reinsurers, the receiver should verify that the loss is within the covered terms of the reinsurance agreement.

**D. Secured Reinsurance**

At the present time, the NAIC is considering the design of a revised United States reinsurance regulatory framework. This revised framework would establish a Reinsurance Evaluation Office. Among other things, this office would determine which other foreign countries have equivalent regulatory systems as the U.S. Reinsurers from those countries would be certified to access the United States market through a port of entry similar to foreign direct insurers. Additionally, collateral requirements would be set based on the nature of the reinsurance exposure, rather than on reserves. For a summary of the NAIC's work on this, see *NAIC Reinsurance Collateral Update*, Brian Fuller NAIC Senior Reinsurance Manager, Sept. 27, 2007.

1. Credit for Reinsurance in General

U.S. licensed reinsurers are regulated in essentially the same manner as primary insurers, except for rate and form regulation. Because U.S. insurance regulators have no, or limited jurisdiction over non-U.S. reinsurers, the reinsurance transaction (as opposed to the reinsurer) is regulated through the cedent by prescribing the terms under which the cedent can take financial statement credit for reinsurance recoverables.

While an insurer can opt to obtain reinsurance that does not qualify for financial statement credit, in most circumstances, it will be very important to a ceding insurer that it be allowed to take credit on its financial statements for reinsurance which it procures. However, there is no regulatory requirement that reinsurance meet this standard.

All U.S. jurisdictions have developed standards prescribing the circumstances in which a ceding insurer is allowed to take credit for reinsurance. The credit for reinsurance laws are important to a receiver for several reasons. If a reinsurer is licensed or authorized in a state, no security is typically required. However, if a reinsurer is not licensed or authorized, it is important for a receiver to know that there

[215] *GTM, Inc. v. Transcontinental Ins. Co.*, 5 F.Supp.2d 219 (D.Vt. 1998); *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715 (Cal. Ct. App. 1993).

[216] *Liberty Mutual Ins. Co. v. Gibbs,* 773 F. 2d 15 (1st Cir. Mass. 1985).


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may be security posted in favor of the insolvent insurer securing obligations owed to that insurer by reinsurers. Alternatively, if the insolvent insurer was a reinsurer, assets of the insolvent insurer may be encumbered elsewhere to provide security necessary for credit for reinsurance purposes. This security usually takes one of three forms: letters of credit, trust funds and funds withheld.

2. Letters of Credit (LOC)

Situations where letters of credit are used for credit for reinsurance purposes involve three separate and distinct contractual arrangements. First, the reinsurance agreement itself usually will expressly require the reinsurer to provide security necessary for credit for reinsurance purposes. Second, there will be a contract between the reinsurer and the issuer of the letter of credit (LOC) (almost always a bank) pursuant to which the issuer agrees to issue the LOC in return for compensation. This agreement is sometimes referred to as an "account agreement." The account agreement usually requires the reinsurer to post collateral with the issuer to protect the issuer in the event that the issuer is compelled to make payment under the LOC. The third contract is the LOC itself, which is a separate and distinct contract entered into between the issuer of the LOC and the ceding insurer as the beneficiary of the LOC.

a. Maintenance

The mechanics involved in maintaining letters of credit are discussed in Chapter 7. The receiver should bear in mind two legal issues in connection with maintenance of LOCs. First, in most cases, the reinsurance agreement will expressly impose a contractual obligation upon the reinsurer to maintain the LOC for as long as the reinsurer has outstanding obligations under the agreement. If the receiver of an insolvent ceding insurer receives notice that a LOC will not be renewed while a reinsurer's obligations are still outstanding, the receiver should consult counsel immediately. The reinsurer's actions may give the receiver a contractual right to draw on the LOC. Such failure may also provide the receiver with a basis to charge the reinsurer with breach of the reinsurance contract.

Second, all LOCs posted for credit for reinsurance purposes are required to include an "evergreen clause" under which the issuer of the LOC agrees to give the beneficiary advance written notice prior to termination of the LOC. If appropriate notice is not provided, the LOC automatically renews. If the issuer allows termination without providing the receiver with requisite advance notice, there may be a cause of action available against the issuer for breach of the terms of the LOC and possibly for failure to fulfill the issuer's fiduciary responsibility to the ceding insurer as beneficiary.

b. Draw Down on LOC

The key legal issue for the receiver to remember in connection with a draw down on a LOC is the fact that the LOC and the reinsurance contract are separate and distinct contracts. A commercial dispute as to whether a particular obligation is due under the reinsurance agreement should not form a basis for a court to prevent a draw under the LOC. Letters of credit established for credit for reinsurance purposes are generally "clean" and "unconditional," meaning that all that is necessary for a draw to take place is for the ceding insurer to make a proper demand upon the issuer. It is generally well established that courts will not interfere with such a draw except in two cases: first, where the attempted draw is fraudulent; and, second, where the underlying transaction is so tainted with fraud that the draw should not be allowed (called "fraud in the transaction"). Of course, a draw that is appropriate under the terms of the LOC may ultimately be found to have constituted a breach of the underlying reinsurance agreement if the obligation is not actually due.

c. Right to Collateral

Once an issuer pays on a letter of credit, it will most certainly apply the collateral posted as security for the LOC by the reinsurer under the account agreement against the outstanding balance due from the reinsurer. Thus, wrongful or premature draws on LOCs may damage the estate of an insolvent



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reinsurer. The damages may be based not only on the loss of collateral, but also on the loss of interest income which would have been earned by the reinsurer had a premature draw not taken place. Consequently, wrongful or premature draws may provide a basis for the receiver to bring suit against the cedent for breach of the underlying reinsurance agreement and consequent damages. The receiver of an insolvent cedent which draws down an LOC wrongfully or prematurely may also face a claim by the reinsurer.

3. Trust Funds

An alternative security device to letters of credit is trust funds. Trust fund arrangements involve two separate contracts. The first is the reinsurance agreement itself. The second is the trust agreement pursuant to which the reinsurer, as grantor, places assets in trust under the control of the trustee (again, usually a bank) with the ceding insurer named as beneficiary of the trust. See the NAIC Credit for Reinsurance Model Act (#785), Section 2D.

a. Maintenance

Unlike clean, irrevocable LOCs, trust agreements are fairly detailed and spell out the respective rights and duties of the parties. The receiver and his attorney should review the text of trust agreements to ascertain the rights and duties of the insolvent insurer. Failure of the trustee or the insurer who is a party to the agreement to comply with the agreement's terms and conditions may form a basis for a breach of contract action in favor of the estate.

b. Access to Trust Assets

This is largely spelled out by the terms and conditions of the trust agreement. General principles of contract law are applicable.

c. Chapter 15—Proceedings Under the United States Bankruptcy Code

An insurer will frequently cede business to a non-U.S. reinsurance company that is not licensed or authorized to do business in any state. In order for the insurer to take credit for the reinsurance it procures from such insurer, most states require the insurer to provide collateral to secure its U.S. obligations, in case the reinsurer becomes unable to fulfill those obligations for any reason. The reinsurer may provide this collateral in the form of a trust. The trust must contain enough funds to cover the reinsurer's U.S. liabilities.[217] The reinsurer can set up the trust for the benefit of a single ceding insurer, or for the benefit of all the ceding insurers with which it does business in the U.S. In the case of these latter trusts, known as multiple-beneficiary trusts, there must be a trusteed surplus in addition to the funds covering the reinsurer's liabilities, e.g., $20 million for most reinsurers, and $100 million for Lloyd's.

If the reinsurer becomes insolvent and fails to pay U.S. claims, state laws intend that the U.S. claimants may then turn to the trust for payment. In order to receive payment, claimants must follow the steps set forth in the trust instrument. These steps usually include acquisition of a judgment, exhaustion of appeals of the judgment, filing of the judgment with the trustee, and a 30-day notice to the reinsurer (or its receiver) that the cedent will obtain payment of its claim from the trust unless the reinsurer pays the claim itself.

Chapter 15 of the Bankruptcy Code states that a court may not grant relief under Chapter 15 with respect to any deposit, escrow, trust fund or other security which is required or permitted by any applicable state insurance law or regulation for the benefit of claim holders in the U.S. The purpose

[217] For single beneficiary trusts the amount of the trust cannot be more than the amount of financial credit that the cedent has taken on its financial statements. This might be less than the reinsurer's total liabilities to the ceding insurer.



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of this language is to make certain that bankruptcy courts have no power over U.S.-based reinsurance collateral posted for the benefits of U.S. claimants.

Additionally, states which have adopted the most current version of the NAIC model law and regulation on credit for reinsurance have addressed the problems which used to be posed by 18 U.S.C § 304. A U.S. receiver with trust claims should determine whether the state where the trust is located has adopted the most current version of the NAIC model law and regulation on credit for reinsurance. If the state has enacted those provisions, the U.S. receiver should consult an attorney to determine whether the provisions are applicable to the trust and claims in question.

4. Funds Withheld

A third alternative is for the reinsurance agreement to provide that the ceding insurer will hold funds belonging to the reinsurer in a separate account to secure the reinsurer's duties and obligations to the cedent. Again, general principles of contract law control the parties' respective duties and obligations with respect to funds withheld.

## E. Setoff

While the concept of setoff can involve fairly complex computations, it contemplates that funds owed by an entity to an insolvent insurer's estate will be set-off against funds owed by the insolvent insurer to that entity, so that only the net will be collected or paid. The mechanics and potential financial ramifications of setoffs for an estate are discussed in detail in the reinsurance and accounting chapters of this handbook.

## F. Cancellation of Reinsurance Agreements

A receiver should have staff review all agreements to determine what, if any, provisions are included regarding cancellation in the event of insolvency. Generally, absent such a provision (and frequently even if present) a receiver is empowered by the relevant state statute to cancel any contracts including reinsurance agreements, see § 114 and § 504A(8) of IRMA. Whether representing an insolvent reinsurer, primary insurer, or an insurer with both ceded and assumed reinsurance, notice to the opposite contracting party is essential. This is so that ceding insurers can replace their coverage and reinsurers can be aware of the date when their liabilities are cut off.

In the context of a life and health insurer insolvency, guaranty associations should be consulted before the company's ceded reinsurance agreements are canceled or otherwise terminated. Indemnity reinsurance may provide guaranty associations with valuable financial support in transferring policy obligations to an assuming insurer. Model #520 and IRMA §612 recognize this by providing guaranty associations with the right to assume the insolvent company's indemnity reinsurance agreements for the purpose of meeting coverage obligations.[218]

## G. Rescission

1. Rescission Defined

Black's Law Dictionary (8th ed. 2004) defines rescission of contract as follows:

A party's unilateral unmaking of a contract for a legally sufficient reason, such as the other party's material breach, or a judgment rescinding the contract; VOIDANCE. • Rescission is generally available as a remedy or defense for a nondefaulting party and is accompanied by restitution of any partial performance, thus restoring the parties to their precontractual positions.

[218] Model #520, at Section 8.N.



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2. Legal Ramifications

Alabama maintains that a reinsurance contract cannot be rescinded absent fraud or collusion. Nebraska law permits rescission of a reinsurance agreement if the ceding insurer has failed to perform its duties respecting reserving, reporting and other aspects of administration so totally as to constitute a material breach of the reinsurance agreement. In either circumstance, if the jurisdiction supports the grounds, the reinsurer may be entitled to rescind the contract from its inception.

A leading case describes the essential elements necessary to maintain an action for rescission because of false representations.[219] The party seeking rescission must allege and prove: 1) that representations were made; 2) that they were false and so known to be by the party charged with making them; 3) that without knowledge as to their truth or falsity they were made as a positive statement of known fact by the party charged with making them; 4) that the party seeking rescission believed the representations to be true; and 5) that the party relied and acted upon them and was injured thereby.

This case also discusses rescission based on non-performance of contract. Not every breach of contract or failure to perform entitles the other party to rescind. A rescission is warranted only by a breach of contract "so material and substantial as to defeat the objectives of the parties in making the contract."[220] Whether a breach qualifies as material or substantial enough to serve as grounds for rescission is a question of fact which depends on the circumstances of each case.

A party's right to rescind a reinsurance treaty is not absolute. If a party knows of facts giving rise to the right of rescission and fails to declare a rescission and disclaim the benefits of the contract within a reasonable time, the right to rescind may be barred. Also related to an insurer's right to rescind a reinsurance treaty are the questions of whether voluntary rescission may constitute a preference under existing statutes, the Liquidation Model Act and/or IRMA and, if a preference is created, whether it is a voidable preference. For example, if a ceding insurer, immediately before being declared insolvent, agrees to rescind from inception a ceded treaty where reinsurance recoverables exceed ceded premiums, the receiver may attempt to void the transaction. Each transaction should be analyzed in terms of the elements of a voidable preference discussed earlier in this chapter.

## H. Use of Reinsurance to Wind Up the Affairs of an Insolvent Insurer

There are several reinsurance transactions available which may serve as tools for winding up the affairs of the insolvent insurer. These are briefly described below.

1. Commutations

A commutation agreement is one pursuant to which a reinsurer and a ceding insurer agree to terminate all obligations under a reinsurance agreement, accompanied by a final cash settlement. Commutations are discussed in detail in Chapter 7—Reinsurance.

There may be a commutation clause in the relevant reinsurance agreement. Alternatively, the parties may simply agree to the commutation based upon negotiations. The end product of the negotiations will be the reinsurer making a one-time cash payment into the estate in return for a full release from all future liability.

Given the material nature of the transaction, approval of the transaction should be obtained from the receivership court.

[219] See *Stone v. Walker,* 201 Ala. 130, 77 So. 554 (1917), cited with approval in *Johnson v. Jagermoore-Estes Properties,* 456 So.2d 1072 (Ala. 1984).

[220] *Id.*



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§ 614 of IRMA authorizes commutation agreements and requires court approval where the gross consideration for the agreement is in excess of $250,000. This section also authorizes the receiver to have competing commutation proposals submitted to an arbitration panel and outlines the process to be used and the possible outcomes.

2. Assumption Reinsurance

Assumption reinsurance is a misnomer. It is an agreement whereby one insurer transfers to another insurer its contractual relationship and obligations to its insured. Thus, the purpose of the transaction is to bring about a novation. Assumption reinsurance can be a means for a receiver to transfer books of business away from the insolvent ceding insurer to another, solvent insurer, thereby reducing strain on the estate and alleviating one of the hardships otherwise caused by the insolvency. The receiver may pursue the transfer of a book of business during rehabilitation or a transfer of liabilities not covered by the guaranty associations in liquidation. The receiver should coordinate with the guaranty associations on any reinsurance transaction pursued in liquidation, as the guaranty associations also have the authority to reinsure their obligations.

- Mechanics

Notification to policyholders is essential if the agreement is to have the desired effect of precluding future claims by the policyholders against the ceding insurer's estate. In some states, notice alone may not be sufficient to achieve a novation; e.g., the policyholders' written agreement may be required. In some instances, both the transferring insurer and the assuming insurer have been found to have a continuing obligation to the insured where notice was not given and consent was not obtained. Applicable state law should be consulted to determine what law is followed in each jurisdiction. Mechanically, the assuming reinsurer issues what are called "assumption certificates" to the policyholders notifying them of the change in insurer. Given the material nature of the transaction, approval of the receivership Court should be obtained.

## I. Portfolio Transfers and Financial Reinsurance

The various types and effects of financial reinsurance are discussed in detail in Chapter 7—Reinsurance.

1. Regulation of Financial Reinsurance

General Transfer of Risk Provisions

To receive accounting treatment as a reinsurance transaction, a transfer of risk is required. NAIC Statement of *Statutory Accounting Principles 62—Property and Casualty Reinsurance* (SSAP No. 62) requires the transfer of insurance risk for the ceding company to be granted accounting credit for the transaction. SSAP No. 62 states that the reinsurer must indemnify the reinsured entity, not only in form but in fact, against loss or liability by reason of the original reinsurance. Receivers should consult SSAP No. 62 if there are questions surrounding the accounting treatment of a particular reinsurance transaction. See Chapter 7—Reinsurance for a more detailed statement.

2. Financial Reinsurance in the Insolvency Context

Receivers of insolvent insurers which have engaged in financial reinsurance transactions should examine carefully the insurer's reinsurance agreements, giving careful consideration to the nature and purpose of the agreements. Among the factors that a receiver must weigh in evaluating whether a financial reinsurance agreement occurred between the insolvent ceding insurer and a reinsurer(s) are:

- Whether the transaction was accomplished solely to prolong the life of the ceding insurer;



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- Whether a financial reinsurance transaction occurred between affiliates;
- Whether the transaction was close to the date of the declaration of insolvency;
- Whether the transaction was negotiated by officers or directors of an insurer who might have had a personal interest in the transaction;
- Whether accountants who prepared the ceding insurer's annual statement appear to have correctly reflected the transaction; and
- Whether there were any possible affiliations between the reinsurance intermediary and the parties to the financial reinsurance transaction.

If the receiver has reason to believe upon examining all facts that a financial reinsurance transaction did not meet the risk transfer requirements of SSAP No. 62, the receiver should consult with counsel to ascertain whether there are any viable causes of action arising out of the activities of the parties to the financial reinsurance transaction.

**J. Dispute Resolution**

There is no question that an insolvent insurer will have many disputes to resolve. There will be looming questions, however, of how the resolutions will occur, how long they will take and how much they will cost. These are questions a receiver will face on a regular basis and they are virtually always about collecting or paying money. More often than not, they involve reinsurance proceeds.

The insolvent insurer has various options in settling disputes: negotiation; mediation; arbitration; and litigation. As a general rule, negotiation is the fastest and least expensive option and litigation is the most costly and time consuming.

Arbitration has many advantages in the dispute resolution process. A majority of reinsurance agreements provide for it as the sole means of resolving conflict.[221] Most courts, including the U.S. Supreme Court, favor enforcing agreements to arbitrate, but a small number of New York and Ohio cases have held otherwise.[222] Historically, arbitration awards were forthcoming much sooner than a similar decision from a court of law. The result was usually less expensive than litigation and had other advantages such as: confidentiality of process; expert triers of fact; broad ranges of relief; and other procedural and substantive benefits.

The confidentiality aspect has been criticized because it prevents the award from having any precedential effect. However, the agreements which are generally the subject of arbitration proceedings are complex reinsurance agreements with multiple parties. In addition, the industry has such arcane, esoteric language and customs that it is unlikely a court decision as to the interpretation of a particular agreement would have precedential effect in any event.

One reason a receiver may want to resolve disputes through litigation is because of the cases being heard in a perceived "friendly forum." Since insolvent insurers are liquidated by virtue of the statutes of the state

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[221] See e.g., *Selcke v. New England Ins. Co.* 995 F.2d 688, 689, 690 (7th Cir. 1993).

[222] See e.g., *Quackenbush (as Liquidator of Mission) v. Allstate* 517 U.S. 706 (1996) (U.S. Supreme Court ruled that receiver may be required to arbitrate); *Foster v. Philadelphia Manufacturers,* 592 A.2d 131 (Pa. Commw. Ct. 1991) (Court ruled that arbitration clause was enforceable against receiver under Pennsylvania state law), contra *Koken v. Reliance Ins. Co.*, 846 A. 2d 778 (Pa. Comm. Ct. 2004) which held that arbitration could not be compelled where receivership was liquidation rather than rehabilitation as in *Foster*, there was a court order which prohibited bringing actions against the Liquidator, and the Liquidator did not initiate the lawsuit where arbitration was in issue; *Benjamin v. Pipoly,* 155 Ohio App. 3d 171, 800 N.E. 2d 50 (2003 Ohio App.) and *Hudson v. John Hancock Fin. Serv.* ,2007 Ohio App. LEXIS 6137 (Enforcing arbitration clause is against Ohio public policy in insurance receiverships); *Washburn v. Corcoran,* 643 F.Supp. 554 (S.D.N.Y. 1968) (Court ruled that arbitration clause was unenforceable against receiver under New York law.).



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of domicile, the receivership court has broad powers to wield in protecting the estate. It may restore a spirit of cooperation and settlement, giving the insolvent insurer back some of the leverage it lost with the reinsurers when it ceased to be a potential source of future business. Reinsurers will typically resist litigation. Each receiver must determine in each case when arbitration would be advantageous to the estate.

**K. Pre-Answer Security**

Courts may require certain insurers to post security when sued in U.S. jurisdictions in which they are not licensed. Thirty-eight states have adopted the Uniform Unauthorized Insurers Act. For example, New York Insurance Law Section 1213(c) requires a foreign or alien (nonadmitted) insurer to post "pre-answer security" before it files any pleadings in the court. The security must be sufficient to guarantee the payment of a final judgment that may be issued against the insurer. In New York, a failure to post the required security may result in a default judgment.

The law was originally enacted to protect policyholders who experienced difficulty executing judgments against unauthorized foreign and aliens insurers with insufficient assets in the state in question to satisfy the judgment. Although reinsurers have argued that the statute was not intended to apply to them, courts consistently have applied the statute to reinsurers being sued by ceding insurers or their receivers.[223]

Courts have addressed several other issues in recent decisions, such as the amount of security that is required, or the circumstances, under which an insurer is "doing business" in a state, that are sufficient to invoke the pre-answer security requirement.

In reinsurance disputes, courts often require an amount of security equal to the plaintiff's alleged damages. In a New York case, however, the required amount of security was limited to paid losses, excluding case reserves and IBNR.[224]

In at least one case, a ceding insurer licensed in New York invoked the pre-answer security requirement against an alien reinsurer even though no policy was delivered in New York and the reinsurance transaction took place through the mail.[225] Some cases have noted, however, that the Foreign Sovereign Immunities Act 28 USCA § 1602, et. seq. may preempt state security statutes if the foreign insurer or reinsurer is an agency or instrumentality of a foreign state.[226]

Additionally, some courts have held that arbitrators have broad authority to require pre-hearing security.[227] Arbitration panels also are increasingly requiring the posting of security. Reinsurers may be subject to posting security in actions seeking to compel arbitration or to confirm arbitration awards.

**L. Discovery of Reinsurers**

Reinsurance information has been generally undiscoverable to policyholders. In those instances where policyholders have tried to obtain information regarding their insurer's reinsurance, the release of the information has been denied on the basis of relevancy since the policyholder had no contractual right to the reinsurance proceeds.[228] Insurers and reinsurers have also contested production on the basis that the information was proprietary and confidential.[229]

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[223] See e.g., *Morgan v. American Risk Management, Inc.*, 1990 WL 106837 (SDNY July 20, 1990).

[224] *Morgan v. American Risk Management, Inc.,* 1990 WL 106837 (SDNY July 20, 1990);

[225] *John Hancock Property & Casualty Insurance Co. v. Universale Reinsurance Co.,* 1993 U.S. Dist. LEXIS 9411 (SDNY July 12, 1993).

[226] See e.g., *Stephens v. National Distillers and Chemical Corp.,* 69 F.3d 1226 (2d Cir. 1995).

[227] *Pacific Reinsurance Management Corp., v. Ohio Reinsurance Corp.,* 935 F.2d. 1019 (11th Cir. 1991).

[228] See e.g., *Leski, Inc. v. Federal Ins. Co.,* 129 F.R.D. 99, 106 (D.N.J. 1989).

[229] See e.g., *National Union Fire Ins. Co. v. Stauffer Chemical Co.,* 558 A.2d 1091, 1097 (Del. Super. Ct. 1989).



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Increasingly, policyholders in large coverage disputes are pressing for reinsurance information and courts are allowing production based on the typical analyses applied to other industries and litigants, e.g., whether the communications were protected by the attorney-client privilege or work-product doctrine, and whether the communications between a lawyer and his client constituted legal or business information.[230]

If discovery of reinsurance information is being sought by the receiver or discovery demands are being made on the receiver, counsel should consult local law to determine the extent to which such information is discoverable.

**M. Priority of Claims for Payment of Reinsurance**

Both the Liquidation Model Act and IRMA exclude from the policyholder level distribution class "obligations of the insolvent insurer arising out of reinsurance contracts," see § 801 C(1) of IRMA and § 47C(1) of Liquidation Model Act. Those claims are subordinated to the unsecured claim distribution class. States without this exclusion that have considered the issue have reached the same conclusion, See *Covington v. Ohio General Insurance Co*, 99 Ohio St.3d 117, 789 N.E.2d 213 (2003); *Neff v. Cherokee Insurance Co.*, 704 S.W.2d 1 (Tenn. 1986); *In re Liquidation of Reserve Insurance Co.*, 122 Ill.2d 555,524 N.E.2d 538 (1988); *Foremost Life Insurance Co. v. Indiana Dept. of Ins.*, 274 Ind. 181, 409 N.E.2d 1092 (1980).

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[230] *Lipton v. Superior Court,* 56 Cal. Rptr. 2d 341 (Cal. Ct. App. 1996); and *Allendale Mutual Insurance Co. v. Bull Data Systems,* 152 F.R.D. 132 (N.D. Ill. 1993).


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# CHAPTER 10 – CLOSING ESTATES

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# I. INTRODUCTION

The closure of a receivership—i.e., the termination of the receivership proceeding in the supervisory court—represents the culmination of the efforts of the receiver to complete those duties and wind up the insolvent insurer's affairs as quickly and efficiently as possible. This applies whether the receivership proceeding is one of rehabilitation or liquidation, domiciliary or ancillary.

The conclusion of the affairs of the insurer, both from an asset and a liability standpoint, has to be accomplished in such a way that each of the statutory responsibilities of the receiver has been fully, fairly and promptly addressed. Planning for the closure of the estate should begin at the outset of the receivership proceeding. The receiver must establish and coordinate the legal, administrative, claims handling and accounting functions and set up the related reporting systems to facilitate the closure process. For a discussion of these functions, see Chapter 1—Takeover and Administration. A review of Chapter 5—section on Governmental Agencies, is also advised.

Guidelines within this chapter are based largely upon the NAIC Insurers Receivership Model Act (IRMA).

# II. CLOSING REHABILITATION PROCEEDINGS

## A. General

Rehabilitations usually become liquidations or, less frequently, come to a point where control over the insurer is turned back to original or successor management. In a successful rehabilitation, there is a transition to normal operations that evolves from negotiation with former or proposed management and other constituencies. That negotiation is so unique to a particular rehabilitation effort that there is little in the way of guidelines to offer. There will generally be a final accounting and reporting process to the rehabilitation court and an application for termination of the formal proceeding. Accordingly, the receiver should lay the groundwork early for the timely discharge of the receiver, as rehabilitator, and the termination of the rehabilitation proceedings.

## B. Closing the Rehabilitation Proceeding

Anytime the rehabilitator or the former directors of the insurer believe the purposes of the rehabilitation have been accomplished, a petition may be filed in the receivership court for an order terminating the rehabilitation, discharging the rehabilitator and restoring the company to private management. The court is also permitted to issue a termination order on its own motion. Before the company can be released from rehabilitation, Section 901 of IRMA requires that any funds paid by the guaranty associations must be repaid or the associations must have agreed to a repayment plan.

The order of discharge should include a release of the rehabilitator, agents, successors and assigns from all claims that may be asserted by creditors of the estate.

The rehabilitator and new management will want to determine and reach agreement on entitlement to and the value of the net operating losses pertaining to insurers which are part of holding company systems which have filed consolidated tax returns and consider other tax ramifications of the transactions.

The preparation of a final accounting by the rehabilitator and new management is necessary. The accounting will include what was originally agreed to between the parties as of the date of disposition to closing.

Under Section 404 of IRMA, the rehabilitator is allowed to file a petition to liquidate the insurer if the rehabilitator determines that further rehabilitation efforts would be futile or would increase the risk of financial loss to policyholders, creditors or the public. If the rehabilitator imposes a moratorium on the payment of policy benefits for six months without filing a rehabilitation plan, IRMA requires the rehabilitator to file a liquidation petition.



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Section 405 of IRMA further requires the rehabilitator to reserve assets so that the estate can continue claims payments for a short time after liquidation while the guaranty associations prepare. This is particularly true for workers compensation indemnity and medical payments and first party medical benefits under no-fault automobile insurance.

Coordination and reporting by and between the liquidator and the affected guaranty funds are critical. The Uniform Data Standard (UDS) was designed to facilitate this reporting. Prior to filing the petition to liquidate, the rehabilitator should ensure that the estate will have the ability to transmit claims and premium data via UDS to the impacted guaranty funds that will be triggered by liquidation. For further discussion of UDS and the coordination and function of guaranty associations, refer to Chapter 6—Guaranty Associations.

## III. CONSIDERATIONS PRIOR TO CLOSURE OF A LIQUIDATION

### A. Legal

1. Illiquid Assets and Causes of Action

There may be both assets and causes of action that may not be cost beneficial for the liquidator to pursue. Since the duties of the liquidator include marshaling and liquidating assets for the benefit of the creditors of the insolvent insurer, it is advisable for the liquidator to obtain court approval of any decisions regarding abandonment of assets where marshaling or liquidating is not possible. The liquidator may also wish to consider negotiating with guaranty associations for the transfer of assets and causes of action to the guaranty associations as distributions in-kind. See IRMA Section 802C.

2. Termination of Proceedings

Pursuant to Section 902 of IRMA, when the liquidator has liquidated and distributed all assets that can be economically justified, the liquidator shall apply to the liquidation court for an order approving a final distribution of assets, closing the estate and discharging the liquidator. The order may set aside funds for post-closing administrative costs and provide for in-kind distribution of assets, if appropriate. The liquidator should consider formal corporate dissolution in the application unless the domiciliary state receivership statute dissolves the corporate entity by operation of law.

3. Record Retention

The liquidator should identify the various types of documents in his/her possession and determine the appropriate length of time that the documents should be preserved. In many cases, it may be appropriate to review and deal separately with the documents in different categories, e.g., the insurer's pre-receivership records, the insurer's post-receivership records, the records of the liquidator, etc.

Counsel should determine whether the destruction of these categories of documents is governed by the state law concerning the destruction of public or governmental documents, or by state law concerning business documents generally. In certain situations, state law and/or the IRS may require that records be maintained for a specific period of time. Ethical standards for attorneys, as well as others may require retention periods. Federal regulation for record retention, if applicable, may also affect certain retention periods, e.g., Medicare health insurance records. Certain documents may need to be permanently preserved, perhaps through the state archival process.

Once the legal requirements of the domiciliary state and any other states where the insurer did business have been reviewed, the liquidator should recommend to the court specific retention periods and procedures.


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The receiver should reserve funds from the estate for the maintenance of records after the discharge of the receiver. Once the receiver is discharged, the entity assuming maintenance of necessary records of the estate, if any, must be established.

## B. Tax Issues to be Considered Prior to Closure

1. General

Generally, federal and state tax returns should be filed by the liquidator throughout the liquidation. The final returns will be filed as of December 31 of the year during which final distributions are paid. As set forth above, the expenses that will be incurred to prepare the returns should be prepaid, as the actual filings will occur in the year subsequent to closure.

With each of the federal tax returns filed during the liquidation, the liquidator may consider the submission of a writ application requesting a Prompt Audit and Determination under Revenue Procedure 2006-24 to the IRS. Generally, this will expedite the entire process and end the statute of limitations for the returns. Technically, this procedure only applies to companies in a bankruptcy proceeding (Title 11), but in the past the IRS has extended it to insurers in receivership. If this procedure is not extended to an insurer in receivership, insurance company receivers are required to file federal income tax returns in the normal course of business as if the insolvent insurer were a perpetual concern, with no mechanism to sever the statute of limitations period. This is an impediment to closure of an estate that must be dealt with by receivers on a case by case basis through closing agreements with the IRS.

For more information regarding tax issues, refer to Chapter 3—Accounting and Financial Analysis. ***It is strongly recommended that the receiver consult and retain a tax expert for all tax related issues.***

2. Internal Revenue Codes Relative to Insurance Contracts and Distributions

Tax implications and/or consequences of assumption transactions, 1035 exchanges or other such transfer of policyholder liabilities or payout of policyholder benefits is also an area of concern and consideration by the receiver. In response to insurer insolvencies, the IRS has addressed several issues affecting such taxation and tax implications. Such rulings have addressed issues such as funding in "steps,"[1] tax free exchanges,[2] multiple contract issues[3] and contract dates and testing for compliance,[4] to name a few, and specifically relate to Internal Revenue Codes 72 and 7702.

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[1] (Rev. Rul.) 92-43, 1992-1 CB 288. The IRS will allow a valid exchange where funds come into the contract or policy in a series of transactions if the insurer issuing the contract or policy to be exchanged is subject to a "rehabilitation, conservatorship or similar state proceeding." Funds may be transferred in this "serial" manner if: (1) the old policy or contract is issued by an insurer subject to a "rehabilitation, conservatorship, insolvency or similar state proceeding" at the time of the cash distribution; (2) the policy owner withdraws the full amount of the cash distribution to which he is entitled under the terms of the state proceeding; (3) the exchange would otherwise qualify for Section 1035 treatment; and (4) the policy owner transfers the funds received from the old contract to a single new contract issued by another insurer not later than 60 days after receipt or, if later, September 13, 1992. If the amount transferred is not the full amount to which the policy owner is ultimately entitled, the policy owner must assign his right to any subsequent distributions to the issuer of the new contract for investment in that contract. Revenue Proc. (Rev. Proc.) 92-44, 1922-1 CB 875, as modified by Rev. Proc. 92-44A, 1992-1 CB 876; (Let. Rul.) 9335054.

[2] If a non-qualified annuity contract is exchanged under Section 1035 within the scope of Rev. Rul. 92-43 (i.e., as part of a rehabilitation proceeding), the annuity received will retain the attributes of the annuity for which it was exchanged for purposes of determining when amounts are to be considered invested and for computing the taxability of any withdrawals.

[3] An annuity that is received as part of a Section 1035 exchange that was undertaken as part of a troubled insurer's rehabilitation process under Rev. Rul. 92-43 is considered to have been entered into for purposes of the multiple contract rule on the date that the new contract is issued. The newly-received contract is not "grandfathered" back to the issue date of the original annuity for this purpose. Let. Rul. 9442030.

[4] The IRS, in response to insurer insolvency proceedings, stated that modification of an annuity, life insurance, or endowment contract after Dec. 31, 1990, that is necessitated by the insurer's insolvency will not affect the date on which such contract was issued, entered into or purchased for purposes of IRC Section 72, 101(f) 264, 7702 and 7702A and also as not resulting in retesting or the start of a new test period under §§7702(f)(7)(B)-(E) and 7702A(c). Rev. Proc. 92-57, 1992-2 CB 410; Let. Rul. 9239026. See also Let. Rul. 9305013. The date is not



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Section 72 of the IRC, "Annuities; Certain Proceeds of endowment and life insurance contracts," specifically subsection (s), references required distributions where the holder of an annuity dies before the entire interest is distributed. The rules in Section 72 govern the income taxation of all amounts received under annuity contracts and living proceeds from life insurance policies and endowment contracts. Section 72 also covers the tax treatment of policy dividends and forms of premium returns.

IRC Section 7702 relates to the definition of a life insurance contract. For purposes of this section, the term "life insurance contract" means any contract that is a life insurance contract under the applicable law, but only if such contract meets the cash value accumulation test as defined in Section 7702(b), or meets the guideline premium requirements of Section 7702(c) and falls within the cash value corridor of Section 7702(d).

a. Cash Value Accumulation Test

Generally, a contract meets the cash value accumulation test if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract.

b. Guideline Premium Requirement and Cash Value Corridor

With respect to the guideline premium, a contract generally meets this requirement if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of such time. Guideline premium limitation means, as of any date, the greater of the guideline single premium or the sum of the guideline level premiums to such date. Guideline single premium means the premium at issue with respect to future benefits under the contract. Guideline level premium means the level annual amount, payable over a period not ending before the insured attains age 95, computed on the same basis as the guideline single premium.

A contract generally falls within the cash value corridor if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value.

As with any tax issue, the implications of all Internal Revenue Codes to a particular liquidation proceeding and that proceeding's specific transactions should be explored with tax counsel.

3. Collection of Tax

Under Section 801 of IRMA, claims of the federal government are assigned a Class 5 priority and claims of state or local government are assigned a Class 8 priority, unless the claims represent losses incurred under policies of insurance (Class 3 or 4 claims). Thus, tax liabilities not properly characterized as an expense of receivership administration (Class 1) rank behind any claims for guaranty fund administrative expenses (Class 2) and all claims of policyholders (Class 3 or 4), including guaranty funds. Conversely, under the federal "super-priority" statute, 31 U.S.C. § 3713, claims of the federal government (in cases not covered by the bankruptcy code) are given first priority. The Supreme Court of the United States has resolved this conflict in *United States Department of the Treasury, et al v. Fabe*, 508 U.S., 491, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993). The Court held that the Ohio priority of distribution statute was not pre-empted by the federal statute to the extent that the Ohio law protects policyholders, because to that extent it constitutes a law enacted "for the purpose of regulating the

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affected by assumption reinsurance transactions entered into by the insurer provided that the terms and conditions of the policies, other than the insurer, do not change. Let. Ruls. 9323022, 9305013. The IRS also concluded that where a nonqualified annuity is exchanged for another via Section 1035 as part of a troubled insurer's rehabilitation process under Rev. Rul. 92-43, the annuity received in the exchange will be treated as issued, entered into, or purchased as of the date of the exchange except as provided in IRC Sections 72(e)(5) and 72(q)(2)(F). Let. Rul. 9442030.



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business of insurance." Since the court also viewed administrative expenses as incurred in the process of protecting policyholders, administrative expenses also were ranked ahead of federal claims.

More recently, the 1st U.S. Circuit Court of Appeals has ruled that the federal government does not automatically have priority over other creditors, including state guaranty funds, in insurer liquidations. The 1st Circuit panel's ruling in *Ruthardt vs. United States of America* (see Chapter 9—Legal Considerations, section on Federal Government Claims) affirmed a Massachusetts district court's decision. In this litigation, the federal government challenged two aspects of the Massachusetts liquidation statute. First, the government argued that the liquidation priority provision in the statute is preempted by federal law to the extent it provides for payment of guaranty association claims ahead of claims of the federal government. The federal government also argued that the state's statutory bar date for filing claims against the insolvent insurer's estate does not apply to claims of the federal government. The federal district court ruled that the provision affording priority to guaranty association claims under the Massachusetts statute is a provision enacted for the purpose of regulating the business of insurance and is therefore shielded from federal pre-emption in accordance with the McCarran-Ferguson Act. With respect to the claims bar date, the district court concluded that it was bound by a controlling 1993 First Circuit decision finding that the benefits provided to policyholders by a state's claim bar date were too tenuous for that provision to constitute the regulation of the business of insurance subject to the McCarran-Ferguson protections. The Court of Appeals affirmed on both issues.

Generally, taxes are, at most, an expense of administration if the taxes arise during the period of administration (as distinguished from unpaid taxes for periods ending before commencement of liquidation) and are incurred by the estate, i.e., imposed on income from which the estate derived some benefit. Decisions regarding the payment of computed taxes should only be made after consultation with legal counsel.

4. Filing of Tax Returns

The entry of an order of liquidation does not terminate the existence of the insurer for tax purposes, regardless of the impact the order may have under state law. The taxable entity remains in existence until the liquidation is complete, i.e., all the assets have been distributed. Accordingly, the liquidator must attend to the continued filing of tax returns during the liquidation proceeding, which may include several taxable years. Therefore, the liquidator should recognize the need to undertake tax planning.

As set forth above, it is possible that over the period of administration, an insolvent insurer may lose its status as an insurance company or become exempt from taxation altogether. Since these classifications are based on a testing of the company's activities and reserve characteristics, as activities cease, premium diminishes and insurance obligations are ceded under assumption reinsurance arrangements, the company may begin to fail these tests. The liquidator should anticipate the occurrence of this, and plan for the attendant consequences (reserve restoration, etc.).

If the insurance company placed in liquidation is the common parent of a group that has been filing consolidated returns, the receiver may have to continue filing on that basis. If the company was a subsidiary in a consolidated group, it is arguable that an order of liquidation should cause a termination of membership in the group. It should be noted that the only apparent pronouncement in this area is a 1985 private ruling (LTR 8544018) in which the IRS held that continued inclusion in a consolidated group is required of an insurer throughout the period of administration. However, among the consequences of entering an order of liquidation are the facts that the liquidator is given the power to exercise all shareholder rights (Section 504A(16) of IRMA), the receiver may contemporaneously dissolve the corporate existence under state law (Section 503) and the shareholders, in their capacity as owners, become creditors of the estate (Section 501). Any one of these conditions, and certainly all of them in combination, would seem to indicate that the parent company no longer has any stock ownership interest in the insurer, much less any voting rights. Furthermore, considering that this is a permanent stockholder displacement rather than a mere suspension of rights, the ruling seems rather


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questionable. In this situation, tax counsel should be consulted. When dealing with tax sharing agreements and consolidated tax returns, the need for termination of any prior agreements should quickly be assessed. Termination of these agreements could prevent a parent of a subsidiary insurance company from taking away tax benefits that rightfully belong to the estate.

The liquidator needs to also be aware of the tax consequences for a member of a consolidated group upon its ceasing to be a member. It will have two short-period years, one ending on the day it leaves the group that will be included in the group's consolidated return, and one beginning on the next day and ending at the insurer's normal year-end that will require a separate return. Even though the insurer might be included in the group's consolidated return for a small portion of the year, it will be jointly and severally exposed to the group's consolidated tax for the entire year, which tax could be increased by the recognition of an excess loss account (i.e., negative basis) that the group might have in the stock of the insurer. If gains of the insurer on prior transactions with other members were deferred, the gains must be recognized in the consolidated return upon the member's departure. The tax thereon can come back to the insurer, either through joint and several liability or under a tax allocation agreement of the group. Any estimated tax payments made by the group during the year must be allocated. Operating losses sustained by the insurer in subsequent periods that can be carried back to prior consolidated returns will produce refunds that will be made to the common parent of the group.

Affiliates' use of losses within a consolidated return presents a difficult issue regarding the estate's ability to recover any portion of the benefit. If the group had entered into a tax allocation agreement, the estate's benefit would be determined pursuant to that agreement. However, absent a written agreement, as a matter of equity, courts seem to allocate tax benefits according to which entities paid the tax being recovered, or whose income is being offset (thus giving value to the loss). Note that the rules contained in the Department of the Treasury's regulations regarding allocations of consolidated tax are effective only for determining income tax consequences and do not, in and of themselves, create a contractual right of any member to receive any tax payments from another member.

Accordingly, a loss of the insurer, which can only be used against income of other members in the current year or another year and producing a refund of consolidated tax paid in by other members, is not likely to provide a material benefit for the insurer. If a refund potential exists, the liquidator might consider taking the position that inclusion in a consolidated return by a subsidiary insurer is no longer permitted or required (pursuant to the discussion above), thereby perhaps developing some leverage in negotiating a tax allocation agreement.

5. Net Operating Losses

An insurer placed under a liquidation order will ordinarily have incurred large operating losses, some of which may have been realized prior to the receivership and remain eligible for carryover to periods ending after the receivership began, and some of which may be realized during the receivership and may be carried back to earlier periods. Operating losses incurred by life insurers may no longer be carried back for taxable years beginning after December 31, 2017. Net operating loss deductions ("NOLs") are limited to 80 percent of taxable income (without regard to the deduction) for losses arising in taxable years beginning after December 31, 2017. Carryovers to other years are adjusted to take accounting of this limitation and may be carried forward indefinitely. Property and casualty insurers may carry back losses 2 years and forward 20 years. The 80 percent limitation on use of NOLs does not apply to a property and casualty insurance company.

It may be necessary for the liquidator to project the probable timing of income realization, particularly for property and casualty insurers where loss carryovers expire if not used within a certain period of time. The major item of income realization may be debt cancellation income when advances from guaranty funds, for example, are forgiven at closing.



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The general rules for carryback and carryover of losses are modified if there is a change in the status of the insurer before January 1, 2018. A loss of a life insurance company may only be carried back to a year in which it qualified as a life insurance company if the loss occurs prior to January 1, 2018. For years beginning after December 31, 2017, life insurance companies are allowed the NOL deduction under section 172. A similar rule exists for property and casualty companies. As to loss carryovers, a change in character does not result in denial of the carryover, but the amount of loss from the earlier year may not exceed the amount it would have been if the insurer had the same character in all relevant years as it has in the year to which the loss is carried.

Loss carryforwards generally become severely restricted upon a substantial change in the ownership of the stock of a corporation. However, the rules requiring this result should not apply in these cases. If the IRS takes the position that the entry of an order of liquidation does not affect stock ownership (as, for example, in LTR 8544018), then the rules are not invoked. Conversely, if the entry of the order, in fact, does represent a complete change in ownership, then the exception for "Title 11 or similar case," e.g., bankruptcy or receivership, should be available (see 26 U.S.C. § 382(l)(5)).

The liquidator should consider techniques having the effect of accelerating income, such as the sale of appreciated property, reserve adjustments or reinsurance transactions. If the insurer can remain in a profitable consolidated group with which it has a tax allocation agreement, benefits can be realized without regard to extraordinary transactions.

6. Federal Claims and Releases

   a. Communicating with the Department of Justice.

Contact with the Department of Justice ("DOJ") at the inception of a receivership estate is critical to obtaining a prompt release of personal liability of the Receiver under 31. U.S.C. 3713(b) (the "3713 Release") to facilitate estate distributions to policyholders, claimants against policyholders, guaranty associations and other creditors. DOJ has historically identified a single Assistant U.S. Attorney as gatekeeper between the receiver and all federal agencies, except for the Internal Revenue Service, that may have claims against the receivership estate. Receivers may want to limit the number of people communicating with the DOJ to reduce the possibility of mixed messages, or messages going to the wrong person. Additionally it is recommended that Receivers follow the checklist provided by the DOJ when submitting documents. Contact the NAIC's office in DC if you need assistance to identify the current DOJ receivership contact

   b. Identifying potential federal claims, particularly long tail claims.

The Receiver's initial goal should be to identify potential federal claims from the insurer's claim and corporate files. Federal claims that are classified at the policyholder priority level as claims under an insurance policy or against an insured under an insurance policy should be reviewed and adjusted as soon as possible and their resolution and adjudication should be summarized for the DOJ in connection with the 3713 Release request. In addition to potential federal claims identified by the receiver, DOJ will typically request the receiver to identify all former policyholders of the insurer, including policy periods and limits of coverage so that federal agencies can perform their own search of potential claims against the insurer. An example of claims with a federal agency as a claimant are claims identified as having an environmental exposure.

   c. Classification and handling of federal claims.

Pursuant to *United States Dept. of Treas. v. Fabe, 508 U.S. 491 (1993)*, state law may prioritize payment of administrative expenses and policyholder claims, including claims by third parties against policyholders and claims by guaranty associations, ahead of claims of all other general unsecured creditors, provided that the priority of federal claims immediately follows that of policyholders and



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precedes all other creditor classes. Claims of federal agencies under a policy of insurance or against a policyholder, however, are entitled to policyholder priority treatment.

d. Facilitating the process of obtaining a federal release.

All federal claims that are prioritized at the policyholder priority level should be identified and resolved before applying to the DOJ for a 3713 Release. The process of interacting with the DOJ, including the DOJ's survey of federal agencies for potential federal claims can take several years. Long-tail claims, such as claims involving environmental liability and coverage, as well as the number of policy years that the insurer provided coverage for long-tail exposures, is likely to increase the amount of time needed to resolve the potential federal claims and obtain the 3713 Release.

A best practice is to provide the DOJ with very detailed information on policies and claim information in order to avoid prolonging the process unnecessarily and lead to a long series of back-and-forth requests and production of additional data. For example, include a list of all policyholders unless the lines of business were limited to medical insurance. It may be helpful to segregate the various lines of business as the Environmental Protection Agency (EPA) is more interested in general liability lines as opposed to workers compensation exposures. If the company uses specific policy prefixes for different lines of business, a listing of the policy prefix definitions should be submitted with the list of policies. DOJ resource are usually limited, so key to successfully receiving the Release, it is helpful to keep the lines of communication open, not press for immediate results, consider routine follow-ups with the DOJ such as scheduled monthly status calls.

e. Impact of federal release on receivership closure.

Obtaining the 3713 Release is essential to protecting the receiver against the personal liability imposed under 31 U.S.C. s.3713, and accordingly impacts the receiver's ability to make final distributions of estate assets and close the estate. The foregoing practices should be commenced at the outset of the receivership and pursued with diligence throughout the life of the estate to ensure that the ultimate discharge of the estate is not prolonged.

7. Closing Agreement

The liquidator may want to consider utilizing a closing agreement pursuant to Revenue Procedure 2019-1, IRS Procedures for providing advice to taxpayers in the form of letter rulings, closing agreements, determination letters and information letters, and orally on issues under the jurisdiction of the Associate Chief Counsels (Corporate), (Financial Institutions & Products), (Income Tax & Accounting), (International), (Passthroughs & Special Industries), (Procedure and Administration) and Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). The closing agreement is a final agreement between the IRS and the taxpayer on a specific issue or liability and is entered into under the authority in §7121. The closing agreement would provide for a final determination to be made by the IRS with respect to tax returns filed on behalf of the insolvent company for specific years and would be final and conclusive except in the event of fraud, malfeasance or misrepresentation of material fact.

Additionally, retaining a Taxpayer Advocate's opinion is a possible best practice to address potential tax liability after receivership closure. Because the Taxpayer Advocate is associated with the IRS, this type of opinion could create an obstacle for tax authorities if they decide to revisit a tax return.

## IV. CLOSING LIQUIDATON PROCEEDINGS

### A. General



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As the liquidator focuses on the steps necessary to conclude the four primary obligations of a receiver—marshaling the assets, liquidating the assets, adjudicating claims and making distributions to creditors—the liquidator should use some form of task list or project management software in the planning process to keep track of the objectives necessary to satisfy those obligations. The liquidator should allocate resources and determine a critical path indicating when tasks must be started to accomplish closure of the estate in the shortest time.

Timing of the closure process required careful planning and calculation. Utilizing a critical path methodology should assist in assuring that tasks are completed in their proper order.

**B. Objectives to be Accomplished Prior to Closure of Liquidation Proceedings**

Before the liquidator can be discharged and the estate closed:

1. Assets

All estate assets, both balance sheet and off balance sheet, must be marshaled and liquidated, when possible. After most of the estate assets are liquidated, the liquidator typically is left with certain assets that cannot be readily converted to cash for a considerable period of time or at all. Rather than hold the estate open pending the disposition of these illiquid assets, the liquidator should consider placing the assets in a liquidating trust, or, alternatively, negotiating with guaranty associations for the transfer of assets to guaranty associations as distribution in kind. As discussed in Subsection C.3. below, the distribution must be allocated in a manner that will afford equal treatment to guaranty funds and other priority claimants. In transferring the asset, all records necessary for the guaranty fund to ultimately convert the asset to cash must be transferred, including proper assignments and all other supporting documentation. A value for the asset should be agreed upon and the agreed upon value and transfer must be approved by the court (IRMA §802 C).

Reinsurance recoverables will have been commuted or otherwise collected prior to closure, including the resolution of disputes or arbitration proceedings.

2. Liabilities

All liabilities, through the proof of claim process, must be quantified and either allowed or disallowed by the supervising court.

a. Claim Filing and Adjudication

The proof of claim and claim adjudication processes are complete as mandated in Article VII of IRMA, and the liquidation court has entered appropriate claim determination orders. The liquidator may want to consider the procurement of a formal written release from the federal government as a part of the claim adjudication process.

b. Classification of Claims

The liquidator has grouped claims by priority class pursuant to Section 801 of IRMA and has calculated the asset distribution percentage by class of creditor. With regard to partial and final distributions, the liquidator will want to make sure that policy claimants not covered by guaranty associations are afforded equal treatment with claims of guaranty associations.

c. Claim Adjudication Process



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Claims adjudication and administration procedures are discussed in detail in Chapter 5—Claims. An important objective that will facilitate closure is for the liquidator to establish a tracking system to capture proof of claim adjudication results. The tracking system information should include:

- Name and address of claimant, organized by class;
- Claim number;
- Claim amount and priority classification;
- Status;
  - Allowed;
  - Denied;
  - partially allowed; and
  - determination;
- Liquidator's recommendation;
- Court determination; and
- Results of objections.

The tracking system should be continually updated as contingent claims mature and as the liquidator and the liquidation court deal with contested claims. The system tracking proof of claim amounts should reconcile with respective balance sheet amounts at any point in time. In short, the system should allow data to be kept current going forward so that reporting is fast and the calculation of amounts for claim recommendations to the court is simplified. The NAIC has developed ClaimNet, an on-line proof of claim submission system, which can be used by receivership offices.

The Uniform Data Standard (UDS) reporting system is discussed in detail in Chapter 6—Guaranty Association. UDS provides for the reporting of policy and claim information between guaranty funds and receivers. The data provided by UDS may be integrated with the liquidator's claim tracking system to maintain current guaranty fund claim amounts. Again, these amounts should reconcile with the respective balance sheet amounts at any point in time.

Depending on the size of the liquidation and available assets, it may be economically preferable to petition the liquidation court to dispense with the claims adjudication process for certain classes if distributions to such classes are unlikely. Keep in mind, however, that the claimant's right to object to the classification of his claim would not be affected.

Ongoing litigation of excess or non-covered claims may impede closure. Moreover, with regard to third party claims against insureds to which the typical insolvency injunction does not extend, the liquidator must determine, based on the nature and size of the litigation, whether to defend. The risk of potential diluted distributions to other Class 3 creditors should be considered by the liquidator.

The insured or the third party may file a claim in the liquidation. The claims must be resolved and included as components of the liquidator's recommendations prior to closure. See Sections 801 and 802 of IRMA.



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Pursuant to Section 705 of IRMA, claims that are contingent, unliquidated or immature may be allowed and may participate in all distributions declared subject to the criteria set forth in Section 705. The liquidator should consider commuting remaining treaties and facultative certificates on existing reserves with the assistance and approval of the liquidation court. Contingent claims must be resolved and included as components of the liquidator's recommendations under Section 802 of IRMA prior to closure.

An alternative to the traditional approaches of quantifying long tail IBNR claims to facilitate interim and final distributions and thereby expedite closing, is a process commonly known as "claims estimation." For a more detailed discussion of the claims estimation concept, see IRMA Section 705. Claim estimation can raise issues when seeking to collect reinsurance covering those claims. Procedures for settling reinsurance through commutation based in part on estimated claims are described in detail in IRMA Sections 614 and 615.

Pursuant to Subsection 701B of IRMA, late claims may be allowed and may participate in distributions declared to the extent that the orderly administration of the liquidation is not prejudiced provided stated criteria are met. Late filed claims that do not meet the criteria are placed into priority class.

3. Litigation

All litigation must be concluded. In the event litigation has resulted in the liquidator receiving a judgment against a party or if the liquidator is collecting restitution payments from any party, the liquidator may also consider placing such assets in a liquidating trust or negotiating with guaranty associations for the transfer of assets to the guaranty associations as distributions in kind. As discussed in Subsection C.3. below, the distribution must be allocated in a manner that will afford equal treatment to guaranty funds and other priority claimants.

4. Ancillary Proceedings

Ancillary proceedings must be closed or to a point where there is no continuing financial or legal impact on the domiciliary proceeding. All general and special deposits held by the ancillary receiver should be accounted for, i.e., transferred to its state's guaranty fund, returned to the liquidator, or otherwise appropriately disbursed.

## C. Administration of the Closing Process

1. Order Approving Termination of Proceeding

As discussed herein, and as specified in Section 902 of IRMA, the liquidator should apply to the liquidation court for an order approving a final distribution of assets, closing the estate and discharging the liquidator.

Specific issues to be addressed in the order may include:

- All major transactions, procedures and expenditures of the estate which were not previously approved by the court;
- The expense reserve set for final and post-closure expenses;
- Amounts to be paid in final distribution to claimants;



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- Arrangements for storage or destruction of records and the reservation of funds to pay these expenses;

- Assignment of and the valuation of any distributions of assets in-kind to any claimants;

- Release of the receiver and his agents from further liability; and

- Provision that the proceeding will automatically terminate upon the completion of the above issues with the liquidator's filing of a "Closing Statement." The closing statement is simply a statement advising the court that all of the issues have indeed been resolved.

2. Final Expenses

The liquidator has made provision for the final expenses necessary to close the estate. To the extent possible, these Class 1 and Class 2 expenses should be paid in advance of closure. Examples of expenses to be estimated, agreed to and paid in advance are as follows:

- Legal fees and professional fees pertaining to the preparation of the final accounting to the liquidation court;

- Fees pertaining to the preparation of federal and state tax returns, and possibly final audit, pursuant to Section 905 of IRMA;

- Expenses pertaining to the storage and destruction/disposition of records after the termination of the liquidation;

- Legal fees pertaining to the termination of the liquidation proceeding and dissolution of the corporate entity;

- Final salaries and other administrative expenses necessary to wind up the affairs of the estate including but not limited to:

    - Final inventory preparation;

    - Interfacing with tax advisors on final tax preparation;

    - Oversight of records destruction;

    - Final distributions—cutting and processing checks;

    - Responding to inquiries relative to final distribution;

    - Final bank fees; and

    - Unclaimed property report generation; and

- Administrative expenses of guaranty funds (Class 2 claims under IRMA).

3. Calculation of and Final Distribution

A date must be selected upon which the liquidator will make a final distribution to creditors. The date of final distribution is important because the liquidator usually attempts to assure that no additional transactions, such as cash receipts and disbursements, will occur subsequent to that date, and no additional expenses will be incurred, thus avoiding the preparation and filing of additional federal and state income tax returns. In effect, every task should be completed and every open issue resolved, except



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for the distribution of remaining monies. Alternatively, remaining cash assets can be transferred to a liquidating trust.

A good deal of planning must precede the preparation of final distribution amounts to creditors. Since Class 1 and Class 2 creditors can generally be satisfied in full, the final distribution percentage is calculated by dividing total assets available for distribution for a particular class (typically Class 3 policyholders for direct insurance writers or Class 4 for mortgage or financial guaranty insurers) by the amount of claims in a particular class as approved by the liquidation court. Generally, the distribution percentage for Class 3 claimants is less than 100%, but if Class 3 claims can be paid in full, then the calculation is applied to the next lower priority class that cannot be paid in full. Also, the calculation is complicated by the need to reserve sufficiently for administrative expenses to close the estate and expenses incurred after the distribution is made, if any.

A useful internal tool to provide a snapshot of asset distribution by creditor class at any time during the receivership is the interim Liquidating Balance Sheet (LBS). See Exhibit 10-1 for an example.

The interim LBS allows the receiver to periodically adjust assets to liquidated values based on the best and latest information available, and apply the liquidated asset values to liabilities by creditor class, thereby projecting distribution percentages at each balance sheet date.

There may have been previous interim or partial distributions from the estate that will need to be taken into account when calculating the final distribution percentage. Early access advances may have been made directly or indirectly to guaranty funds and directly to non-covered or excess claimants by order of the liquidation court and should be accounted for at or before final distribution is made. If partial distributions were made to guaranty funds, but not to non-covered/excess policyholder claimants, the final distribution calculations must take this into consideration so that all Class 3 creditors are treated equally.

In the event guaranty funds received early access distributions of funds or other assets in excess of the final distribution percentages to which they are entitled, the early access assets must be returned to the liquidator prior to the payment of a final distribution. The return of early access amounts by the guaranty fund is mandated by Section 803 of IRMA and typically by the Early Access Agreement executed pursuant to other early access laws. The fact that distributions made to non-covered/excess policyholders may not be collectible later if those policyholders received too much, is probably a good reason to take special care in calculating the amounts of any distributions to claimants other than guaranty funds.

It should not be necessary to hold up the closure of the estate simply because certain assets have not been reduced to cash. Section 802C of IRMA allows distributing assets in-kind provided the creditor and liquidator agree on the value and the receivership court approves the distribution.

Once the final distribution amount has been determined, the funds to be distributed should be aggregated into a single checking account. The bank must be consulted in advance to provide final service charges and other debit amounts to enable the liquidator to determine the exact amount of remaining funds to be distributed. The bank should be provided with a listing of final distribution payees and amounts. Once all checks clear, the account should be closed. Checks for final distribution amounts that do not clear will need to be reported as Unclaimed Property (see subsection C6 of this section). In preparation for a final distribution, the final LBS will set forth distribution percentages by creditor class. Note the accrual for estimated expenses necessary to close the estate. These estimated expenses are detailed in subsection C2 of this section.

4. Reporting to the Liquidation Court

Throughout the liquidation process, financial reporting to the liquidation court is important, but it becomes more so as the liquidator starts to plan for closure. Many liquidators file quarterly or semi-



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annual status reports with the liquidation court, including a balance sheet, summary of cash receipts and disbursements, income statement and narrative report on liquidation activities. The narrative report usually contains a general overview/background of receivership activities, including details on the insurance business by line, a discussion and status of the assets, the proof of claim and claim adjudication processes, tax returns and litigation. Financial reposting requirements under IRMA are set out in §117.

This reporting process enables the liquidation court and creditors to keep abreast of the proceeding and its major issues, and simplifies the ultimate final accounting to the liquidation court prior to closure.

5. Final Accounting

As part of the termination proceedings, the liquidator will file with the liquidation court a final accounting that discusses the disposition of major issues during the liquidation and has a summary of significant events, key orders entered by the liquidation court, pending issues, if any, and distribution percentages to remaining creditor classes, along with detailed schedules reflecting creditors, early access and partial distribution amounts previously paid, if any, and final distribution amounts. The liquidator should consider filing basic financial statements with the court (balance sheet and income statement) as well as an inception to date summary of cash receipts and disbursements. The distribution plan should be pursuant to the liquidation court's orders regarding the liquidator's claim recommendations. The filing of the final accounting will have been preceded by requisite notice to the appropriate parties.

6. Unclaimed and Withheld Funds (Escheat Items)

Uncashed checks or drafts that have not been negotiated prior to a final distribution should be handled in accordance with the applicable state unclaimed property laws or Section 804 of IRMA, as appropriate.

7. Other Required Reporting

Final distributions may require reporting to the IRS as 1099 Miscellaneous Income to the recipient or as other reportable income as determined by tax counsel.

In the event the liquidated company continued to have employees through its final year, certain employer reporting such as W-2 forms, quarterly wage and tax forms, etc. must be completed post-closure. If there were employees retained by the insolvent company, health insurance and any other such benefits must be terminated prior to closure. If a 401k plan was in existence prior to liquidation, closure of the plan may require a letter of determination from the IRS for plan termination.

8. Final Tax Returns

The liquidator will make arrangements with its tax advisors to complete and file the final tax return subsequent to the closure of the estate. A final expense for tax preparation should be included as part of the expense reserve.

Records must be accessibly maintained during the preparation of the returns.

9. Corporate Dissolution

The liquidator will comply with any statutory provisions and file any necessary documents to permanently delete the company from applicable agencies. This may include other jurisdictions in which the company maintained a license to operate. The order terminating the liquidation and discharging the liquidator should be provided to the agencies in order for them to close their files.



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10. Record Retention

The liquidator will identify the various types of documents in his/her possession and determine, with counsel, the appropriate length of time that the documents should be preserved. The petition for termination and discharge should include a recommendation to the court on retention periods based on type of documents.

Whether records are placed in an off-site storage facility for the retention period or transferred to a state agency for archiving, records should be inventoried for ease in retrieval in the event questions arise in the future.

If an off-site storage facility is utilized, the facility should be prepaid through the final expense distribution as per subsection C2 of this section. Records should be identified with destruction dates, if applicable.

11. Destruction of Records

A part of the final petition and court's order discharging the liquidator, an order authorizing the destruction of the mass of company records should also be included. Those items that have been identified with specific retention periods, of course, will be excluded from this process. Typically, the vendor handling the destruction will provide a certification of destruction and such certification will become part of the retained records.

12. Closure of Office

The actual physical plant will need to be closed, if not already closed. Proper notice to vendors such as utilities must be given prior to closure, as well as terminating any contracts or leases entered into by the liquidator during the liquidation proceeding.

13. Post Closure

Subsequent to the closure of the liquidation, there may be inquiries for records and information made by former business associates of the company and/or policyholders. Arrangements should be made to ensure proper handling of such inquires.



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# CHAPTER 11 – STATE IMPLEMENTATION OF DODD-FRANK RECEIVERSHIP

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## I. INTRODUCTION

As extraordinarily remote a set of circumstances necessitating it may be, under § 203(e) of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, 18 USC § 5383(e) (Dodd-Frank Act), state insurance Commissioners, their designated deputy receivers and Guaranty Funds are charged with the enormous responsibility of resolving a systemically important insurance company. Those circumstances by definition would be unique and extraordinary. The circumstances also by definition would bring enormous time pressure with high stakes for the U.S. economy and the policyholders and creditors of the particular insurance company in receivership. Responding to those unique challenges would require advanced planning and analysis, which this Chapter addresses, by describing four baseline implementation areas for Commissioners, deputy receivers and guaranty funds to consider.

After a general introduction to the Dodd-Frank insurance receivership framework, the analysis in this chapter focuses on the following considerations:

1) Establishing processes at the state level to ensure the state receivership mechanism will respond effectively to a Dodd-Frank receivership.

2) Analyzing and preparing for the situation in which an insurance company is a subsidiary or affiliate of a covered financial company.

3) Describing national coordination initiatives to ensure the national state-based systems provide further support to administering a Dodd-Frank receivership.

4) Developing state laws that will ensure that state mechanisms can effectively initiate and administer a Dodd-Frank receivership.

## II. OVERVIEW OF DODD-FRANK INSURANCE RECEIVERSHIP FRAMEWORK

The Dodd-Frank Act was enacted on July 21, 2010. [1] Title II of the Dodd-Frank Act[2] creates a new orderly liquidation authority (OLA) for the dissolution of failing systemically important financial companies and certain of their subsidiaries when certain conditions are found to exist. In addition to the overview below, the federal and state processes are summarized in flowcharts attached as Exhibits 11-A and 11-B.

The Dodd-Frank Act defines the term "financial company"[3] as any company incorporated or organized under federal or state law that is a bank holding company as defined in the federal Bank Holding Company Act of 1956 (BHCA)[4]; a nonbank financial company supervised by the Federal Reserve Board of Governors (Board); any company (other than an insured depository institution or a nonbank financial company supervised by the Board) that is predominantly engaged in activities that the Board has determined are financial in nature or incidental thereto for purposes of Section 4 (k) of the BHCA (which includes an insurance company)[5]; or any subsidiary of the

[1] Public Law 111-203, 12 U.S.C. 5301 *et seq.*

[2] §§ 201 to 217, 12 U.S.C. 5381 *et seq.*

[3] § 201(a)(11); 12 U.S.C. 5381(a)(11).

[4] 12 U.S.C. 1841(a).

[5] 12 U.S.C. 1843(k). Section 4(k)(4) of the BHCA (12 U.S.C. 1843(k)(4)) provides: "For purposes of this subsection, the following activities shall be considered to be financial in nature: …(B) Insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death, or providing and issuing annuities, and acting as principal, agent, or broker for purposes of the foregoing, in any State…."


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foregoing that is "predominantly engaged" in activities that are financial in nature or incidental thereto for purposes of the BHCA, other than a subsidiary that is an insured depository institution or an insurance company.[6]

Under the OLA, the Federal Deposit Insurance Corporation (FDIC) may be appointed as receiver of a "covered financial company" for purposes of liquidating the company.[7] The Dodd-Frank Act defines the term "covered financial company"[8] as a financial company for which the Secretary of the Treasury (Secretary) in consultation with the President has made a determination under § 203(b).[9] However, if the financial company is an insurance

---

[6] § 201(b) provides that no company may be deemed to be predominantly engaged in activities that are financial in nature or incidental to a financial activity unless the consolidated revenues of such company from such activities constitute at least 85% of the total consolidated revenues of such company, including any revenues attributable to a depository institution investment or subsidiary.

[7] Subject to certain exceptions (notably for insurance companies), the Dodd-Frank Act does not contemplate a receivership for the purpose of rehabilitation or reorganization. § 204(a) provides:

It is the purpose of this title to provide the necessary authority to liquidate failing financial companies that pose a significant risk to the financial stability of the United States in a manner that mitigates such risk and minimizes moral hazard. The authority provided in this title shall be exercised in the manner that best fulfills such purpose, so that—

> (1) creditors and shareholders will bear the losses of the financial company;
>
> (2) management responsible for the condition of the financial company will not be retained; and
>
> (3) the Corporation and other appropriate agencies will take all steps necessary and appropriate to assure that all parties, including management, directors, and third parties, having responsibility for the condition of the financial company bear losses consistent with their responsibility, including actions for damages, restitution, and recoupment of compensation and other gains not compatible with such responsibility.

[8] § 201(a)(8).

[9] § 203(b) (12 U.S.C. 5383(b)) provides:

> (b) DETERMINATION BY THE SECRETARY.—Notwithstanding any other provision of Federal or State law, the Secretary shall take action in accordance with section 202(a)(1)(A), if, upon the written recommendation under subsection (a), the Secretary (in consultation with the President) determines that—
>
> > (1) the financial company is in default or in danger of default [see footnote 10];
> >
> > (2) the failure of the financial company and its resolution under otherwise applicable Federal or State law would have serious adverse effects on financial stability in the United States;
> >
> > (3) no viable private sector alternative is available to prevent the default of the financial company;
> >
> > (4) any effect on the claims or interests of creditors, counterparties, and shareholders of the financial company and other market participants as a result of actions to be taken under this title is appropriate, given the impact that any action taken under this title would have on financial stability in the United States;
> >
> > (5) any action under section 204 would avoid or mitigate such adverse effects, taking into consideration the effectiveness of the action in mitigating potential adverse effects on the financial system, the cost to the general fund of the Treasury, and the potential to increase excessive risk taking on the part of creditors, counterparties, and shareholders in the financial company;
> >
> > (6) a Federal regulatory agency has ordered the financial company to convert all of its convertible debt instruments that are subject to the regulatory order; and
> >
> > (7) the company satisfies the definition of a financial company under section 201.

§ 203(c)(4) (12 U.S.C. 5383(c)(4)) provides:

> (4) DEFAULT OR IN DANGER OF DEFAULT.—For purposes of this title, a financial company shall be considered to be in default or in danger of default if, as determined in accordance with subsection (b)—
>
> > (A) a case has been, or likely will promptly be, commenced with respect to the financial company under the Bankruptcy Code;
> >
> > (B) the financial company has incurred, or is likely to incur, losses that will deplete all or substantially all of its capital, and there is no reasonable prospect for the company to avoid such depletion;
> >
> > (C) the assets of the financial company are, or are likely to be, less than its obligations to creditors and others; or
> >
> > (D) the financial company is, or is likely to be, unable to pay its obligations (other than those subject to a bona fide dispute) in the normal course of business.



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company[10] or its largest U.S. subsidiary (measured by total assets) is an insurance company, the director of the Federal Insurance Office (FIO) and the Board, at the request of the Secretary or on their own initiative, will make a written recommendation, by two-thirds vote of the Board and the affirmative approval of the Director of the FIO in consultation with the FDIC, to the Secretary on whether the Secretary should make a determination to invoke the OLA with respect to the financial company.[11]

The Secretary is required to notify the FDIC and the covered financial company subsequent to any determination under § 203. If the company's board of directors acquiesces or consents to the appointment of the FDIC, the Secretary must then appoint the FDIC as receiver. If the board of directors of the financial company does not acquiesce or consent to the appointment of the FDIC as receiver, then the Treasury Secretary must petition the U.S. District Court for the District of Columbia for an order before appointing the FDIC as receiver of any covered financial company.[12] The Court's review is limited to determining whether the Secretary's determination that the covered financial company is in default or in danger of default and satisfies the definition of a financial company under the Dodd-Frank Act is arbitrary and capricious.

This review is made on a confidential basis and without any public disclosure, but with notice by the court to the company and a hearing in which the company may oppose the petition. If the court determines that the Secretary's determination is not arbitrary and capricious, the U.S. District Court is required to issue an order immediately authorizing the Secretary to appoint the FDIC as receiver of the covered financial company. The court is required to make its ruling within 24 hours of receiving the petition of the Secretary; otherwise, the petition will be deemed granted by operation of law. Either party may appeal the decision to the U.S. Court of Appeals for the D.C. Circuit and then to the U.S. Supreme Court (which is given discretionary jurisdiction to review the Court of Appeals decision on an expedited basis), but the decision may not be stayed or enjoined pending appeal.

Notwithstanding Section 203(b) of the Dodd-Frank Act, if an insurance company is a covered financial company or a subsidiary or affiliate of a covered financial company, then the liquidation or rehabilitation of such insurer and any insurance company subsidiary or insurance company affiliate of the covered financial company would be conducted as provided under applicable state law (by the appropriate state insurance regulator).[13]

However, with respect to such state-based receiverships, if within 60 days after a determination has been made to subject such entity to the OLA the appropriate state insurance regulator has not filed the appropriate judicial action in the appropriate state court to place such insurance company into "orderly liquidation" under the laws and requirements of the state, the FDIC is given the authority "to stand in the place of appropriate regulatory agency and file the appropriate judicial action in the appropriate State court to place such company into orderly liquidation under the laws and requirements of the State."[14]

If the covered financial company in receivership is an insurance company (or its largest U.S. subsidiary is an insurance company), the Dodd-Frank Act authorizes the FDIC to be appointed as receiver of an insurance company subsidiary which itself is not an insurance company (such as third-party administrators, brokerages, managing general agents and any entities that are not "subject to regulation"), even though the FDIC is not the receiver of the insurance company and the insurance company may not be insolvent or in receivership proceedings in state court.[15]

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[10] Defined as "…any entity that is (A) engaged in the business of insurance; (B) subject to regulation by a State insurance regulator; and (C) covered by a State law that is designed to specifically deal with the rehabilitation, liquidation or insolvency of an insurance company." § 201(a)(13); 12 U.S.C. 5381(a)(13).

[11] § 203(a)(1)(C); 12 U.S.C. 5383(a)(1)(C).

[12] § 202(a)(1); 12 U.S.C. 5382(a)(1).

[13] § 203(e); 12 U.S.C. 5383(e).

[14] § 203(e)(3); 12 U.S.C. 5383(e)(3).

[15] § 210(a)(1)(E)(i); 12 U.S.C. 5390(a)(1)(E)(i) provides:



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Upon the appointment of the FDIC as receiver over such subsidiary, the subsidiary itself will be considered a financial company subject to the OLA, and the FDIC will have all of the powers and rights with respect to that covered subsidiary as it has with respect to a covered financial company.[16]

The Dodd-Frank Act requires the FDIC as receiver to consult with the primary financial regulatory agency or agencies of any subsidiaries of the covered financial company that are not covered subsidiaries (such as state insurance regulatory officials), and coordinate with such regulators regarding the treatment of such solvent subsidiaries and the separate resolution of any such insolvent subsidiaries under other governmental authority.[17] The statute does not provide precise guidance as to how the FDIC would coordinate with the state insurance receiver of the insurance company if the subsidiaries or affiliates' operations are integral to the operation of the insurance company. Examples are management or service companies (when the insurer has no employees of its own), or third-party administrators (if the subsidiary has contracts with the insurance company), or if the insurance company and the subsidiary are jointly obligated to third parties (such as under a lease). In such instances, it is unclear how the state insurance receiver would protect the interests of the insurer. The appointment of the FDIC as receiver of an insurance company subsidiary may leave the insurance company parent in a weaker financial condition. To protect these operations, the states, through NAIC, must implement procedures for immediate initiation and administration of state insurance receiverships with a high degree of coordination with the FDIC, applicable guaranty funds and others.

## III. STATE LEVEL PROCESS FOR IMMEDIATE INITIATION OF STATE INSURANCE RECEIVERSHIP

### A. Rapid Response Protocol

Most states have enacted statutes governing the conservation, rehabilitation and liquidation of insurance companies that are patterned after one of three model acts that have been adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) or by the NAIC over the years: the Uniform Insurers Liquidation Act (Uniform Act); the Insurers Rehabilitation and Liquidation Model Act; and the Insurer Receivership Model Act (#245) (IRMA). NAIC Model Acts uniformly require that the chief insurance regulator of the insurer's domiciliary state (Regulator) be appointed receiver of the insurer to administer the receivership under court supervision.

Title II of the Dodd-Frank Act does not change state liquidation statutes. Nevertheless, the state Dodd-Frank responsibilities require state statutes that assure immediate execution of state receiverships necessary to effectively respond to a national crisis. If there is a federal determination that an insurance company meets the § 203(b) standards codified in 12 U.S.C. § 5383(b), then the Dodd-Frank Act anticipates that the insurance company would be placed immediately into receivership pursuant to state law, 12 U.S.C. § 5383(e). Subject to certain exceptions (notably for insurance companies), the Dodd-Frank Act does not contemplate a receivership for the purpose of rehabilitation or reorganization. See footnote 7, supra. Under state law, the form of receivership is not limited to liquidation. And Section 203(e)(1) of the Dodd-Frank

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(i) IN GENERAL.—In any case in which a receiver is appointed for a covered financial company under section 202, the Corporation may appoint itself as receiver of any covered subsidiary of the covered financial company that is organized under Federal law or the laws of any State, if the Corporation and the Secretary jointly determine that—

(I) the covered subsidiary is in default or in danger of default;

(II) such action would avoid or mitigate serious adverse effects on the financial stability or economic conditions of the United States; and

(III) such action would facilitate the orderly liquidation of the covered financial company.

[16] § 210(a)(1)(E)(ii); 12 U.S.C. 5390(a)(1)(E)(ii).

[17] § 204(c); 12 U.S.C. 5384(c).



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Act, 12 U.S.C. § 5383(e)(1), explicitly refers to both rehabilitation and liquidation of insurance companies in the insurance company context.

If state regulators do not file the appropriate action within 60 days of the federal determination, then the FDIC has the authority to stand in the place of the state regulator for purposes of initiating the appropriate action under and pursuant to state law, § 203(e)(3), 12 U.S.C. § 5383(e)(3). Regulators, receivers, the courts and other interested persons should not plan to rely on the 60-day window. Immediate state action will be required in most Dodd-Frank insurance company receivership scenarios. Even in the unlikely event that the FDIC filed the state court action due to the passage of 60 days, state laws continue to require that the Regulator be appointed as receiver of an insurance company and that the receivership be conducted under state law.

This section outlines the steps individual states should take to create a rapid response protocol, organizational structure and coordinated interagency effort to immediately initiate a Dodd-Frank receivership and, in any event, meet the 60-day requirement under Title II of Dodd-Frank. The steps include:

- Advanced planning
- Coordination with the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and National Conference of Insurance Guaranty Funds (NCIGF)
- State-federal coordination with proper deference to state insurance regulators and receivers in the orderly liquidation of any insurance company
- Creation of a contact list and executive committee to coordinate receivership implementation
- Formal communication protocols
- Procedures for immediate initiation of receivership and contacting attorneys general
- Procedures or rules for expedited judicial review

**B. Advanced Planning**

State regulators have long recognized that state receivers who expect to successfully administer a receivership must become familiar with the insurer's operations, business and structure as soon as possible. Ch. 1, § V (A), NAIC *Receivers Handbook for Insurance Company Insolvencies* (2009) (Receivers Handbook). The FDIC recognizes that advanced communication and planning is critical to a resolution that mitigates significant risk and minimizes moral hazard in a Dodd-Frank scenario. If there are multiple proceedings, coordination of those proceedings is essential to resolution of a Dodd-Frank scenario as much or more than in a traditional dual liquidation/bankruptcy scenario.

There are both existing and developing mechanisms in place for both state and federal regulators to consider the impact of the Dodd-Frank Act in the course of regulation. These mechanisms also assist regulators, the NAIC and, at the appropriate time, receivers to have advance (even if separate) direction and warning of the potential for a Dodd-Frank receivership affecting an insurance company. Beginning with the designation of companies as Federal Reserve Board-supervised nonbank financial companies under § 113(a) and spanning all the way to determinations of the Secretary under 12 U.S.C. § 5383(b), and encompassing all regulation in between, both state and federal regulators ideally will be provided with information sufficient to take some pre-receivership regulatory protective action, when necessary, and also engage in some level of advance receivership planning.

Indeed, state regulators may know in advance of federal regulators that significant financial problems exist in an insurance company. State regulators, therefore, may have opportunity for advance receivership


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planning and/or independent grounds prior to a 12 U.S.C. § 5383(b) determination to trigger state regulatory action, including:

- A confidential order of supervision by the state insurance regulator.
- Other heightened regulation/prudential standards by the state regulator, including but not limited to, examination, watch list or other restrictions limiting the insurer's issuance of new business.

Thus, there may be a platform in the current state regulatory structure for advance notice and planning by state regulators and receivers in advance of the notice of a federal determination under 12 U.S.C. § 5383(b).

Ideally, the Regulator's advance planning for a Dodd-Frank scenario involving a state-regulated insurer should be highly coordinated with the NAIC and the Receivership Financial Analysis (E) Working Group; other affected state regulators; NOLHGA and NCIGF; and federal regulators and receivers, including the FDIC and the affected insurance company. The insurance company or its parent/affiliate may be required to submit a confidential federal resolution plan providing for rapid and orderly resolution in the event of a future material financial distress or failure, Section 165(d), 12 U.S.C. § 5365(d). That plan should be provided to and reviewed by the Regulator as part of the Regulator's work to broadly pre-identify theoretical scenarios and responses, and certainly as part of the planning to implement an actual Dodd-Frank referral under 12 U.S.C. § 5383(b). The confidentiality provisions under the Dodd-Frank Act, as well as the federal and state confidentially restrictions, must be respected and addressed up front in memorandum of understanding (MOU) or other protections in formulating all pre-planning and communication plans. Alternatively, confidential state-based plans, such as Contagion Reports[18] (where applicable) or confidential Corrective Action Plans, can be used confidentially by state regulators as early planning tools.

Although the Dodd-Frank Act does not expressly require that a determination made under § 203(b) with regard to an insurance company be communicated to the Regulator (the determination is expressly required to be communicated to the FIO, FDIC, Federal Reserve and the covered financial company, and that information is confidential), that basic communication is implied as part of the FDIC's consultation obligations under § 204(c), 12 U.S.C. § 5384(c), and is obviously necessary to the orderly initiation of a Dodd-Frank receivership. Procedures should establish, at a minimum, that the recommendation and determination is immediately communicated in all cases to the NAIC as a central coordination point for state regulators and receiver, and also directly to the domestic Regulator when the company is itself an insurance company and the insurance regulators when there is an insurance company subsidiary or affiliate of a covered financial company. Discussions with the relevant federal actors should focus on state receivership planning and advance warning under the confidentiality constraints of the Dodd-Frank Act.

### C. Internal Procedure for Presenting Federal Determination to Commissioner and for Immediately Initiating Receivership

Whether a receivership is expected, preplanned or arises unexpectedly, state insurance regulators and receivers must be prepared internally for the immediate initiation of a receivership well before the expiration of 60 days where there is a federal systemic risk determination as to an insurance company.

In general, as discussed above, under 12 U.S.C. § 5383(a), the FDIC and the Board of Governors of the Federal Reserve System (Federal Reserve), on their own initiative or at the request of the Secretary, recommend that the Secretary appoint the FDIC as receiver for a covered financial company. The recommendation to place an insurance company or a financial company of which the largest domestic subsidiary is an insurance company into receivership is made by the Federal Reserve and the director of the

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[18] The NAIC Model Insurance Holding Company Act requires that annual reports to regulator identify material risk within the holding company systems that could pose a financial or reputational contagion to the insurer.


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FIO in consultation with the FDIC, 12 U.S.C. § 5383(a)(1)(C). The Secretary, in consultation with the President, determines whether the covered financial company satisfies the criteria in 12 U.S.C. § 5383(b). If such a determination is made, the Secretary notifies the covered financial company of the determination pursuant to 12 U.S.C. § 5383(c) and 12 U.S.C. § 5382(a)(1)(A)(i). There is no exact time limit for the notice, but the expectation is that the notice will be immediate.

Once the determination is made, if the company consents to the determination, the FDIC's appointment as receiver is immediate., 12 U.S.C. § 5382(a)(1)(A)(i). If there is no consent, then the Secretary, upon notice to the covered financial company, shall petition the U.S. District Court for the District of Columbia under seal for an order authorizing the Secretary to appoint the FDIC as Receiver, 12 U.S.C. §§ 5382(a)(1)(A)(i), (ii). The Court has 24 hours to determine whether the Secretary's determination that the covered financial company is in danger of default and satisfies the definition of a financial company is arbitrary and capricious, 12 U.S.C. § 5382(1)(A)(iv). If the Court determines the Secretary's findings are not arbitrary and capricious and that the company is a covered financial company, then the Court shall enter an order immediately authorizing the Secretary to appoint the FDIC as Receiver, Id. If the Court fails to make a determination within 24 hours, the petition is granted by operation of law, and the Secretary shall appoint the FDIC as receiver, 12 U.S.C. §§ 5382(a)(1)(A)(v)(I), (II). The Court's determination is subject to a limited scope and expedited appeal process, but not to stay or injunction, 12 U.S.C. §§ 5382(a)(1)(B), (a)(2). See Flowcharts, (Exhibit 11-A and 11-B).

One exception is that if the covered financial company is an insurance company or an insurance company subsidiary or affiliate of a covered financial company, the rehabilitation or liquidation of such company, and any insurance company subsidiary or affiliate of such company, shall be conducted as provided under state law, 12 U.S.C. §§ 5383(e)(1), (2). In that case, the Regulator has 60 days from the date on which the 12 U.S.C. § 5383(a) determination is made—not communicated—to file the appropriate judicial action in state court to place the insurance company into orderly liquidation under state law, or else the FDIC shall have the authority to make the filing. 12 U.S.C. § 5383(e)(3). The Dodd-Frank Act does not expressly require entry of a liquidation order in 60 days (or ever for that matter), but entry of a receivership order well in advance of the 60-day expiration must be the Regulator's goal in order to be consistent with the federal framework seeking to swiftly resolve company failure that threatens the national economy.

1. Internal Discussions

As referenced above, the first discussion that must occur is, minimally, notice of the federal determination from the Secretary or other federal representative to the state Regulator. That notice should be immediate.

However best interlocking with federal processes, discussions must occur as to how the federal government prefers to coordinate and plan for notice. For example, regulators may pre-identify themselves and other persons to be notified. NAIC mechanisms may also be useful to effect fast multi-state notice. Once the state regulator receives notice of the federal determination, the Internal Procedures in the domiciliary state, discussed more specifically below, are triggered if those procedures have not already been triggered as the result of advanced planning. There will be a critical need to respect statutes requiring confidentiality of non-public information in the hands of regulators in this and other preplanning processes. The notice will also likely trigger formal discussions and procedures with stakeholders outside the domiciliary state, but those procedures are not discussed at length in this section.

2. Key Elements of Initial Due Diligence

As in all receiverships, the Regulator who expects to successfully prosecute a receivership action must become familiar as soon as possible with the insurer's overall operations and business, as must any potential special deputy receivers and staff. Ch. 1, § V(A), Receivers Handbook. This cooperation and advance planning among the Regulator, the receiver and ideally also the company itself is especially



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imperative in a systemically important Dodd-Frank scenario. Indeed, the FDIC cites Lehman Brothers' lack of such a plan as a factor that contributed to the chaos of its bankruptcy. See FDIC Report, *The Orderly Liquidation of Lehman Brothers Holdings Under the Dodd-Frank Act*, April 18, 2011.[19]

The circumstances of a Dodd-Frank receivership will dictate the priorities in the initial response once the significant risk to the financial stability of the U.S. is identified. Coordination and information sharing with the federal government, needless to say, will drive much of the early activity and due diligence. Beyond those initial priorities, a number of items will inevitably be a part of any initial due diligence process. Among priority due diligence items in a Dodd-Frank receivership will be for the receiver to meet with the Regulator's staff and possibly also key company personnel as soon as possible to discuss Resolution Plans to the extent they are available, as well as the perceived causes of the insurer's difficulties, the insurer's "place" in the overall corporate structure and its relationship to the systemically important company, and receivership options best suited to accomplish an orderly resolution and liquidation. See Ch.1, § V(A) Receivers Handbook.

In the Dodd-Frank scenarios, as in all receiverships, the Receiver must be able to readily assess which assets are the insurer's assets. There must be a prompt review and analysis of the interaction and agreements between the insurer and its affiliates and vendors—service agreements, management agreements, key employment agreements, pooling agreements and other similar arrangements. See Ch. 8, 9 Receivers Handbook. In particular, identification and analysis of qualified financial contracts and the impact of any termination and netting rights must be conducted. There must be a prompt assessment by the Receiver of the potential for a successful rehabilitation of the insurance company prior to or in connection with liquidation. Information from state and federal regulators can greatly assist the Receiver. It is also important for the Receiver to meet with the insurer's officers and/or directors, when possible. While these are elements of nearly all insurance receiverships, the receiver should plan for a faster and more focused analysis under the urgent circumstances a Dodd-Frank receivership of an insurance entity presents.

3. Attempt to Broadly Pre-Identify Theoretical Scenarios and Responses

As referenced above, Resolution Plans, Contagion Reports or other regulatory mechanisms exist by which companies confidentially file with the Regulator their plans in the event of a § 203(b) determination as to the failure of an insurer or related entity. Using these or other regulatory mechanisms, such as financial examination, the Regulator can broadly pre-identify theoretical scenarios and responses for actual or potential systemically important companies in the state.

4. Internal Procedure for Initiating State Receivership, Including Procedure for Early Consultation with the State Attorney General or Other Stakeholders

   a. Assuming there is an external procedure for communicating the federal determinations and/or prior proceedings to the domestic Regulator, the Regulator must, in turn, trigger internal procedures for filing the appropriate judicial action seeking liquidation or rehabilitation within 60 days of the determination.

   b. Most Regulators and Receivers have established internal procedures for contacting the chief liquidation officer, consulting with the attorney general or others needed to file a state receivership action and for notifying the Court once the action is filed. These internal procedures should be adapted, strengthened and memorialized for Dodd-Frank scenarios to provide for heightened and expedited notice and court action. In some states, statutory or rule change will be required to adapt to a Dodd-Frank scenario. For example, if the state requires a public or non-public bidding process for the appointment of a Receiver, that process must be

[19] www.fdic.gov/analysis/quarterly-banking-profile/fdic-quarterly/2011-vol5-2/lehman.pdf



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expedited or eliminated in the unique Dodd-Frank scenarios in order to assure federal statutory compliance and expedited appointment of a state receiver.

c. Each Regulator should, as an initial matter, establish an inter-agency Dodd-Frank Executive Committee (Committee) in advance of a Dodd-Frank insurance receivership. The Committee is a working group for preplanning functions and a resource for confidential coordination of a complex and urgent Dodd-Frank receivership. The Committee does not have independent powers, nor can the Commissioner delegate his or her authority to the Committee. The Committee would initially be charged with pre-identifying expedited procedures and pre-identifying contact points (Contact List) unique to each state in the event of a Dodd-Frank insurance company receivership. This would include the development of state-specific, formal communication protocols based on NAIC models and similar to state disaster and recovery plans. This would also include the adaptation of NAIC-based, or development of state-specific, pre-screened and/or outlined court or administrative documents for receiverships prompted by systemic risk determinations.

   In an actual Dodd-Frank scenario, the Committee could act as a group of multidisciplinary experts who are particularly tasked with assisting the Commissioner in the planning for and executing of the orderly resolution and liquidation of particular systemically risky insurance companies.

d. The mission of the Committee is to:

   - Plan in advance (pre-identify contact points and pre-identify expedited procedures that are annually reviewed) for a Dodd-Frank insurance receivership.
   - Assist the Commissioner in the assessment of alternatives for cost-effective resolution or receivership while maximizing protection of policyholders, creditors and the public. Accurate and timely information is critical to perform these functions.
   - Assist the Commissioner in assessing and rapidly responding to federal determinations in a manner that complies with Dodd-Frank and meets the goals of Dodd-Frank Title II.
   - Assure through preplanning or otherwise that adequate assets of any designated systemically important insurance company exist, or that other lending/funding exists, to pay for the receivership of an insurance company receivership arising under Dodd-Frank.
   - Assess early on the severity of potential obligations of guaranty funds resulting from liquidation of a systemically important insurer.
   - Work with the state Receiver to coordinate, implement and resolve the receivership.

e. Depending on the state, the Committee and the Contact List may be comprised of the same or different people. The Contact List is a list of key stakeholders who must be notified by the Regulator immediately in the event of a § 203(b) determination, certainly as to a domestic company, and also possibly in relation to a foreign company with business in that Regulator's state. A communication protocol similar to that in place under most states' disaster plans in general must be implemented.

   The Committee and/or the Contact List should include:

   - Regulator (Chair of Committee) and/or Chief Financial Regulator/Key Department of Insurance Personnel (Committee and Contact List). The Regulator is charged with immediately notifying the members of the Committee and the Contact List upon



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notification of the federal determination. This notification may occur outside of normal business hours. Therefore, the communication procedures and protocols must anticipate a need to contact key stakeholders at any time of any day.

- Governor or appointed representative (Contact List)
- Chief Liquidation Officer, or Special Deputy Receiver (Committee and Contact List)
- Chief Legal Counsels of Regulator/Receiver (Committee and Contact List)
- Other agencies. It should be noted that some entities (for example. health maintenance organizations and other managed care organizations) may be regulated primarily or jointly by other state agencies, such as the department of health or specialized agencies.
- Attorney General or designated Assistant Attorney General (Committee and Contact List) and/or contracted outside counsel
- If state law and process allow, Chief or Administrative Judge of the receivership court (Contact List)
- Depending on state structure, Contracted Receivers (may need pre-approved short list for magnitude of a Dodd-Frank receivership; consider training core group of current state receivers who can be loaned to other states in the systemically significant circumstances) (Committee and Contact List). Commissioners may in their discretion consider sources of previously identified receivership expertise in assembling resources for the administration of a Dodd-Frank receivership. The NAIC Directory of Receivership and Run-Off Resources to Assist State Insurance Regulators provides commissioners, in their capacity as receiver, a list of professional resources. Examples of other sources of expertise may include the ABA Tort & Insurance Practice Section; the Association of Insurance & Reinsurance Run-Off Companies (AIRROC); the International Association of Insurance Receivers, which also accredits insurance receivers; and the International Association of Restructuring, Insolvency & Bankruptcy Professionals.
- NOLHGA and NCIGF, and specialized guaranty funds, such as title and managed care, where appropriate. (Committee and Contact List)
    - Additional Potential Parties for Active Receivership:
        - NAIC, including the Receivership Financial Analysis (E) Working Group. The NAIC can particularly assist with the notification to all affected state Regulators in the event that ancillary receiverships must be rapidly initiated.
        - FIO.
        - Ancillary receivers, if any.
        - FDIC to coordinate treatment of solvent and insolvent insurance company subsidiaries and affiliates and other issues.
        - Other state agencies that also regulate the insurance company.



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## D. Procedure for Rapid Consultation with the State Attorney General or Other Counsel Required to Prepare and Make the Initial Filing

1. In most states, the State Attorney General represents the Regulator. In many states, the State Attorney General also represents the Receiver. Therefore, early consultation and coordination with the State Attorney General in those states where they represent the Regulator and Receiver, or the retained legal staff who represents the Regulator and Receiver is required to swiftly transition a systemically risky insurance company to receivership under state law.

2. In some cases, national coordination with Attorneys General and others who represent the Regulator and Receiver will be required to promptly and cost-effectively domesticate the receivership order in all or the majority of states.

3. States should plan for expedited and/or flexible procedures for the appointment of outside counsel, if required by the Regulator or Receiver. There will be a need for rapid conflicts checking and immediate retention.

4. Depending on state structure, states should consider development of a pre-approved short list of Attorneys General, internal counsel, and/or qualified outside counsel who can respond to the magnitude of a Dodd-Frank receivership. This could ensure immediate consultation with attorneys needed to prepare and make the required filing in state court and execute the receivership under the urgent circumstances presented by a Dodd-Frank receivership.

5. Special attention should be devoted to those special cases in which the federal courts may also be involved, such as the insolvency of a risk retention group or the resort to Chapter 11 of the bankruptcy code by the parent or an affiliate of the troubled insurer that could result in the Section 362 automatic stay impeding accelerated proceedings.

## E. Other Considerations

1. States and the NAIC should develop pre-screened/outlined court documents.

2. In some states, statutory amendments may be required or favored to assure that a federal determination under § 203(b) or consent at the federal level is grounds for liquidation. Potential changes are discussed below in section VI. Notwithstanding that, there are provisions in the NAIC models and Model #245 that can be incorporated into pre-screened court administrative documents for receiverships prompted by systemic risk determinations, such as:

   a. Rehabilitation may be the best first step for all or part of an insurance company subject to a Dodd-Frank receivership, especially if there is a filed resolution plan providing for the orderly transfer, reinsurability or runoff of policyholder liabilities. Liquidation may be required if there is a critical need to trigger guaranty funds and an order of liquidation. Plus, a finding of insolvency is required by state law for that trigger. All receivership mechanisms should be considered in consultation with any applicable guaranty funds. In any case, rapid but sophisticated analysis of how a state receiver is going to close or resolve the insurance company must occur. This includes what liquid assets exist to run the receivership; what assets are (un)encumbered, including what liens have been taken by the FDIC; how assets can be sold or liquidated; how claims are going to be filed, determined and paid; and what is the effect of qualified financial contracts.

   b. The following grounds for receivership or liquidation in most current state codes could provide grounds for an insurance company receivership order in the event of a federal determination and can be incorporated into a consent, model complaint and order along with other grounds that may exist (i.e., insolvency):



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- The insurer is in such hazardous condition that the further transaction of its business would be hazardous financially to its policyholders, creditors and the public. Compare § 203(b)(4).

- The board of directors or the holders of the majority of voting shares request or consent to state receivership.

### F. Timeline for Prompt Consideration by State Trial Court

Once a petition for receivership is filed, the company will have an opportunity to defend itself, which can result in a trial or an evidentiary hearing. Some states may require or favor a statutory rule change to assure that a Dodd-Frank insurance company receivership complaint (where there is no consent) is fully litigated through appeal on an emergency track analogous to that set forth in § 202(b). All states will, at a minimum, require procedures for emergency intake and consideration of the complaint and any pro hac vice motions by the trial court. When possible, Regulators and Receivers should meet in advance with the Chief Administrative Judge or other appropriate official in the Receivership Court to discuss (i) the new requirements under Dodd-Frank; (ii) how the Court prefers to manage such complaints and cases, in particular if all or part of the initial complaint must be filed in person or heard outside of normal business hours; and (iii) what likely questions the Court would have in the event of a Dodd-Frank filing. Reference can be made to the U.S. District Court for the District of D.C. rules promulgated to implement the federal determination process.

While these court processes will not be entirely in the control of the Regulator and may potentially require legal changes, ideally the procedures would provide for:

1. Intake and administration protocol that results in automatic assignment to a particular judge (such as the chief administrative judge or duty judge) and that avoids jurisdictional disputes (e.g., whether the complaint and case is or is not assigned or transferred to a specialized court or docket).

2. Filing the complaint under seal where appropriate.

3. Intake and administration protocols that provide for expedited processes and orders, ideally hearing and determination of the complaint within 24 hours of filing. This may be accomplished pursuant to a court scheduling order or other order, or existing rules in some states.

   Separately, many, if not all, states have adopted special statutes or rules for expedited litigation and appeal of particular classes of cases. Although those classes of cases are more frequent than insurance receiverships in general, and Dodd-Frank receiverships in particular, state courts should give consideration now to the issue whether new rules or statutes are warranted to provide for immediate and expedited litigation of a Dodd-Frank insurance receivership on an analogous track as is set forth in § 203(b).

4. Limited or no intervention by third parties. To the extent existing state law in a particular state permits third parties (other than the company) to intervene as parties at the outset of an insurance company receivership, consider limiting the right to seek intervention in a Dodd-Frank receivership to ancillary proceeding that occur after entry and appeal of the receivership order. This will assure that states can meet the Dodd-Frank Act's need for immediate entry of a rehabilitation or liquidation order in response to a federal determination and that interventions do not interfere with the emergency activities of the court and the regulator. In states where statutes or case law do not presently grant third parties intervention and appeal rights in receivership cases, that law should be preserved in a Dodd-Frank receivership.

5. Domestication of the receivership order and/or initiation of ancillary receivership proceedings.



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6. Limited appeal, both in terms of standing and scope of review, analogous to that set forth in Dodd-Frank, Title II, Section § 202. Conversely, only the insurance company, as represented by its board, should have standing to defend against a complaint for receivership as provided for in existing statutes. Affiliates, subsidiaries and creditors should not be permitted to participated in the litigation of the discreet issue whether a liquidation order should be entered because of the existence of a federal determination under § 203(b).

## IV. SUBSIDIARY AND AFFILIATE ISSUES

### A. Overview

Subsidiary and affiliate issues require that Commissioners and deputy receivers expand their scenario analysis and planning beyond situations in which an insurance company would be the covered financial company. As described below, several scenarios can emerge whereby the insurance company is affected by a Dodd-Frank receivership, although not as the covered financial company. In particular, issues emerge where the insurance company is an asset, direct or indirect, of a covered financial company, or where the FDIC's lien authority is brought to bear.

Section 2(1) of the Dodd-Frank Act defines "affiliate" as having the meaning set forth in 12 U.S.C. 1813[20], which defines the term as having the meaning set forth in 12 U.S.C. 1841(k), as follows: " ... any company that controls, is controlled by, or is under common control with another company."

Section (2)(18)(A) of the Dodd-Frank Act—Other Incorporated Definitions—provides that "subsidiary" has the meaning set forth in 12 U.S.C. 1813, where is it defined as follows:

(w) Definitions relating to affiliates of depositary institutions

(4) Subsidiary. The term 'subsidiary'

(A) means any company which is owned or controlled directly or indirectly by another company; and

(B) includes any service corporation owned in whole or in part by an insured depository institution or any subsidiary of such a service corporation.

Section 2(18)(A) of the Dodd-Frank Act also provides that the term "control" has the meaning set forth in 12 U.S.C. 1813,[21] where the term is defined as having the meaning set forth in 12 U.S.C. 1841, as follows:

(a)(2) Any company has control over a bank or any company if -

(A) the company directly or indirectly or acting through one or more other persons owns, controls, or has power to vote 25 per centum or more of any class of voting securities of the bank or company;

(B) the company controls in any manner the election of a majority of the directors or trustees of the bank or company; or

[20] 12 U.S.C. 1813(w)(6).

[21] 12 U.S.C. 1813(w)(5).


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(C) the Board determines, after notice and opportunity for hearing, that the company directly or indirectly exercises controlling influence over the management or policies of the bank or company.

Determination of an entity's status as an affiliate or subsidiary may vary under the Dodd-Frank Act from that under holding company or state law.

## B. Advanced Planning

Section 210(a)(1)(G) of the Dodd-Frank Act provides broad power to the FDIC, as the receiver of a covered financial company, to transfer the company's assets without obtaining approval from any other entity.[22] If an insurance company is owned by a covered financial company, it is, therefore, an asset of the covered financial company, and the FDIC can transfer its ownership. The Dodd-Frank Act does not specify any conditions or limitations on the FDIC's power to transfer ownership, such as obtaining the approval of the domiciliary regulator. Thus, it appears that compliance with Insurance Holding Company System Regulatory acts is not contemplated, nor is compliance with other state laws governing ownership (for example, limitations on foreign ownership). It is possible that § 210(a)(1)(G) preserves state authority because comparable authority allowing the FDIC to transfer assets to a "bridge financial company" specifically excludes state approval. Whereas § 210(a)(1)(G) provides that the FDIC can make a transfer "without obtaining any approval, assignment or consent. …," § 210(h)(5)(D), governing transfers by the FDIC to a bridge financial company, provides that a transfer is effective " ... *without any further approval under Federal or State law*, assignment, or consent with respect thereto."[23] The express exemption from obtaining "Federal or State law" approval is not contained in § 210(a)(1)(G), which, therefore, might be interpreted as simply exempting the FDIC from obtaining approval from shareholders, lien holders or other private parties.[24]

An insurance company's assets would not appear to be subject to transfer by the FDIC because § 210(a)(1)(G) only authorizes the transfer of assets of the "covered financial company" for which the FDIC is the receiver. The section does not appear to authorize the FDIC to "transfer" the insurer's business through reinsurance or other arrangements. It also, therefore, does not appear to give the FDIC authority to transfer a wholly owned subsidiary of an insurer. The subsidiary is an asset of the insurer, not the covered financial

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[22] § 210(a) - Powers and Authorities.

(1) General Powers

(G) Merger; Transfer of Assets and Liabilities. –

(i) In General. Subject to clauses (ii) and (iii), the Corporation [FDIC], as receiver for a covered financial company, may –

(I) ...

(II) transfer any asset or liability of the covered financial company (including any assets and liabilities held by the covered financial company for security entitlement holders, any customer property, or any assets and liabilities associated with any trust or custody business) without obtaining any approval, assignment, or consent with respect to such transfer.

[23] § 210(h) - Bridge Financial Companies

(5) Transfer of Assets and Liabilities.

(A) Authority of Corporation. The Corporation [FDIC], as receiver for a covered financial company, may transfer any assets and liabilities of a covered financial company (including any assets or liabilities associated with any trust or custody business) to one or more bridge financial companies, in accordance with and subject to the restrictions of paragraph (1).

(D) Effective Without Approval. The transfer of any assets or liabilities, including

those associated with any trust or custody business of a covered financial company, to a bridge financial company shall be effective without any further approval under Federal or State law, assignment, or consent with respect thereto.

[24] § 210(h)(5) is ambiguous in its reference to exemption from "further" approval under Federal or State law. § 210 does not specify *any* State approval requirements, hence exemption from "further" approval is without an antecedent reference.



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company. But authority granted to the FDIC to impose liens (discussed below) is analogous, and that authority is interpreted as extending to an insurer's subsidiaries.

Under its authority to transfer assets of a covered financial company, the FDIC could transfer ownership of an insurer's affiliates. Transferring an affiliate (or a subsidiary) could be highly problematic for an insurer in numerous situations, such as transfer of an affiliated management company that runs the insurer's operations (the insurer itself may have no employees), transfer of an affiliate or subsidiary that generates profits recirculated by the parent company (or dividend by the subsidiary) to provide capital to the insurer, or transfer of an affiliate or subsidiary whose operations are essential to or interwoven with the operation of the insurer.

The Dodd-Frank Act also provides that the FDIC may transfer the assets of a covered financial company for which it has been appointed as receiver to a "bridge financial company." As noted above, the transfer may be made without approval under "State Law." Again, the FDIC does not appear to be bound by any provisions of Insurance Holding Company System Regulatory acts or other state laws. Transfer of an insurer or its affiliates to a bridge financial company raises the same issues regarding ownership and operation as are raised by the FDIC's power to otherwise transfer ownership. Transfer to a bridge financial company contemplates a further transfer or other disposition of assets when the status of the bridge financial company terminates.[25] Hence, a further transfer of ownership of an insurer could occur.

### C. Lien and Funding Issues

Section 204(d) of the Dodd-Frank Act provides that when the FDIC is appointed as receiver of a covered financial company, it can "make available ... funds" to the receivership. and it can use those funds for a number of purposes[26]. The contemplated purposes include: making loans to the covered financial company

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[25] Section 210(h)(13) - Termination of Bridge Financial Company Status. -- The status of any bridge financial company as such shall terminate upon the earliest of --

(A) the date of the merger or consolidation of the bridge financial company with a company that is not a bridge financial company;

(B) at the election of the Corporation, the sale of a majority of the capital stock of the bridge financial company to a company other than the Corporation and other than another bridge financial company;

(C) the sale of 80 percent , or more, of the capital stock of the bridge financial company to a person other than the Corporation and other than another bridge financial company;

(D) at the election of the Corporation, either the assumption of all or substantially all of the liabilities of the bridge financial company by a company that is not a bridge financial company, or the acquisition of all or substantially all of the assets of the bridge financial company by a company that is not a bridge financial company, or other entity as permitted under applicable law; and

(E) the expiration of the period provided in paragraph (12), or the earlier dissolution of the bridge financial company, as provided in paragraph (15).

[26] § 204 - Orderly Liquidation of Covered Financial Companies.

(d) Funding for Orderly Liquidation. - Upon its appointment as receiver for a covered financial company, and thereafter as the Corporation [FDIC] may, in its discretion, determine to be necessary or appropriate, the Corporation may make available to the receivership, subject to the conditions set forth in section 206 and subject to the plan described in section 210(n)(9), funds for the orderly liquidation of the covered financial company. All funds provided by the Corporation under this subsection shall have a priority of claim under subparagraph (A) or (B) of section 210(b)(a), as applicable [administrative expenses or amounts owed to the United States, respectively], including funds used for --

(1) making loans to, or purchasing any debt obligation of, the covered financial company or any covered subsidiary;

(2) purchasing or guaranteeing against loss the assets of the covered financial company or any covered subsidiary, directly or through an entity established by the Corporation for such purpose;

(3) assuming or guaranteeing the obligations of the covered financial company or any covered subsidiary to 1 or more third parties;



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or any "covered subsidiary[27]"; purchasing assets of a covered financial company or covered subsidiary[28]; selling or transferring all or any part of "such acquired assets, liabilities or obligations" of a covered financial company or covered subsidiary[29]; and making payments to certain creditors[30]. Section (d) also provides that the FDIC may take a lien on property of a covered financial company or a covered subsidiary, as follows:

[I]ncluding funds used for --

(4) taking a lien on any or all assets of the covered financial company or any covered subsidiary, including a first priority lien on all unencumbered assets of the covered financial company or any covered subsidiary to secure repayment of any transactions conducted under this subsection.

Unlike the term "covered financial company," which is defined in relation to systemic risk[31], a "covered subsidiary" is defined as *any* "subsidiary" of a covered financial company, other than an insured depository institution, an insurance company, or a covered broker or dealer.[32] Further, the term has been interpreted as meaning a subsidiary at any level in the corporate organization; thus, the term appears to include the subsidiary of an insurance company.

For example, in the hypothetical illustration below, a covered financial company owns an insurance company, a federally insured depository, and several other direct and indirect subsidiaries. Under the Dodd-Frank Act, each of the subsidiaries will also be deemed to be a "covered subsidiary," except for the insurance company and the federally insured depository.

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(4) taking a lien on any or all assets of the covered financial company or any covered subsidiary, including a first priority lien on all unencumbered assets of the covered financial company or any covered subsidiary to secure repayment of any transactions conducted under this subsection;

(5) selling or transferring all, or any part, of such acquired assets, liabilities or obligations of the covered financial company or any covered subsidiary; and

(6) making payments pursuant to subsections (b)(4), (d)(4), and (h)(5)(E) of section 210.

[27] Subsection (d)(1), *supra*.

[28] Subsection (d)(2), *supra*.

[29] Subsection (d)(5), *supra*.

[30] Sections 210(b)(4), 210(d)(4) and 210(H)(5)(E).

[31] *See* § 203(b).

[32] § 201(a)(9) - Covered Subsidiary. -- The term "covered subsidiary" means a subsidiary of a covered financial company, other than ---

(A) an insured depository institution;

(B) an insurance company; or

(C) a covered broker or dealer.



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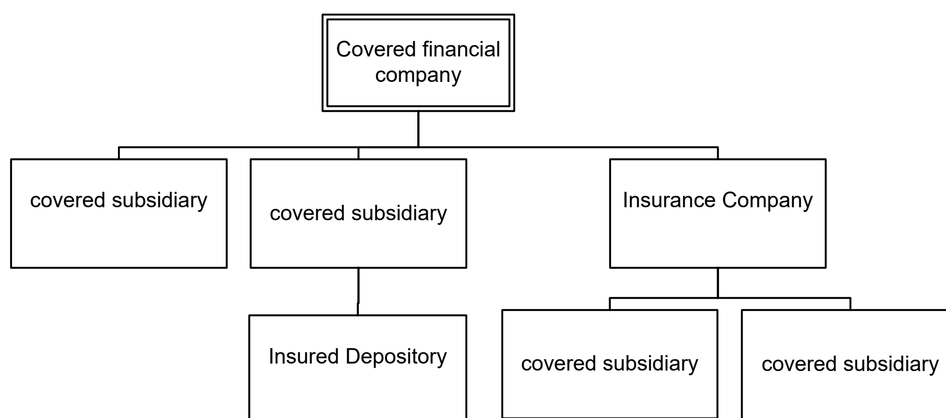


The FDIC adopted Regulation § 380.6[33] regarding its lien authority under § 204(d) as applied to insurance companies and their subsidiaries. The Regulation was amended from its original proposed form, in response to comments by the NAIC, NOLHGA/NCIGF and others, to provide that liens would only be imposed, generally, on the assets of the entity that actually received funds pursuant to § 204(d). The Regulation provides as follows:

Limitation on liens on assets of covered financial companies that are insurance companies or covered subsidiaries of insurance companies.

a) In the event that the Corporation [FDIC] makes funds available to a covered financial company that is an insurance company or to any covered subsidiary of an insurance company or enters into any other transaction with respect to such covered entity under 12 U.S.C. 5384(d), the Corporation will exercise its right to take liens on any or all assets of the covered entities receiving such funds to secure repayment of any such transactions only when the Corporation, in its sole discretion, determines that:

    1. Taking such lien is necessary for the orderly liquidation of the entity; and

    2. Taking such lien will not either unduly impede or delay the liquidation or rehabilitation of such insurance company, or the recovery by its policyholders.

b) This section shall not be construed to restrict or impair the ability of the Corporation to take a lien on any or all of the assets of any covered financial company or covered subsidiary in order to secure financing provided by the Corporation or the receiver in connection with the sale or transfer of the covered financial company or covered subsidiary or any or all of the assets of such covered entity.

Regulation 380.6, subsection (a) limits the FDIC to obtaining liens only on the entity that receives a loan from the FDIC and only if the lien will not unduly interfere with the liquidation or rehabilitation of the parent or affiliate insurer. Generally, this limitation would prevent liens on the assets of an insurance company that is a subsidiary of a covered financial company that received FDIC funding. Subsection (b), however, is a reservation of rights as to subsection (a) that may apply when the FDIC intends to place a lien on an insurer's assets in connection with obtaining financing or in connection with the sale or transfer of the covered financial company, a subsidiary or an affiliate.

The FDIC's lien authority could conflict with the authority of the receiver or the receivership court as to imposition of liens on an insurer's assets. Imposing liens on subsidiaries' assets could negatively affect the

[33] 12 C.F.R. § 380.6



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operations of an insurer when a subsidiary's operations are interwoven with or integral to the operation of the insurer.

## V. NATIONAL COORDINATION

In the event of a Dodd-Frank receivership, national coordination between state insurance departments may require use of multiple resources, distribution lists and tools currently in place and available to state insurance departments/receivers. These include, though are not limited to, relying on the expertise of NAIC committees, such as the Receivership Financial Analysis (E) Working Group and the Financial Analysis (E) Working Group. The Receivership Financial Analysis (E) Working Group was established to monitor nationally significant insurers/groups within receivership to support, encourage, promote and coordinate multi-state efforts in addressing problems. This will include interacting with the Financial Analysis (E) Working Group, domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s) with regard to the receiverships. The Financial Analysis (E) Working Group was established to analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled and determine if appropriate action is being taken, as well as to interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s).

It is likely that coordination between state insurance departments and federal bodies may include providing and receiving contact information with various parties (e.g., FDIC, FIO, and the U.S. Department of the Treasury ). Thus, it is important to remember that the NAIC maintains distribution lists for various state insurance department parties, including primary receivership contacts, general counsel, chief financial regulator, etc. The NAIC also maintains contact information for federal bodies.

National coordination efforts may also need to involve the expertise of the state guaranty fund system and its existing national framework, if applicable. Thus, please refer to the NAIC's white paper *Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System*. Prepared by the Receivership and Insolvency (E) Task Force, the white paper describes these communication and coordination considerations. Highlights from the publication include the following:

> Guaranty association involvement should be early enough that the guaranty associations can immediately undertake their statutory duties upon liquidation. As a practical matter, this calls for involvement as soon as it appears that there is a significant possibility of liquidation. This point may be reached even before the insurer is under administrative supervision or in conservation or rehabilitation. Assuming that the size, complexity and type of business of any given company has a direct bearing on how much lead-time is needed by the guaranty associations, there is a minimum amount of time, prior to being triggered, in which guaranty associations need to receive information, including quantification of covered liabilities by state, claims system information, lines of business and product specifics, third party agreements, as well as any other arrangements. If adequate information is not gathered pre-liquidation, delays in payments to claimants will result. Guaranty associations can often assist a regulator with formulating a plan for liquidation. Associations are frequently able to devote valuable resources, including legal, financial, actuarial, and other consulting services, in the design of a plan in circumstances in which budgetary or staffing constraints may pose challenges for regulators.

## VI. POTENTIAL CHANGES TO STATE LAW

Receivership and the call for orderly liquidation under Title II of Dodd-Frank may be triggered well before the existence of insolvency, impairment or other hazardous conditions have traditionally been established with respect to domestic companies. A Dodd-Frank orderly liquidation will also require a rapid response, as discussed fully in section III above. Accordingly, states should review and consider whether their existing state laws, including the grounds for rehabilitation or liquidation of a domestic company and related procedural rules for obtaining receivership orders, are sufficient to respond to federal determinations that domestic insurers meet the standards codified in Title II of Dodd-Frank, 12 U.S.C. § 5383(b), and the receivership processes established under 12 U.S.C. § 5382(a) and § 5383(e).



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In order to assist the states in this review, the Dodd-Frank Receivership Implementation (E) Working Group prepared the *Guideline for Implementation of State Orderly Liquidation Authority* ("Guideline"). See (Exhibit 11-C.) The Guideline is intended to provide guidance and serve as a template for potential state law drafting revisions. The Guideline provides that any of the triggers for a Dodd-Frank receivership under 12 U.S.C. § 5382(a), either consent by the company, entry of an order by U.S. District Court for the District of Columbia, or by operation of law under 12 U.S.C. § 5382(a)(1)(A)(v), see flowchart (Exhibit 11-A), constitute automatic grounds for rehabilitation or liquidation under state law. The Guideline also mirrors the Dodd-Frank Act by establishing timing and procedural rules for the expeditious entry and implementation of receivership orders that support both the policy goals of the Dodd-Frank Act and federal regulators, as well as the extraordinary responsibilities of state regulators for ensuring policyholder protection while resolving a systemically important insurance receivership.


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## XII. EXHIBITS

*Exhibit 1-1: Model Language for Selected Provisions of Liquidation Orders for Property and Casualty Insurers*

*Exhibit 1-2: Model Language for Selected Provisions of Liquidation Orders for Life and Health Insurers*

*Exhibit 1-3: Insurer Insolvency Questionnaire*


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***Exhibit 1-1: Model Language for Selected Provisions of Liquidation Orders for Property and Casualty Insurers***

MODEL LANGUAGE FOR SELECTED PROVISIONS
OF LIQUIDATION ORDERS
OF PROPERTY AND CASUALTY INSURERS

1. FINDING OF INSOLVENCY LANGUAGE

[Insolvent Company] is hereby found to be insolvent, within the meaning of [cite provision of liquidation statute stating insolvency as a ground for liquidation].

2. ORDER OF LIQUIDATION LANGUAGE

An Order of Liquidation with a Finding of Insolvency is hereby entered against [the Insolvent Company].

3. LANGUAGE CANCELING THE POLICIES OF THE INSOLVENT COMPANY

All of the contracts, covenants, bonds or policies, evidences, or certificates of coverage or insurance issued by or in the name of [the Insolvent Company], under which any guarantee or insurance is provided, shall be canceled upon the earliest of the following:

(a) Thirty (30) days after the date the Order of Liquidation is entered, at 12:01 a.m. local time of the insured or policyholder of such direct policy or certificate of insurance; or

(b) Upon the expiration date of any such direct policy and/or certificate of insurance, if the expiration date is sooner than thirty (30) days after the entry of the Order of Liquidation; or

(c) Upon the date the insured or policyholder of any such direct policy and/or certificate of insurance replaces the direct policy and/or certificate of insurance, or effects cancellation, if the insured or policyholder does so within thirty (30) days after the entry of the Order of Liquidation; or

(d) Upon such other date as established by the court.

[Another provision of the Order will deal with cancellation of assumed reinsurance contracts.]; or

4. LAST DATE TO FILE CLAIMS

A. The Liquidator shall notify all persons who, according to [the Insolvent Company's] books and records, have or may have claims against [the Insolvent Company], its property or assets, to present and file with the Liquidator or a duly authorized Ancillary Receiver of [the Insolvent Company], proper proofs of claim in the form hereafter set forth, on or before 4:30 p.m., [Time Zone] [Date]. Said notice by the Liquidator shall specify [Date] at 4:30 p.m., [Time Zone], to be the last day by which a proof of claim may be received by the Liquidator, or a duly authorized Ancillary Receiver of [the Insolvent Company], for purposes of participating in any distribution of assets that may be made on timely filed claims that are allowed in these proceedings.

B. The Liquidator shall also provide notice by publication to all persons who have or may have claims against [the Insolvent Company] or against its insureds or policyholders, by causing a notice to be published [at least once a week for three (3) consecutive weeks] in a newspaper of general circulation published in the County of ________________, State of ________________,



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and such other newspapers as the Liquidator may deem advisable. The notice shall: (a) advise all such persons of their right to present their claim or claims against [the Insolvent Company], its property or assets, or against an[Insolvent Company] insured or policyholder, to the Liquidator; (b) advise all such persons of the procedure by which they may present their claims to the Liquidator; (c) advise all such persons of the Liquidator's office where they must present their claims; and (d) specify the last day by which proofs of claim may be received by the Liquidator for purposes of participating in any distribution of assets that may be made on timely filed claims allowed in these proceedings.

C. All persons having or claiming to have any accounts, debts, claims or demands against [the Insolvent Company], its property or assets, or against an [Insolvent Company] insured or policyholder, shall present their claims to the Liquidator at his or her office as designated in the notice, on or before the claim filing deadline set forth above, by way of a properly completed proof of claim. A proof of claim must consist of a statement, under oath, in writing, signed by the claimant, setting forth the following: 1) the specific claim and the consideration therefore; 2) whether any payments have been made on the claim, and, if so, what payments; and 3) that the sum claimed is justly owing from [the Insolvent Company] to the claimant. Whenever a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim and, if such instrument is lost or destroyed, a statement of such fact, and the circumstances of the loss or destruction shall be filed under oath with the claim.



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***Exhibit 1-2: Model Language for Selected Provisions of Liquidation Orders for Life and Health Insurers***

MODEL LANGUAGE FOR SELECTED PROVISIONS
OF LIQUIDATION ORDERS
OF LIFE AND HEALTH INSURERS

1. FINDING OF INSOLVENCY LANGUAGE

[Insolvent Company] is hereby found to be insolvent, within the meaning of [cite provision of liquidation statute stating insolvency as a ground for liquidation].

2. ORDER OF LIQUIDATION LANGUAGE

An Order of Liquidation with a Finding of Insolvency is hereby entered against [the Insolvent Company].

3. LANGUAGE REGARDING THE POLICIES OF THE INSOLVENT COMPANY

- Upon issuance of this Order, the rights and liabilities of [the Insolvent Company] and of its creditors , policyholders, shareholders, members and all of the persons interested in this estate are affixed as of the date of the filing of Petition for Liquidation except as provided in [statutory reference] and in this Order.

- Entry of this Order of Liquidation shall not constitute an anticipatory breach of any contracts of [the Insolvent Company], and it shall not be grounds for revision, revocation, or cancellation of any contracts of [the Insolvent Company] in force as of the date of liquidation, except as provided in [statutory reference].

- All of the policies of life or health insurance or annuity contracts of [the Insolvent Company] shall continue in force until such time as the guaranty associations and liquidator implement a reinsurance plan or the guaranty associations assume the covered portions of those policies. Moreover, the policies of life or health insurance or annuity contracts or any other type of policies or contracts about which there is an issue of guaranty association coverage shall not terminate until such time as a non-appealable Order has been entered by a court of competent jurisdiction on whether such contract or policy is entitled to guaranty association coverage.

1. LAST DATE TO FILE CLAIMS

A. The Liquidator shall notify all persons which [the Insolvent Company's] books and records reveal have, or may have, claims against [the Insolvent Company], its property or assets, to present and file with the Liquidator, or a duly authorized Ancillary Receiver of [the Insolvent Company], proper proofs of claim in the form hereafter set forth, on or before 4:30 p.m., [Time Zone] [Date]. [Said notice by the Liquidator shall specify [Date] at 4:30 p.m., [Time Zone], to be the last day by which a proof of claim may be received by the Liquidator, or a duly authorized Ancillary Receiver of [the Insolvent Company], for purposes of participating in any distribution of assets that may be made on timely filed claims which are allowed in these proceedings.]

B. The Liquidator shall also provide notice by publication to all persons who have, or may have claims against [the Insolvent Company] or against its insureds or policyholders, by causing a notice to be published [at least once a week for three (3) consecutive weeks] in a newspaper of general circulation published in the County of ________________, State of



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***Exhibit 1-2***

________________, and such other newspapers as the Liquidator may deem advisable. The notice shall: [(a) advise all such persons of their right to present their claim or claims against [the Insolvent Company], its property or assets, or against [an Insolvent Company] insured or policyholder, to the Liquidator; (b) advise all such persons of the procedure by which they may present their claims to the Liquidator; (c) advise all such persons of the Liquidator's office where they must present their claims; and (d) specify the last day by which proofs of claim may be received by the Liquidator for purposes of participating in any distribution of assets that may be made on timely filed claims allowed in these proceedings.]

C. All persons having or claiming to have any accounts, debts, claims or demands against [the Insolvent Company], its property or assets, or against an insured or policyholder, excepting only persons whose claims arise under life insurance policies or annuity contracts, shall present their claims to the Liquidator at his or her office as designated in the notice, on or before the claim filing deadline set forth above, by way of a properly completed proof of claim. A proof of claim must consist [of a statement, under oath, in writing, signed by the claimant, setting forth the following: 1) the specific claim and the consideration therefore; 2) whether any payments have been made on the claim, and, if so, what payments; 3) that the sum claimed is justly owing from [the Insolvent Company] to the claimant.] Whenever a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim and, if such instrument is lost or destroyed, a statement of such fact, and the circumstances of the loss or destruction shall be filed under oath with the claim. Owners of life insurance policies and annuity contracts whose claims arise under such policies or contracts shall not be required to file a proof of claim to the extent such claims are limited to the benefits due under such policies or contracts.

**NOTE: This sample retains most of the language from Exhibit 1-1 for Property and Casualty Insurer liquidations, however for Paragraphs 4B and 4C, the language will only apply where the life or annuity company has health policies with potential claims by health policyholders or providers; these provisions will have little value in a life or annuity insolvency where all life and annuity policyholders will have claims (e.g. cash surrender value) regardless of specific policy triggering events.



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## INSURER INSOLVENCY QUESTIONNAIRE

**Investigative Checklist**

I. Identification

1. Company name: ____________________
   Last business address: ____________________
   ____________________
   ____________________

2. Contact person for information regarding this estate:

   Name: ____________________
   Address: ____________________
   ____________________
   ____________________
   Title: ____________________
   Phone: ____________________ Fax: ____________________

3. State of domicile: ____________________

4. Corporate structure: Stock [ ] Mutual [ ] Other [ ]____________________

5. Type of insurer: Life & Health [ ] P&C [ ] HMO [ ] Other [ ] _____
_______________

6. Estimated amount of insolvency ____________________ Date ____________________

7. If part of a holding company system, attach organizational chart.

8. Grounds for Delinquency proceedings

   (Check all that possibly apply.)

| | | | |
|---|---|---|---|
| Inadequacy of capital and surplus | [ ] | Failure to utilize good info or to react to bad information | [ ] |
| Inability to pay debts when due | [ ] | Pricing | [ ] |
| Reserving | [ ] | Asset portfolio investments | [ ] |
| Delegation of authority or control | [ ] | Inadequate control of administrative expenses | [ ] |
| Fraud | [ ] | | |
| Party-at-interest transactions (Example: excessive level of fees paid to affiliates or parent company) | [ ] | Other ____________________ ____________________ ____________________ | [ ] |



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II. Legal Activities

9. Status of company and date of court orders:

| | Date | Docket Number | Jurisdiction |
|---|---|---|---|
| Conservation/supervision | _______ | _____________ | ___________________ |
| Rehabilitation | ________ | _____________ | ___________________ |
| Liquidation | ________ | _____________ | ___________________ |
| Other | ________ | _____________ | ___________________ |
| Closed | ________ | _____________ | ___________________ |

10. If this company is a closed or discharged rehabilitation, how was it resolved? (Check all that apply.)

| | | | |
|---|---|---|---|
| Sold company | [ ] | Business was run off | [ ] |
| Sold subsidiaries | [ ] | Sold lines of business | [ ] |
| Infusion of additional capital | [ ] | Other (please describe) | [ ] |

______________________________
______________________________
______________________________

11. This receivership is/was:

| | | | |
|---|---|---|---|
| Agreed | [ ] | Adversarial | [ ] |
| Non-contested default | [ ] | Other (please describe) | [ ] |

______________________________
______________________________
______________________________

12. Material litigation initiated, pending or completed as of date of report? (Please repeat for each piece of litigation.)

Caption ______________________________________________
______________________________________________
______________________________________________

Docket ______________________________________________
______________________________________________
______________________________________________

Jurisdiction ______________________________________________

Brief description______________________________________________
______________________________________________
______________________________________________

If litigation is completed, what is the result?

Judgment [ ] Settlement [ ] Dismissal [ ]



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***Exhibit 1-3***

13. Form prepared by ______________________
Position ______________________
Organization ______________________
Phone No. ______________ Date ______________ (mo./date/yr.)

III. Suspected Violation

14. Is there any indication of any of the following suspected violations: Check appropriate item(s).

____ Defalcation/embezzlement
____ False statement by insurance company (assets/liabilities, ownership, reserves)
____ False statement/claims to insurance companies
____ Check kiting
____ Bank fraud
____ Wire/mail fraud
____ Securities fraud
____ Bank secrecy act
____ Public corruption
____ Bribery/gratuity
____ Misuse of position or self-dealing; other abuses by insurance
____ Credit card fraud
____ METS, MEWAs or union activities
____ ERISA violations
____ Uncollectable or non-existent reinsurance
____ Money laundering
____ Other (Describe)
______________________
______________________
______________________

15. Person(s) suspected of criminal violation. (If more than one, use continuation sheet.)

A. Name ______________ ______________ ______________
first middle last

B. Address ______________ ______________ ______________ ______________
street city state zip

C. Date of birth ______________ (if known) mo./day/yr.  Social Security No. ______________ (if known)

D. Relationship to the insurance entity. Check all applicable item(s).

___ Officer
___ Director
___ Employee
___ Accountant
___ Consultant
___ Managing general agent
___ Agent/broker
___ Appraiser
___ Lawyer
___ Adjuster
___ Stockholder
___ Policyholder
___ Third-party administrator
___ Other (specify)
______________________
______________________



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E. Location of suspected offenses ________________________________________

F. Approximate date and dollar amount (prior to any allowance for restitution or recovery) of suspected violation.

Date __________________________ Amount _____________________
mo./day/yr.

G. Is person still affiliated with the insurance entity?

____ yes ____ no If no, ____ terminated ____resigned

Date ____________________
mo./day/yr.

H. If person is not affiliated with insurance entity, was person:

________ Policyholder ________ Doctor
________ Lawyer ________ Other professional
________ Accountant ________ Other (specify)
___________________________
___________________________

I. Prior or related criminal referrals? ____ yes ____ no
If yes, please identify.
________________________________________________________________________________
________________________________________________________________________________
________________________________________

J. Is person affiliated with any other insurance entities?

____ yes ____ no

Or business enterprise?

___ yes ____ no

K. Has there been any admission or a confession?

____ yes ____ no

If so, by whom ______________________________________

To whom was confession made? _______________________________________



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16. Witnesses:

If the information is available, list any witnesses who might have information about the suspected violation and describe their position or employment. Indicate if they have been interviewed. (Use continuation sheet if necessary.)

| | Name Position Address Tele. | Interviewed Yes | No |
|---|---|---|---|
| (1) | ______________________ | ____ | ___ |
| | ______________________ | | |
| (2) | ______________________ | ____ | ___ |
| | ______________________ | | |
| (3) | ______________________ | ____ | ___ |
| | ______________________ | | |
| (4) | ______________________ | ____ | ___ |
| | ______________________ | | |

Have you sent this referral to any other state, local or federal agency? If so, please list below:

| Agency | City/State |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |


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***Exhibit 1-3***

**Questions to be Asked by Investigator**

Explanation/description of suspected violation. (Give a brief summary of the suspected violation, explaining what is unusual or irregular about the transaction.) Details will be required below. The purpose of this paragraph is to provide a summary description of the overall transaction.

Give a chronological and complete account of the suspected violation. (Use continuation sheets, if necessary.)

--- Relate key events to documents and attach copies of those documents.

--- Explain who benefited, financially or otherwise, from the transaction, how much and how.

--- Furnish any explanation of the transaction provided by the suspect and indicate to whom and when it was given.

--- Furnish any explanation of the transaction provided by any other person.

--- Furnish any evidence of cover-up or evidence of an attempt to deceive state examiners, auditors or others.

--- Suggest any further investigation that might assist law enforcement in fully examining the suspected violation.

**THIS SECTION OF THE REFERRAL IS CRITICAL.** It should be as detailed as circumstances permit. The care with which this section is written may make the difference in whether the described conduct and its criminal nature are clearly understood. The discussion points listed in this section are not exhaustive. They should be covered, but to the extent additional explanation would be useful as to any particular item or to the extent an additional category should be addressed, it should be done here. Feel free to use attachments or to continue the description on a separate sheet. Include any suggestions for the interviewing of any witnesses, gathering of any documents, or other suggestions that might prove useful in following up on the referral (e.g., tracing of proceeds).



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In order to effectively utilize the following pre-receivership procedures, it is recommended to first differentiate between a stand-alone entity and a group. To make the best judgement, evaluate the type of the entity and choose the applicable components of the checklist.

| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| INITIAL STEPS | | | | |
| Assign takeover responsibilities for each of the insurer's departments/functional areas to an appropriate representative of the Receiver's team and distribute checklists accordingly. | | | | |
| Undertake a thorough review of available information pertaining to the insurer, its operations and a description of core lines of business to obtain a detailed understanding of the insurer to assist the receiver in planning an efficient and effective takeover. | | | | |
| Review commercial publication reports such as A.M. Best, Dunn & Bradstreet, Standard & Poor's, and Moody's in order to obtain an overview of the insurer. | | | | |
| REGULATORS AND SUPERVISORS | | | | |
| Determine the identities and contact information of all relevant supervisory authorities. (i.e. from most current analysis, examination or supervisory college information) | | | | |
| Secure contact information for the person(s) at the Department of Insurance responsible for oversight of this company. | | | | |
| Receiver's staff should meet with the Department of Insurance to obtain background information and specific issues with the insurer. | | | | |
| COMPANY INFORMATION & OVERVIEW | | | | |
| Obtain overview of the insurer's situation, including type of proceeding and timing of takeover. | | | | |



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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain from the Department of Insurance<br>• Its most recent examination work papers,<br>• The insurer's most recent annual and quarterly statements,<br>• Audited financial statements with auditor's opinion,<br>• Actuarial certifications,<br>• Any SEC filings,<br>• Tax returns and any other financial statements,<br>• Holding Company Analysis,<br>• Most recent Insurer Profile Summary,<br>• Most recent Holding Company Registration Statement and related filing (Form B, Form F, etc.) | | | | |
| Obtain copies of any other insurer documents held by the Department such as insurer charter, by-laws, Form A's and other applications, etc. | | | | |
| Obtain list of management, including officers and directors, along with biographical affidavits on file with the Department. | | | | |



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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain or prepare an organization chart of the insurer and its subsidiaries and affiliates. A description of the company's organizational structure, including:<br><br>1) A hierarchical list of all material entities within the company's organization (including legal entities that directly or indirectly hold such material entities) that identifies:<br>a) The holder of each legal entity and foreign office,<br>b) Differentiate between stand-alone and group<br>c) The location, jurisdiction of incorporation, licensing, and key management associated with each material legal entity and foreign office identified.<br>d) Whether the company utilizes any third party vendors (affiliated or unaffiliated )<br>• Investment manager,<br>• Managing General Agents (MGA), Third Party Administrators (TPA), Individual Practice Associations (IPA)<br>• Reinsurance intermediary<br>e) Working relationships with<br>• Professional Employer Organizations (PEO)<br>• Administrative Services Organizations (ASO)<br>f) Identify if a premium finance company is being utilized for any material contracts, such as the D&O policy.<br>2) A mapping of the company's critical operations and core business lines, including material asset holdings and liabilities related to such critical operations and core lines of business, to material entities. | | | | |
| Obtain description and review foreign operations. | | | | |
| Obtain description of the corporate governance structure and processes related to resolution planning. | | | | |



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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| If possible, obtain all of the above for any affiliated companies that might be affected by the takeover such as parent, affiliates and/or subsidiaries. | | | | |
| • Obtain a detailed inventory and description of the key management information systems and applications, including those for risk management, policy and claims administration, reinsurance, and financial and regulatory accounting, used by the company and its material entities.<br>• Draft a description of each system or application provided to identify the legal owner or licensor, the use or function of the system or application, service level agreements related thereto, any software and system licenses, and any intellectual property associated therewith.<br>• Obtain detail on the company's system back-up procedures. Include information on the following:<br>o Frequency of back-up and software/methods used for backup process.<br>o Location of any off-site storage and frequency of back-up restored off-site.<br>o Date of oldest back-up.<br>o Date of most recent back-up. | | | | |
| Obtain an identification of the scope, content, and frequency of the key internal reports that senior management uses to monitor the financial health, risks, and operations of the company, its material entities, critical operations and core lines of business. | | | | |



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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Review the processes the company employs for:<br><br>1) Determining the current market values and marketability of the core lines of business, critical operations, and material asset holdings of the company;<br>2) Assessing the feasibility of the company's plans for executing any sales, divestitures, restructurings, recapitalizations, or other similar actions; and<br>3) Assessing the impact of any sales, divestitures, restructurings, recapitalizations, or other similar actions on the value, funding, and operations of the company, its material entities, critical operations and core business lines. | | | | |
| Obtain a description of the process for the appropriate supervisory or regulatory agencies to access the management information systems and applications. | | | | |
| Obtain a mapping of the key management information system/application to the material entities, critical operations and core lines of business of the company that use or rely on them. | | | | |
| Obtain information on remote access to company management information systems (e.g., Who has access? How is remote access implemented and managed?) | | | | |
| Obtain information regarding location of offices and storage facilities, staffing and how to deal with satellite offices. | | | | |
| Obtain information on office layouts and security issues. | | | | |
| Pre-inspect premises if possible. | | | | |
| Obtain information on related party transactions and agreements, including leases, service agreements, agreements containing collateral calls, and ownership of shared assets, including personnel. | | | | |


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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain information on items that will affect immediate operational needs such as leases (including those on computers), telephones, Web sites, supply vendors and key personnel. | | | | |
| Obtain information on agents, TPAs, administrators, MGAs, intermediaries and reinsurers, including locations and contacts. | | | | |
| Obtain information on auditors/accountants and attorneys. | | | | |
| Request information relating to payroll and employee benefits. Is payroll handled internally or by a payroll provider? How frequently is payroll made? If it is handled by a payroll provider, obtain the name of the provider. What types of benefits does the company provide to its employees (401K, health insurance, etc.)? | | | | |
| Identify banking relationships and obtain information on bank accounts, financial institutions and securities custodians (including Federal Home Loan Bank agreements, if applicable). This information should include the bank contact's name and title, the branch address, and the contact's information (phone, fax, email address, etc.). | | | | |
| Obtain information on licenses in other states, statutory deposits, special deposits and communications with other states. | | | | |
| Determine any possible guaranty/fund association involvement. Contact NCIGF and/or NOLHGA if insurer was licensed in multiple states. If guaranty funds/associations are involved, advanced planning for the transition of claims data and file information is essential. Please see Chapter 6 of the Receivers Handbook for additional information. | | | | |
| <u>FINANCIAL INFORMATION</u> | | | | |
| Review and analyze insurer's annual statement balance sheet by line item to obtain as much information as possible about the assets and liabilities, including any subsequent events, potential problems/unusual circumstances and special items in the Examiner's report for each line item. | | | | |



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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
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| Obtain or develop an unconsolidated balance sheet for the company and a consolidating schedule for all material entities that are subject to consolidation by the company.<br><br>Also include request from most recent exam, CPA workpapers or recent analysis. | | | | |
| Obtain a description of the material components of the liabilities of the company, its material entities, critical operations and core lines of business that separately identifies types and amounts of short-term and long-term liabilities, and secured, unsecured, and subordinated liabilities. | | | | |
| Request claim information for the company, to include averages of count of claims/year, total amount in claim payments/year, and funding mechanism(s) for claim payments. | | | | |
| Review financial information regarding the company's capital position and major sources of capital and funding. | | | | |
| Review description of funding, liquidity and capital needs of, and resources available to, the company and its material entities, which shall be mapped to its critical operations and core business lines. | | | | |
| Review any material off-balance sheet exposures (including guarantees and contractual obligations) of the company and its material entities. | | | | |
| Review notes and interrogatories to financial statements. | | | | |
| DERIVATIVES AND COUNTERPARTY EXPOSURE | | | | |
| Obtain information and describe the practices of the company, its material entities and its core lines of business related to the booking of trading of derivative activities. | | | | |
| Identify material hedges of the company, its material entities, and its core lines of business related to trading and derivatives activities, including a mapping to legal entity. | | | | |



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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Review the hedging strategies of the company. | | | | |
| Review the process undertaken by the company to establish exposure limits. | | | | |
| Identify the major counterparties of the company and describe the interconnections, interdependencies and relationships with such major counterparties. | | | | |
| Analyze whether the failure of each major counterparty would likely have an adverse impact on or results in the material financial distress or failure of the company. | | | | |
| Identify each trading, payment, clearing, or settlement system of which the company, directly or indirectly, is a member and on which the company conducts a material number or value amount of trades or transactions. Map membership in each such system to the company's material entities, critical operations and core lines of business. | | | | |
| Identify the processes used by the company to:<br><br>1) Determine to whom the company has pledged collateral;<br>2) Identify the person or entity that holds such collateral; and<br>3) Identify the jurisdiction in which the collateral is located, and, if different, the jurisdiction in which the security interest in the collateral is enforceable against the company. | | | | |
| <u>NEXT STEPS</u> | | | | |
| Review condition and location of insurer's books and records. | | | | |
| Coordinate with counsel to assist in preparation of the petition and order and determine parties to be served. | | | | |
| Determine method(s) of notification of various parties in other locations, e.g., financial institutions, securities custodians, etc. | | | | |



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| Checklist 1—Pre-Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Reconfirm Receivership team assignments, and determine Receivership team needs in other locations and logistics of getting team members to assigned locations. | | | | |
| If possible arrange for a meeting with management to discuss ramifications and procedures. | | | | |
| Prepare agenda for meeting with insurer personnel (or memo for distribution to personnel) that discusses ramifications of order and procedures to be implemented. | | | | |
| Prepare phone scripts for customer service representatives. | | | | |
| Prepare information to be posted on Web sites. | | | | |
| Prepare notices for posting on office doors as may be required. | | | | |
| Determine if security service is required and hire as needed. | | | | |
| Determine frequency of Receiver team meetings after takeover and method of communicating issues to team/Receiver and the decision-making process. | | | | |
| Contact applicable guaranty association(s) as early as possible. | | | | |



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| Checklist 2—Takeover | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Overview*** | | | | |
| Meet with management to discuss procedures, unless a meeting was held pre-takeover. | | | | |
| Meet with insurer personnel (or distribute memo to insurer personnel) that discusses order and procedures to be implemented. | | | | |
| Meet with the insurer's CFO/accounting manager (and/or other appropriate personnel) to discuss the insurer's financial operations in general, managers/supervisors and their responsibilities, staffing, and what will be required from their department's staff as a result of the order. | | | | |
| Identify if insurer has internal actuary or if they utilize external actuarial firm. Obtain appropriate information. | | | | |
| Inform insurer management and personnel that document destruction must immediately cease. | | | | |
| Post door signs/notices as required to inform visitors of receivership. | | | | |
| Secure insurer Web site and post information as needed. | | | | |
| If necessary, determine current status of insurer's state licenses and requirements to avoid revocation. | | | | |



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| Checklist 3—Human Resources and Payroll | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| nce on site, meet with the insurer's personnel manager (and/or appropriate personnel) to discuss:<br>▪ Jobs that need to be accomplished (also what resources/personnel you'll need)<br>▪ What he or she can expect and what is expected from him/her | | | | |
| If multiple entities exist, determine the entity that employs personnel and what entity funds payroll. | | | | |
| Consult human resources counsel and tax advisors to determine any requirements that must be met or what notices should be sent. | | | | |
| Determine the insurer's next payroll date and lead time for processing and make arrangements for distribution. Discuss payroll process with the payroll manager and document (flow chart). | | | | |
| Determine if payroll is processed by a service or in-house.<br>▪ Determine who has access to personnel and payroll records.<br>If by a service:<br>▪ Obtain contract<br>▪ Contact service to notify of order<br>▪ Work with service on logistics of issuing checks considering possible new checking account and new authorized signatures<br>▪ Work with accounting on securing facsimile signature of appropriate receiver personnel. | | | | |
| Interview human resources manager and staff to obtain:<br>▪ Insurer organization chart<br>▪ Organization charts by department, staffing and tasks<br>▪ Specify number of full-time, part-time and temporary employees, including location, department, job, salary, accrued leave time, employment date and review date<br>▪ Telephone directory for each office/branch location<br>▪ Listing of the insurer's officers and directors | | | | |



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| Checklist 3—Human Resources and Payroll | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Identify control of access to insurer’s facilities, review employee access rights and modify as necessary. | | | | |
| ***Records Security*** | | | | |
| Secure the following payroll and personnel files after takeover:<br>▪ Payroll files and computer runs, including current and historical q-t-d and y-t-d cumulative totals and most recent W-2s and 1099s<br>▪ Payroll tax records, including all deposits<br>▪ Personnel files<br>▪ Computerized personnel data<br>▪ Employment contracts<br>▪ Union contracts<br>▪ Employee claim files, e.g., workers’ compensation claims, unemployment claims, employment discrimination claims, etc.<br>▪ Employee disciplinary files<br>▪ Documentation pertaining to cash advances or short-term loans to officers or employees<br>▪ Personnel rules (e.g., employee handbook, policy and procedures manual, holiday schedule, memos addressing personnel issues, etc.)<br>▪ Material regarding insurer profit sharing, credit unions, thrift, savings, tuition reimbursement programs, 401(k) or pension plans<br>▪ Personnel forms used<br>▪ Employee leave balance reports<br>▪ Documentation pertaining to phone and car allowance for the employees, officers and directors | | | | |



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| Checklist 3—Human Resources and Payroll | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Payroll*** | | | | |
| Obtain and confirm most current pay period data to documentation in the insurer's personnel files (including all deductions), including:<br>▪ Verifying the appropriateness of each check/voucher issued<br>▪ Verifying the payee and check amount<br>▪ Verifying direct deposit authorizations and procedures | | | | |
| Review current payroll procedures, including direct deposits and/or voluntary deductions and determine and publish any new procedures, including approval processes for personnel and payroll actions. | | | | |
| Determine procedures for handling payroll functions at off-site locations. | | | | |
| Consider procedures for reimbursement of the payroll account when insurer employees work for other entities. | | | | |
| Upon distribution of first payroll after takeover, consider requiring identification and a signature before distributing paycheck to assist in determining if individuals who are not performing services for the insurer are receiving paychecks. | | | | |
| Review all employment contracts and determine any actions necessary. | | | | |
| If the insurer is involved with a union of any kind, obtain a copy of all contracts and related material. | | | | |
| Determine whether there are any personnel matters in dispute or litigation. | | | | |
| Identify any potential leave payout liability for the insurer. | | | | |
| Identify any employees on special leave status, such as FMLA. | | | | |



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| Checklist 3—Human Resources and Payroll | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| For employees of related entities who are paid through the insurer's payroll, ensure that personnel/payroll records are copied and forwarded to the appropriate entities. | | | | |
| ***Employee Benefits Packages*** | | | | |
| Prepare an assessment of the employee benefits package to determine any required changes:<br>▪ Determine if any of the programs are self-administered.<br>▪ Determine whether benefits will continue to be offered. | | | | |
| Review employee benefits package, particularly insurance coverage and retirement plans. Ensure that the benefits package agrees to the current policies and employee handbook. | | | | |
| Contact benefits vendor(S) to inform them of the receivership process and any changes that should be implemented. | | | | |
| For any of the following that exist, review a plan document or detail for each. Determine if any modifications are necessary and, if so, update written materials and communicate with affected parties:<br>▪ Group insurance coverage (e.g., life/ad&d, medical, dental, vision, COBRA, STD etc.):<br>o Review enrollment cards or applications for each type of coverage to determine proper enrollment.<br>o Review payroll deductions for above and compare to monthly premium billings.<br>o Locate employee claims. Document claims submission and processing procedures.<br>o If the benefit package is self-funded or self-administered, review the claims processing procedures to determine if insurer funds are being properly handled.<br>o Review COBRA processing procedures.<br>▪ Defined benefit (pension) and/or defined contribution (401(k)) plans:<br>o Review the plan document, summary plan description, and trust agreement. | | | | |



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| Checklist 3—Human Resources and Payroll | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| o Determine details of plan operation. Ensure timeliness of all reporting to plan participants and federal authorities (DOL, PBGC, IRS).<br>o Verify that all payments and funding are made timely.<br>▪ Workers' compensation<br>▪ Profit sharing or thrift plans<br>▪ Severance plans<br>▪ Stock options<br>▪ Credit union<br>▪ Bonus plan<br>▪ Loans to employees<br>▪ 401(k) and/or other retirement plans | | | | |
| Determine whether there are any pensioners who have health coverage or participate in other benefit programs through the insurer. If so, prepare a schedule of the pensioners listing their benefits. | | | | |
| Determine if there are key employees to be retained and if a retention/bonus program needs to be implemented for them (or all employees). | | | | |
| Ensure that copies of the receivership order are sent to third parties who:<br>▪ Administer any programs<br>▪ Hold or distribute funds<br>▪ Issue drafts<br>▪ Coordinate data input and report preparation | | | | |
| Determine which bank accounts are used for payroll (including payment of taxes—FUTA, FICA, etc.), and whether they are current with respect to:<br>▪ Social security and taxes (e.g., federal, state, and city quarterly reports)<br>▪ Insurance premium payments<br>▪ Workers' compensation assessments<br>▪ Unemployment insurance payments | | | | |



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| Checklist 3—Human Resources and Payroll | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ▪ Other benefit contributions<br>▪ If self-funded, outstanding claim payments to employees<br>▪ Loan payments due the insurer by employees | | | | |
| ***Organizational Overview*** | | | | |
| Review organizational charts of insurer departments to determine staffing needs, terminations, etc. | | | | |
| Secure or prepare a personnel listing of current and recently terminated employees including name, social security number, job title, current salary, starting date, and termination date. | | | | |
| Determine if any outstanding personnel audits need to be handled, such as unemployment compensation or time and wage audits. | | | | |
| In early January following the takeover of the insurer, prepare to distribute W2s. Note that extra W2s or 1099s may need preparation if additional compensation (e.g., benefits, expenses, etc.) was not properly reported. Ensure mailing of these forms no later than the last day of January. | | | | |
| Send COBRA and/or other required notices to terminated employees. Certain state and federal laws may require the insurer to notify terminated employees of their right to extension of benefits, conversion privileges, or other contractual obligations due them by the insurer. | | | | |
| Determine whether the insurer must file an EEO-1, Form 5500, census, or other federal, state, or city reports. Assure that all necessary reports are filed in a timely manner or that timely request for extension has been filed. | | | | |
| ***Employee Termination*** | | | | |
| As employees separate or are terminated from employment, coordinate with Accounting/Asset Recovery sections to determine if laptops, cell phones or other property in the possession of the employee should be returned to the receiver. | | | | |



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| **Checklist 4—Property, Real Estate, Records and Facilities Control** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
|---|---|---|---|---|
| ***Investigation / Identification*** | | | | |
| Meet with insurer officer and/or personnel in charge of real estate properties and mortgage loans, and discuss:<br>▪ Location of all real estate files<br>▪ Location of all mortgage loan files<br>▪ List of property management contracts<br>▪ List of real estate brokerage contracts<br>▪ List of appraisal contracts<br>▪ List of mortgage servicing contracts<br>▪ List of mortgage sales contracts<br>▪ All other associated files | | | | |
| Establish a secured space on-site for Receiver's use and records storage. | | | | |
| Secure access to property files. | | | | |
| As appropriate, notify all current property managers and servicing agents of receivership. | | | | |
| Notify landlord(s) of receivership and landlords' obligations. | | | | |
| Notify tenants of receivership and tenants' obligations. | | | | |
| Inspect and digitally photograph and/or videotape exterior and interior of all business locations and off-site storage facilities, and digitally photograph and/or videotape property within. | | | | |
| Obtain plans of interior premises – all locations. | | | | |


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| **Checklist 4—Property, Real Estate, Records and Facilities Control** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
|---|---|---|---|---|
| Change locks/secure premises:<br>▪ Obtain security service to secure premises<br>▪ Notify local law enforcement and provide copy of court order<br>▪ Contact locksmith to meet onsite<br>▪ Re-key exterior locks, as required<br>▪ Re-key/secure interior room(s) for takeover team<br>▪ Change computer area locks<br>▪ Change locks on postal boxes<br>▪ Secure safe and have accounting inventory contents<br>▪ Change alarm codes and contact names<br>▪ Collect exterior door/elevator pass cards and change card codes if applicable<br>▪ As necessary, collect keys to all doors, locked cabinets, etc.<br>▪ Change alarm codes/locks on off-site storage areas<br>▪ Secure shipping and receiving facilities | | | | |
| Suspend document destruction. Secure all shredding machines. Possibly secure wastebaskets and recycle bins. | | | | |
| Determine location of all personal property. Computers, cars, etc., might be in the possession of employees off-site. | | | | |
| For all assets identified in the books and records, and for all of those physically located:<br>▪ Determine ownership<br>▪ Verify that assets were seized and are under the receiver's control | | | | |
| Review all affiliate books (if available) to see if any assets recorded on their books are actually the assets of the insurer. | | | | |
| Identify missing property. | | | | |



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| **Checklist 4—Property, Real Estate, Records and Facilities Control** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
|---|---|---|---|---|
| Identify, secure and inventory all records located at off-site storage areas. | | | | |
| ***Furniture and Fixtures*** | | | | |
| Review insurer inventory listings and reconcile to general ledger. | | | | |
| Conduct physical inventory of furniture and fixtures at all locations. | | | | |
| Identify leased furniture and fixtures. | | | | |
| Obtain copies of leases and determine appropriate action. | | | | |
| List insurer-owned furniture and fixtures (assets). | | | | |
| Record valuation of assets at receivership date. | | | | |
| ***Equipment*** | | | | |
| Conduct physical inventory and determine ownership of data processing equipment, hardware, software, copiers, etc. | | | | |
| Identify leased equipment, obtain copies of leases and determine appropriate action. | | | | |
| List insurer-owned equipment (assets). | | | | |
| Record valuation of assets at receivership date. | | | | |
| If appropriate, discontinue or retrieve:<br>• Cell phones<br>▪ Pagers<br>▪ PDAs<br>▪ Blackberries<br>▪ Laptops<br>▪ Flash drives<br>▪ Vehicles<br>▪ Security<br>▪ Maintenance agreements<br>▪ Copiers<br>▪ Office equipment | | | | |


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| Checklist 4—Property, Real Estate, Records and Facilities Control | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Vehicles*** | | | | |
| Locate and inventory all insurer-owned vehicles. | | | | |
| Identify leased vehicles. | | | | |
| If appropriate, retrieve keys to vehicles. | | | | |
| Obtain copies of leases and determine appropriate action. | | | | |
| List insure-owned vehicles (assets). | | | | |
| Locate titles and verify ownership on insurer vehicles. | | | | |
| Record valuation of assets at receivership date. | | | | |
| ***Control of Real Estate*** | | | | |
| Identify leased real property. | | | | |
| Obtain copies of leases. | | | | |
| Prepare detailed inventory of real property owned by insurer. | | | | |
| Locate titles and other evidence of ownership and verify ownership. | | | | |
| Identify all mortgage loans held. Obtain listings of same and reconcile to the general ledger and Schedule A. | | | | |
| Review carrying value of all owned real property. | | | | |
| Obtain property summaries with all pertinent details, including location, encumbrances, value, etc. | | | | |



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| **Checklist 4—Property, Real Estate, Records and Facilities Control** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
|---|---|---|---|---|
| Inventory all of the following:<br>▪ Title policies<br>▪ Appraisals<br>▪ Mortgage serving contracts<br>▪ Property management reports & operating projections<br>▪ Deeds and notes<br>▪ Escrow funds<br>▪ Loan funding commitments<br>▪ All other pertinent files as necessary | | | | |
| Obtain and update rent rolls for each commercial property, including the following:<br>▪ Scheduled monthly rent<br>▪ Common area, real estate tax & property insurance charges<br>▪ Prepaid rents<br>▪ Security deposits<br>▪ Delinquent rents<br>▪ Other commercial property accounts receivable | | | | |
| If Appropriate, discontinue the following:<br>▪ Janitorial services<br>▪ Electric services<br>▪ Gas<br>▪ Building lease(s)<br>▪ Water<br>▪ Pest Control | | | | |
| Obtain and update an overall review of all accounts receivable from commercial properties, including a narrative, status of the receivable and spreadsheet. | | | | |
| Obtain and update an overall review of the disposability of real estate assets and mortgage loans based on the insurer's needs. | | | | |
| Contact all property managers & servicing agents and review current marketing and management plans, as required. | | | | |



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| Checklist 4—Property, Real Estate, Records and Facilities Control | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Change title of insurer assets to that of receivership (if necessary). | | | | |
| Determine valuation needs. | | | | |
| Determine which properties should be reappraised:<br>▪ Prepare a list of accredited potential appraisers (e.g., MAI or ASA if commercial real estate, or SRA appraisers if residential property). Request at least three (3) quotes.<br>▪ Prepare a list of potential secondary market buyers for mortgage loans. Request at least two (2) bids to establish values on loan portfolios. | | | | |
| Prepare a final asset disposal plan for real estate and mortgage loan assets based on objectives. | | | | |
| Prepare a list of potential listing brokers and property managers for real estate assets. | | | | |
| Prepare a list of potential purchasers and servicing agents for mortgage loan assets. | | | | |
| Prepare individual marketing plans for each real estate and mortgage loan asset based on objectives. | | | | |
| Schedule meetings with the potential property manager, broker, servicing agent or collectors to review and discuss their marketing and/or management plans. | | | | |
| Finalize selections of appraisers, brokers, property managers, collectors and servicing agents. | | | | |
| Contact all contracted brokers, property managers and servicing agents, and emphasize marketing and/or management plans for the particular property. | | | | |
| Arrange for sale or liquidate owned property. | | | | |



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| **Checklist 4—Property, Real Estate, Records and Facilities Control** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
|---|---|---|---|---|
| ***Property Records*** | | | | |
| Determine or locate insurer's inventory of files housed at each branch location, outside facility or other location. Verify accuracy of existing inventory or arrange for an inventory to be taken. | | | | |
| Determine if insurer uses bar code system for record management and determine ownership of the system. | | | | |
| Determine if files at branches or outside facilities need to be returned or sent to other locations. | | | | |
| Complete ID of all property files. | | | | |
| ***Insurer Mail*** | | | | |
| Establish procedures for all incoming and outgoing mail. | | | | |
| Direct the mailroom staff (under receivership employee supervision) to open all incoming mail on hand and turn over all checks to Receiver's accounting staff for deposit. | | | | |
| Open, time/date stamp, and review for sorting by department. | | | | |
| Distribute mail appropriately. | | | | |
| Plan scheduled pick-ups of outgoing mail. | | | | |
| Serve a copy of the court order to the insurer's local postmaster, advising of the insurer's status, and including the names of receiver team members and/or insurer personnel authorized to pick up mail or receive mail. | | | | |
| Secure lock boxes. | | | | |
| Determine need for continued use of P.O. Boxes. Cancel if not necessary. | | | | |
| Secure mailroom, postage machine and all outgoing mail. Pull all checks out of outgoing mail (optional) and provide to receiver's financial representative. | | | | |



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| Checklist 4—Property, Real Estate, Records and Facilities Control | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Request information on any other postal accounts held by the insurer. | | | | |
| Prepare check log. | | | | |
| Provide mailroom a list of receiver's employees to establish proper distribution of mail. | | | | |
| ***Records*** | | | | |
| Determine insurer's record storage media (paper, image, etc.) | | | | |
| Determine where the insurer has records stored in the home office, branch offices, off-site locations, or safe. | | | | |
| Serve any facility/lesser with a copy of the court order, advising of the insurer's status; if permissible, arrange for changes in locks and/or security. Specify authorized access to facilities. | | | | |
| Determine outstanding invoices for storage facilities and make arrangements for prospective storage. | | | | |
| Serve vendors with court orders at locations where files are housed. | | | | |
| Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken. | | | | |
| Determine if there has been unusual activity regarding disposal of records. | | | | |
| Determine if files at branches or outside facilities need to be returned or sent to other locations. | | | | |
| Obtain copies of any and all inventories prepared on files/data from the following areas:<br>▪ Legal<br>▪ Claims<br>▪ Underwriting<br>▪ Accounting | | | | |



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| **Checklist 4—Property, Real Estate, Records and Facilities Control** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
|---|---|---|---|---|
| ▪ Tax & Compliance<br>▪ Agents' Balances/Subrogation/Salvage<br>▪ Property<br>▪ Reinsurance<br>▪ Personnel and Payroll<br>▪ Customer Service<br>▪ Information Technology | | | | |
| Determine/establish a file charge-out or sign-out procedure for the use of records located on/off-site. If a procedure is already in effect at the insurer, review for adequacy regarding security. | | | | |
| As requested by receivership team members, assist in sorting and packing records to be transported to any other office locations or off-site warehouse. | | | | |
| ***Facility Closures*** | | | | |
| Adjust night/weekend answering service as needed. | | | | |
| Adjust voicemail capability as needed. | | | | |
| Discontinue phone lines as needed. | | | | |
| Adjust phone system as needed. | | | | |
| ▪ Arrange for closing of utility accounts as appropriate.<br>▪ Arrange for moving/storing and/or disposal of furniture and equipment.<br>▪ Arrange for transportation of files to receiver's office.<br>▪ Arrange for cleaning or maintenance of facility as needed.<br>▪ Determine if deposit was posted for any equipment, utilities and leased premises.<br>▪ Discontinue any additional services, such as cleaning, | | | | |



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| Checklist 4—Property, Real Estate, Records and Facilities Control | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| trash removal, lawn care, window washing, etc.<br>▪ Meet with building management, return keys to property and receive letter stating facility was left in appropriate order. | | | | |
| Complete and deliver mail forwarding card to post office prior to vacating any facility. | | | | |



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| Checklist 5—Customer Service | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Phones*** | | | | |
| Meet with insurer's manager for the customer services section to discuss the insurer's procedures, staffing and duties required as a result of the order. | | | | |
| Interview the customer services manager (and/or other personnel as appropriate) to discuss the insurer's customer services functions and operations to determine how phones, e-mail requests, etc., are handled by the insurer. Document same. Be sure to obtain information regarding the insurer's night/weekend answering service and automated call distribution system (ACD). | | | | |
| Meet with the insurer's customer service representatives to inform them of the receivership processes and take control of the customer service process. | | | | |
| Secure switchboard. | | | | |
| Secure account numbers for phone lines. | | | | |
| Obtain customer service representatives' passwords for ACD and other systems so as to ensure that the receiver has full access and rights to any ACD system. | | | | |
| Meet with insurer's phone programmer—adjust outgoing phone message. | | | | |
| Distribute prepared phone script, provider refusal forms, accord forms, etc. | | | | |
| Train customer service reps on phone script, advising that all responses to inquiries are to be consistent with information on script. | | | | |
| Increase the number of call senter staff to handle incoming calls, if necessary. | | | | |



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| Checklist 5—Customer Service | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Take advantage of large agent network, if applicable, to provide a mass email and physical mailing of key information to active agents. | | | | |
| Determine need for bilingual reps. | | | | |
| Determine need to maintain phone logs to determine types and number of calls, types of questions raised and need for additional types and updated scripted responses so that the information is current and meaningful. | | | | |
| Obtain Department of Insurance complaint logs. | | | | |
| Establish and monitor dedicated phone line. | | | | |
| Review customer service representative's daily/hourly logs. | | | | |
| Manage customer service representative's phone/time schedules. | | | | |
| Monitor backlogs, or development thereof, and determine how to minimize/control. | | | | |
| Modify instructions to night/weekend answering service as needed. | | | | |
| ***Web site*** | | | | |
| Provide copy of phone script to Webmaster for inclusion on Web sites. | | | | |
| Provide Webmaster with other information to be posted on Web sites. | | | | |
| Develop, post to the website and maintain Frequently Asked Questions (FAQs) for the public. | | | | |
| Provide information to the possible electronic filing of proof of claim (Claim Net), as appropriate. | | | | |
| Monitor/distribute for response any consumer inquiries received via Web site. | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Overview*** | | | | |
| Meet with underwriting manager (and/or other appropriate personnel) to discuss the insurer's procedures, management/ supervisors and their responsibilities, staffing and duties required as a result of the order. | | | | |
| Interview the underwriting manager (and/or other personnel as appropriate) to discuss the insurer's underwriting function and operation to determine the progression of documents through the department. Document same. | | | | |
| Obtain copies of departmental procedures, underwriting, code and rate manuals. | | | | |
| Determine whether the insurer used an off-site storage facility and coordinate with other team members to ensure that any off-site records are inventoried and accounted for. | | | | |
| Determine the underwriting department's filing system, noting:<br>▪ Locations of files and documents<br>▪ Filing method (e.g., alphabetical, numerical, terminal digit, etc.)<br>▪ Possible segregation by line of business<br>▪ Who has access to files and file sign-out procedures – modify as appropriate<br>▪ Whether files are copied to electronic media | | | | |
| ***Insurance*** | | | | |
| Locate, obtain copies and review all insurance policies and contracts:<br>• General Liability<br>▪ Property<br>▪ Auto<br>▪ Workers' Compensation<br>▪ Fidelity Bond<br>▪ Directors and Officers<br>▪ Large Deductible Endorsements | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ▪ Errors and Omissions<br>▪ Professional Liability | | | | |
| Determine that insurance coverage is adequate or modify as appropriate for property lines. | | | | |
| Check on status of pending claims filed against the insurer. | | | | |
| Obtain payment status on all coverage. | | | | |
| Renew coverage as necessary. | | | | |
| ***Gathering Documentation*** | | | | |
| Determine location of all underwriting records – secure and inventory. This should include:<br>▪ Blank policies, binders and/or applications<br>▪ Pending policies, endorsements and applications<br>▪ Underwriting procedure manuals<br>▪ Issued policies and associated underwriting files<br>▪ Specimen copy of each type of insurance contract written by the insurer, including all endorsements, side letter agreements and other forms that may have been used with each policy; document any unique or special forms, exclusions, etc. | | | | |
| Determine types and lines of business written by the insurer. Obtain a listing, by state and policy line, detailing the following information:<br>▪ Valuation of policies<br>▪ Number of policies in-force<br>▪ Annual premium volume<br>▪ Reserves<br>▪ Unearned premium<br>▪ Audit Premiums | | | | |
| As you become aware, document any limited or unusual exposures that do not appear on the insurer's policy registers. | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain a listing of in-force policies, as of date of liquidation, which should include (and be able to sort by):<br>▪ Policy or certificate number<br>▪ Insured name<br>▪ Type of coverage<br>▪ Effective and expiration date<br>▪ Cancellation date if applicable<br>▪ In-force and written premium<br>▪ Premium frequency<br>▪ Paid premium<br>▪ Premium paid thru date<br>▪ Unearned premium<br>▪ Resident state<br>▪ Audit premiums<br>▪ Collateral postings<br>▪ Indemnification agreements | | | | |
| Obtain group table that lists premium history. | | | | |
| Obtain expired/cancelled policy listing by policy number. | | | | |
| Obtain expired/cancelled policy listing by policyholder. | | | | |
| Review the insurer's underwriting interface with the insurer's computer systems:<br>▪ Is the rate/quote system separate from the Policy Mgmt system, or combined? (e.g.: Generate and WINS)<br>▪ What are they? How long have they been in place?<br>▪ If separate systems, determine if there is an electronic interface.<br>o How often is it run?<br>o Are they immediate or batch process systems?<br>o If batch, when is it run and by whom?<br>o What are the backup strategies?<br>▪ Are they under maintenance or license agreement contracts currently? | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Compile an all-time policy report which includes limits information. | | | | |
| Document whether home office copies of declaration pages are maintained by the insurer. | | | | |
| Determine the existence of surplus lines policies. Determine whether surplus lines are identifiable by:<br>▪ Code number<br>▪ State code<br>▪ Policy number<br>▪ Other marking<br>Request a computerized listing of surplus lines policies if available. | | | | |
| ***HMO/Health Insurer*** | | | | |
| Obtain copies of all health plans. | | | | |
| Obtain databases for each of the following:<br>▪ All subscribers, listing name, address, subscriber number, enrollment date, and group name and number<br>▪ Dependents, including their age, enrollment date and subscriber number<br>▪ All COBRA subscribers<br>▪ All conversion subscribers<br>▪ All Medicare/Medicaid subscribers<br>▪ All subscribers of downstream provider groups, if available | | | | |
| ***Binding Application and Non-Renewals*** | | | | |
| Determine and secure insurer's method for binding policies. | | | | |
| If writing of new business has been prohibited, determine which pending applications are binding. Return all other applications along with an approved form letter. | | | | |
| Work with Legal to compose a letter to be used in the non-renewal notification process, if renewals have been prohibited. | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Status of Work*** | | | | |
| Obtain all pending and/or in-process work from the underwriting department and determine its nature and volume. | | | | |
| Determine which work may be completed and processed, and establish priorities. | | | | |
| Utilize the telephone script of responses to common questions regarding the receivership that may be asked by policyholders, producers and claimants. | | | | |
| ***Producers of the Insurer*** | | | | |
| Obtain a list of all producers who did business with the insurer. The list should contain names, addresses, phone numbers and insurer identification number. If possible, the list should also identify type of producer (agent, broker, general agent, etc.). | | | | |
| Obtain copies of all producer, TPA and general agent agreements. Distribute copies to other takeover team members as requested. | | | | |
| Determine ownership of policy renewals. | | | | |
| Be sure Accounting has a copy of the producer's accounts receivable open balances. | | | | |
| ***Loss Experience*** | | | | |
| As necessary, coordinate with other departments to obtain and review copies of the following:<br>▪ Loss experience reports for the past 3 to 5 years (if premium detail isn't included on reports, obtain premium reports for corresponding periods)<br>▪ Actuarial reports (including year-end actuarial reports)<br>▪ Underwriting composite experience reports<br>▪ Premium and loss analysis reports | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Large Deductible Policies*** | | | | |
| Review underwriting, billing and collateral records to determine which policies have large deductible endorsements and the status of collateral held, billings, and reserve calculations | | | | |
| Arrange for continued reporting of loss experience to insureds/producers as appropriate. | | | | |
| ***Premium Finance Companies*** | | | | |
| Obtain an address listing and database of premium finance companies. | | | | |
| Determine if premium finance information is available on a policy-level basis electronically or manually. | | | | |
| Determine whether there is an in-house, affiliate or subsidiary finance company. If so, document all aspects of the finance company. | | | | |
| ***Policies and Premium*** | | | | |
| Review policy files to determine whether they appear to be complete.<br>▪ Determine if it is the insurer's policy that some documents are retained by producers.<br>▪ Determine if lack of completeness is relevant to the current situation.<br>▪ If missing contents are available, but have not yet been placed in files or are in another department, designate a company employee to coordinate retrieval and drop filing of the documents. | | | | |
| Capture all records pertaining to certificate holders, subscribers, etc. | | | | |
| Verify that all UDS return premium data and optional data can be obtained from the insurer's records. | | | | |
| Assist in the composition and/or approval of any notices to be sent | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| to policy and certificate holders regarding the receivership. | | | | |
| Monitor premium receipts to ensure correct application to producer accounts and policies. | | | | |
| Coordinate with appropriate guaranty associations to provide copies of policy forms. | | | | |
| Determine if the department has a work backlog, and if so:<br>▪ Determine the extent of the backlog<br>▪ Determine the volume of work involved<br>▪ Determine what work needs to be completed and processed<br>▪ Develop production goals for elimination of the backlog<br>▪ Begin processing work<br>▪ Provide periodic status updates of processing progress | | | | |
| ***Premium Auditing and Retrospective Rating*** | | | | |
| Review billing records to determine which policies require premium audits or are retrospectively rated. | | | | |
| Determine whether the insurer performs its own premium audits or if an audit service provides this function. Determine the following:<br>▪ If audits are handled by mail or electronically<br>▪ If the insureds' records are examined on-site<br>▪ How often policies are audited or retrospectively rated<br>▪ If audit procedures are sufficient and cost effective<br>▪ Whether alternative audit procedures need to be established | | | | |
| ***Producer Notifications and Commissions*** | | | | |
| Create an appropriate form letter notifying producers of the following:<br>▪ The insurer's state of receivership<br>▪ Revocation of binding authority<br>▪ Subsequent procedures to be followed, including procedures for remitting premiums | | | | |



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| Checklist 6—Underwriting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Prepare a list of commissions due from producers and notify producers accordingly. | | | | |
| ***Certificate of Authority*** | | | | |
| Obtain a list of states in which a Certificate of Authority has been approved and verify what lines of business the insurer is authorized to write in each state. | | | | |
| Determine whether the insurer is complying with other state insurance department’s C&Ds, or actions taken by foreign departments. | | | | |
| Contact DOIs to advise of status of rehabilitation, and request suspension rather than revocation of Certificate of Authority. | | | | |
| If in liquidation, obtain the original Certificates of Authority, coordinating with Legal as necessary. | | | | |
| Determine if any business, other than surplus lines, is being written in states where the insurer is not an authorized insurer. | | | | |
| ***Underwriting Records*** | | | | |
| Determine if files at branches or outside facilities need to be returned or sent to other locations. | | | | |
| Complete ID of all underwriting files. | | | | |



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| Checklist 7—Information Systems | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Overview and Assessment*** | | | | |
| Meet with the insurer's IT Manager (and/or other appropriate personnel) to discuss department procedures, managers/supervisors and their responsibilities, staffing, and what will be required from their department's staff as a result of the order and any dependence on outside third parties/consultants. | | | | |
| Coordinating with Human Resources, obtain or create an organizational chart of the IT Department and review staffing requirements. | | | | |
| Obtain operating procedures, IT hours of operation and schedule for various activities, including processing and back-up operations. | | | | |
| Identify and meet with key IT staff. | | | | |
| Back up files upon arrival (1st day) and all subsequent key dates: i.e., month-end, quarter-end, year-end, conservation, rehabilitation and liquidation. | | | | |
| Obtain administrator rights:<br>▪ Servers<br>▪ Devices<br>▪ Network<br>▪ Applications | | | | |
| Provide receiver on-site access to all applications where possible. | | | | |
| Obtain passwords and change/modify as appropriate:<br>▪ Administration rights<br>▪ User passwords | | | | |
| Obtain and secure physical access to the insurer's computer facilities and change/modify security as appropriate. | | | | |
| Secure data communications, including Internet. | | | | |
| Secure e-mail. | | | | |
| Shut down all remote access to systems (1st day), if appropriate. | | | | |



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| Checklist 7—Information Systems | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain hardware/software license agreements. | | | | |
| Identify operating system environments. | | | | |
| Obtain network/computer diagrams. | | | | |
| Obtain and/or create a systems flow overview and narrative of the insurer's major systems. (Each line of business may be processed differently. One line of business may be processed on a mainframe and another on a PC. Depending on the line of business, different factions (e.g., agents, brokers) may be responsible for various functions. All processes may not be centralized. | | | | |
| Review system status, reports, internal audits and steering committee minutes. | | | | |
| Determine whether the insurer hires an outside service for computer processing, and if so, document the applications. | | | | |
| ***System Security and Control*** | | | | |
| Document backup procedures for mainframe, LAN, servers, PCs and laptops.<br>▪ Verify or establish routine backup procedures<br>▪ Obtain or create backup schedules to be followed<br>▪ Document the storage location and creation date of the last full backup<br>▪ Request a full backup of the insurer's system and send off-site for holding<br>▪ Establish a backup file rotation | | | | |
| Obtain most recent backups and assure completeness:<br>▪ Operating systems/utilities<br>▪ Application systems<br>▪ <u>All</u> data<br>▪ E-mail<br>▪ Complete backups (not incremental) | | | | |



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| Checklist 7—Information Systems | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Establish control of the backup file rotation through the following steps:<br>▪ Instruct the insurer's mainframe, LAN, servers, PC and laptop operators to send the following backups to the designated location:<br>▪ Initial backup (1st day)<br>▪ Date of liquidation<br>▪ Last day backup (Final)<br>▪ Conversion tapes | | | | |
| Analyze backups and verify for completeness and ability to restore:<br>▪ Media<br>▪ Formats<br>▪ Backup program versions<br>Anticipate restore issues and set plan. | | | | |
| Obtain information concerning the insurer's disaster recovery plan. Evaluate and modify as appropriate. | | | | |
| Determine processing locations:<br>▪ On site<br>▪ Off site<br>▪ Affiliates providing servicing<br>▪ Third parties providing servicing | | | | |
| Obtain information concerning the insurer's off-site storage of computer backup files, including:<br>▪ Vendor name, address and phone number<br>▪ Contact person at the location<br>▪ The quantity and content stored | | | | |
| Ensure that the authorization signatures for access at off-site storage facilities are changed. | | | | |
| Review ISP/Web domain services. | | | | |
| Coordinating with Webmaster, determine and effectuate any modifications that need to be made to the Web site, including posting of the court order. | | | | |



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| Checklist 7—Information Systems | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain hardware and software maintenance agreements for computer equipment. Review to determine continuation or modification as appropriate. | | | | |
| Obtain copies of all outstanding purchase orders for computer hardware, software, supplies and services. | | | | |
| Inventory equipment, including the insurer's mainframe, LAN, servers, PC and laptop equipment. Ensure that the following information is available:<br>▪ Type of equipment<br>▪ Make, model, serial number<br>▪ Person and department assigned<br>▪ Workstation address, controller, jack or port identification number<br>▪ System connected<br>▪ Lease or owned<br>▪ Cost of equipment (if known)<br>▪ Purchase date (if known) | | | | |
| Verify and document ownership of computer equipment:<br>▪ For equipment owned by the insurer, obtain a copy of the invoice, draft or check purchasing item<br>▪ For leased equipment, obtain a copy of the lease | | | | |
| Identify and obtain list of all users (including equipment that may be off-site), including:<br>▪ System utilized—mainframe, LAN, servers, PCs, laptops and Blackberries<br>▪ Department name, user name, address and phone number<br>▪ Service provided and reports produced | | | | |
| Identify current use of outside computer consultants, vendors, service bureaus and other outside organizations:<br>▪ Service provided/expertise<br>▪ Name/address/telephone numbers<br>▪ Contact person<br>▪ Current assignments, status and costs | | | | |



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| Checklist 7—Information Systems | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ▪ Determine contractual obligation, if any<br>▪ Rate for services<br>▪ Obtain copies of all outside service contracts and/or agreements<br>▪ Determine unpaid amounts by vendor and dates of service or item delivery<br>▪ Determine vendor items/services to be returned or canceled<br>▪ Identify planned activities with vendor<br>▪ Identify current active projects. Determine status and need for continuation | | | | |
| Change vendor/supplier staff contacts as necessary. | | | | |
| Verify with the insurer's IT Manager whether invoiced services or items have been received and the necessity of the purchase of services or items to the departments past and continued operation. | | | | |
| Review all current and ongoing IT expenses; determine any need for modifications and adjust as appropriate. | | | | |
| Review fire protection equipment and procedure. Evaluate and modify as appropriate. | | | | |
| Review power protection – UPS (uninterruptible power supply). Evaluate and modify as appropriate. | | | | |
| ***Application/Data Security and Control*** | | | | |
| Secure all original operating/application software. Obtain or create a list of all applications on the insurer's various computer systems (mainframe, LAN, servers, PCs and laptops). Identify and describe each of the major applications found within each of the systems, noting:<br>▪ Purpose of the application<br>▪ Departments using application<br>▪ What other applications it interacts with<br>▪ Type of control it provides | | | | |



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| Checklist 7—Information Systems | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ▪ Last rewrite date of application (noting by whom)<br>▪ Application language | | | | |
| Obtain and/or create file layouts for each application. (Tables that define code values may change over time. Find out when the codes were established and became effective, since the database may contain codes from a prior designation.):<br>▪ Obtain and/or create definitions for all fields (note that documentation may not accurately reflect the actual use of a field, and the definition should be confirmed with IT personnel)<br>▪ Obtain tables for required fields<br>▪ Develop a list of files related to the application | | | | |
| Obtain copies of and secure all operating/application documentation (manuals, input/output forms, data dictionaries, reports, etc.) | | | | |
| Develop and test data extract routines. | | | | |
| Review/test systems and data integrity. | | | | |
| Review all reports and data available and determine those elements required to fulfill receivership requirements. Specifically, review the following:<br>▪ Policy/contract information<br>▪ Reinsurance information<br>▪ Financial information<br>▪ Need and ability to convert existing data into another computer system | | | | |
| As to the insurer's IT projects, verify and complete information obtained:<br>▪ Project title and description<br>▪ Current priority level<br>▪ Reason for project and impact if the project was stopped<br>▪ Current schedule for completion | | | | |



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| Checklist 7—Information Systems | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain licensed software inventories:<br>▪ Identify and separate by mainframe, LAN, servers, PC and laptop.<br>▪ Name and address of the developer<br>▪ Release number (current)<br>▪ Software ownership<br>▪ Users' rights and limitations purchase date (obtain copy of purchase order)<br>▪ Lease (obtain copy of lease agreement)<br>▪ Approximate cost<br>▪ Application software is/was used on | | | | |
| ***System Control and Processing*** | | | | |
| Evaluate continued use of in-house systems and evaluate alternatives:<br>▪ Servicing by outside sources, which might result in the sale of equipment and facilities<br>▪ Termination of hardware leases<br>▪ Termination of computer support | | | | |
| Identify and evaluate IT items to be sold or destroyed. | | | | |
| Evaluate termination of computer hardware leases and arrange for physical removal of the equipment with vendor representative. | | | | |
| Evaluate termination of vendor services and arrange with vendor representative for physical removal of any equipment and/or software. | | | | |
| Determine whether to ship insurer-owned hardware to another location or sell. | | | | |
| Provide regular processing and periodic reports of data. | | | | |
| At appropriate time, obtain and pack all data processing records. Coordinate removal to appropriate location(s). | | | | |



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| **Checklist 7—Information Systems** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
|---|---|---|---|---|
| At appropriate time, arrange for orderly shutdown of the computer system, confirming:<br>▪ All records are updated<br>▪ Final reports are run<br>▪ Data processing checklist documentation is complete<br>▪ Full system backup has been performed and all files cleared on the system<br>▪ System is powered down | | | | |
| Review and identify files and related data that may be used to identify proofs of claim by block of business, verifying content of information necessary for the block of business. | | | | |
| Provide the following information and procedures by block of business:<br>▪ A listing of outstanding claims<br>▪ A review of any problems that may exist as to reserve amounts<br>▪ A review of how far back information is available on paid claims | | | | |
| Provide the following information by block of business:<br>▪ A listing of in-force policies by state (totals by state and as a whole) and by line of business<br>▪ A review of how far back information is available on policies<br>▪ A review of any problems that may exist | | | | |


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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Control of Bank Accounts*** | | | | |
| Complete a Bank Signature Authorization List in advance of takeover. | | | | |
| Obtain new authorized signature specimens on an exhibit for distribution to financial institutions, investment custodians, etc. | | | | |
| Prepare a bank notification letter. Be sure letters include:<br>▪ Copy of receivership order<br>▪ Request for a cut-off statement at the effective date of the order<br>▪ Instructions to clear or return outstanding checks/drafts<br>▪ Instructions for wire transfers, authorization procedures and authorized individuals<br>▪ Request to terminate Internet access to accounts until instructed otherwise<br>▪ Notification of authorized persons on the account including signatures of same<br>▪ Request for a listing of all accounts in the company's name (perhaps affiliates also)<br>▪ Request to identify any liens on accounts<br>▪ Request for a listing of any safe deposit boxes and authorized signers<br>▪ Request that copies of monthly statements be forwarded to designated team member | | | | |
| ***Insurance Background Information*** | | | | |
| Obtain or prepare an organizational chart, job descriptions and employees responsible for various tasks or areas. | | | | |
| If a procedure manual is available for all accounting functions, obtain, review and discuss any issues with management. | | | | |
| Document the flow of accounting transactions including decision points, authorizations and controls. | | | | |


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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Utilize above information to evaluate:<br>▪ Procedures<br>▪ Controls<br>▪ Staff requirements<br>▪ Current personnel | | | | |
| ***Establish Control of Bank Accounts*** | | | | |
| Compare preliminary list of financial institutions holding the insurer's cash, investments, and other assets obtained during pre-takeover phase to information provided by management and in insurer records. (The insurer's annual statement (Schedule N) will contain a listing of their open deposits.) | | | | |
| Serve all banks with a certified copy of the receivership order, proof of service, and bank letter. | | | | |
| Obtain proof of service of court orders on senior bank official(s). | | | | |
| Remove all insurer officials' names from signatory authority with any financial institution. | | | | |
| Continue contact and follow-up with all financial institutions and investment custodians regarding new procedures, authorizations and checks outstanding at takeover date. | | | | |
| ***Operating Bank Accounts*** | | | | |
| List all bank accounts, including current balances. | | | | |
| List all funds held, letters of credit (LOC), collateral, and trust and depository accounts with current balances and maturity dates. | | | | |
| Obtain a listing of funds held by or deposited with ceding companies by insurer. Confirm these amounts and review calculations for amounts. This should include any posted LOCs. Determine and prepare schedule identifying type of LOC and expiration dates. | | | | |
| Review current bank reconciliation and determine accuracy. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain cut-off statements for all accounts. | | | | |
| Reconcile all bank accounts to cut-off statements, noting long outstanding reconciling items and any need for further investigation. | | | | |
| Determine process for monitoring available cash and overnight investing. | | | | |
| Obtain a schedule of cash utilization for the past six months. | | | | |
| Prepare cash requirement projections. | | | | |
| Determine available cash and liquid assets. Compare to cash requirement projections and determine length of time cash will be available to fund the operations of the insurer, particularly the payment of workers' compensation indemnity, health insurance, disability and long-term care. | | | | |
| Establish cash monitoring process. | | | | |
| Consider any need to open new accounts and transfer funds. | | | | |
| Review all corporate bank resolutions. | | | | |
| ***General Ledger (G/L) Cut-Off and Accounting Records*** | | | | |
| Obtain most current trial balance. | | | | |
| Obtain chart of accounts and descriptions of any accounts that are not self-explanatory. | | | | |
| Document the insurer's G/L closing procedures and obtain a cut-off G/L as of the takeover date. Identify the last closed accounting period. | | | | |
| Determine if all G/L accounts have been reconciled to subsidiary ledgers, listings or computer runs for the most current month end. | | | | |
| List all documents required in the above processes. | | | | |


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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain any other support reports/schedules/trial balances for the cut-off G/L to complete reconciliations. | | | | |
| Determine location of all accounting records—secure and inventory. This should include:<br>▪ General ledgers, trial balances and other month-end reports<br>▪ Financial statement support work papers – for monthly, quarterly and annual financials<br>▪ Bank statements, check registers, reconciliations and cancelled checks<br>▪ Short-term investment/treasury files<br>▪ Investment statements and reconciliations<br>▪ Support for other investments – real estate, mortgages receivable, etc.<br>▪ Support for premium, reinsurance and agents receivables<br>▪ Support for fixed and other assets<br>▪ Accounts payable and vendor files, including service and supply contracts<br>▪ Support files and runs for claim and other liabilities<br>▪ Debt/notes payable files<br>▪ Lease files<br>▪ Insurance files<br>▪ Correspondence with CPA | | | | |
| Utilizing cut-off G/L and related trial balance and detailed transaction listing(s), investigate and document insurer assets as indicated in following sections. | | | | |
| Have staff begin reconciling all accounts to detail and cut-off statements as of the takeover date. | | | | |
| Monitor and review all work to determine if any additional investigation or action is required as a result of reconciliations. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Inventory and secure any original documents found in the above files such as mortgage notes, stock certificates, or notes (payable or receivable). | | | | |
| If originals of such assets and liabilities are not in above files, locate, inventory and secure. | | | | |
| Determine location of corporate documents such as corporate seal, minute books, stock registers, stock certificates, articles of incorporation and by-laws. Inventory and secure. | | | | |
| Determine need to secure or obtain any of the above items and information for any affiliates of the insurer. | | | | |
| Establish a secure room/space for accounting records. | | | | |
| ***Petty Cash*** | | | | |
| Determine if a petty cash fund exists (which may include such items as postage stamps, etc.), who has control of fund and procedures for disbursement, replenishment and reconciliation. | | | | |
| If petty cash fund exists, secure, count and inventory contents and establish receiver controls and disbursement. | | | | |
| ***Establish Cash Receipt Procedures*** | | | | |
| Document receipt procedures from receipts and deposits to the recording of receipts. | | | | |
| Determine the physical location of cash receipts – any lock boxes, mail room, post office boxes, agents, etc. Secure and change authorizations for access as necessary. Counsel may need to be consulted to secure and change authorization for post office boxes not in the insurer’s name that receive insurer’s cash. | | | | |
| Determine if any receipts are not to be accepted – e.g., renewal premium, rent receipts, etc. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Establish any new procedures as appropriate to maintain security, to include that all incoming checks are logged and given to Accounting for recording and deposit. | | | | |
| Provide notice of the order and appropriate collection procedures to any third party that had been authorized to accept cash on behalf of the insurer. | | | | |
| Review the flow of all cash receipts and disbursements, and modify as appropriate. | | | | |
| ***Secure Miscellaneous Items*** | | | | |
| Determine if there are any corporate credit/phone cards outstanding; collect/cancel/secure as appropriate. | | | | |
| Determine necessity to secure blank letterhead, blank purchase order stock, blank stock certificates; blank invoice stock, billing forms, etc. | | | | |
| ***Control Check Stock and Establish Disbursement Procedures*** | | | | |
| Secure and establish cash disbursement procedures, including:<br>▪ Control of check stock<br>▪ Authorization for disbursements<br>▪ Check signing authority | | | | |
| Locate, secure and inventory all check and draft stock (including payroll). | | | | |
| Document current disbursement procedures, including flow of information and physical check movement from origination to mailing. | | | | |
| Establish a control log for all unused check and draft stock on each bank account. Determine who has access to and is authorized to issue check stock and at what quantities – modify as necessary. | | | | |
| Ensure segregation of duties with regard to control of check stock and check signing equipment. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Secure check imprinting machines, signature stamps, plates and signature machines. Disable electronic and digital signatures. (May also be offsite at payroll service, etc.) | | | | |
| Review and restrict signature authority. | | | | |
| Make effort to identify and hold any checks in the mailroom on day of takeover. | | | | |
| Determine disposition of checks issued prior to order date. | | | | |
| Review wire transfer procedures and modify as appropriate. | | | | |
| Identify and cancel bank accounts handled by third parties, as appropriate. | | | | |
| Obtain a schedule of all recurring disbursements including payee, frequency of payment and approximate amounts of payments. This should include items such as daily claim payments, payroll, lease payments (equipment, office, storage, etc.), supply acquisitions, insurance coverage payments, service/maintenance agreement payments, memberships and dues, etc. | | | | |
| Obtain contracts for vendors on above schedule to determine potential needed actions or modifications/cancellations of any contracts. | | | | |
| Determine if insurer handles payroll internally. | | | | |
| If appropriate, switch to payroll service. | | | | |
| Contact payroll service to set up year-end W-2 procedures. | | | | |
| If multiple entities exist, determine the entity that employs personnel and what entity will fund payroll. | | | | |
| Determine whether there are any safes on premises and conduct a physical inspection and inventory of contents. The safe should be re-keyed, if deemed necessary. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Identify and secure any investments, securities, or cash kept on premises. | | | | |
| Confiscate keys and change safe deposit box access privileges with the appropriate institutions. | | | | |
| Identify, analyze and secure control of other liquid assets. | | | | |
| ***Securities*** | | | | |
| Identify letters of credit, trust agreements and other collateral held to secure obligations of policyholders under large deductible endorsements, and review and/or establish procedures for reviewing the adequacy of such collateral. | | | | |
| Determine and list investments by type and reconcile to schedule D:<br>▪ Bonds<br>o Municipal<br>o Corporate<br>▪ U.S. government obligations<br>▪ T-Bills<br>▪ Strips<br>▪ Notes<br>▪ Agency obligations<br>▪ Stocks<br>o Common<br>o Preferred<br>▪ Repurchase agreements<br>▪ Advance Agreements<br>▪ Funding Agreements<br>▪ Cash balance if not above<br>▪ Partnership agreements<br>▪ Stock options/warrants<br>▪ Collateral loans<br>▪ Other | | | | |
| Identify assets that are held as collateral, outstanding advances or otherwise restricted and the circumstances that could initiate calls on such assets. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Continue contact and follow up with all custodians (and FHLBank, if applicable) regarding new transaction procedures and authorizations. | | | | |
| Obtain cut-off statements for all custodial accounts. | | | | |
| Reconcile all investment accounts to cut-off statements, noting any unusual items for further investigation. | | | | |
| Obtain current market values for all invested assets. | | | | |
| Establish procedures for monitoring status of current investments and procedures for investing maturities and new funds that will comply with maturity requirements for cash flow needs. | | | | |
| Establish a protocol with FHLBank, if insurer is a member, to corrdinate all activities relating to applicable Advance or Funding Agreement(s). | | | | |
| Notify paying agents on registered bonds to forward future checks to receiver. | | | | |
| Obtain a list of securities held for statutory deposit/state deposits; confirm with applicable states. | | | | |
| Determine type and amounts of all statutory deposits, special or general. | | | | |
| ***Review of Insurer's Internal Controls*** | | | | |
| Obtain and review any internal control reports prepared during the previous year by a public accounting firm. | | | | |
| Obtain and review any documentation related to the insurer's recent internal audits (e.g., internal audit reports, work papers, etc.). | | | | |
| Note any reported significant weaknesses in any of the above reports. Determine if corrective procedures were implemented. | | | | |
| Implement any additional changes in procedures as necessary. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Review Of Audit Work papers*** | | | | |
| Meet with outside auditors to discuss recent audit(s), issues and problems. | | | | |
| Obtain copies of all work papers, including correspondence, permanent files and memos. Review files for:<br>▪ Corporate documents<br>▪ Analyses and memos on significant transactions<br>▪ Agreements<br>▪ Memos to management and internal firm memoranda that might indicate issues<br>▪ Work papers for issues and unresolved items | | | | |
| ***Receivables*** | | | | |
| Review large deductible billing procedures to determine that all amounts are billed timely. Determine that there are no outstanding items for billing and obtain an aging of outstanding receivables. | | | | |
| Identify, review and evaluate:<br>▪ Trade receivables, especially premiums<br>▪ Mortgage loans and other promissory notes<br>  o Identification, location, terms, and amounts<br>  o Notification to appropriate parties<br>▪ Valuation of asset; escrow funds<br>▪ Interest receivables<br>▪ All MGAs, brokers and agents<br>▪ Letters of credit<br>▪ Notes receivable<br>▪ Lease funds receivable<br>▪ Royalties<br>▪ Reinsurance receivables<br>▪ Receivables from parents, subsidiaries and affiliates<br>▪ Other receivables<br>▪ Dividends<br>▪ Bonds receivable<br>▪ Premiums and agents' balances receivable | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Determine if there are any unsettled balances from affiliates or subsidiaries, how long they have been outstanding, and collectability. | | | | |
| Determine the transactions that gave rise to the outstanding balances and determine appropriateness of the transactions and amounts. | | | | |
| Obtain all agreements between insurer and affiliates that give rise to inter-insurer receivables/payables – review and determine appropriateness. | | | | |
| Review reinsurance recoverables billing procedures to determine that all amounts are billed timely. Determine that there are no outstanding items for billing, and obtain an aging of outstanding receivables. | | | | |
| If applicable, establish procedures for billing of allowed claims if in liquidation. | | | | |
| Evaluate premiums and agents' balances receivable:<br>▪ Identify all managing general agents, brokers, agents<br>▪ Perform any needed audits<br>▪ Review all fiduciary accounts, deposits with brokers and agents<br>▪ Analyze setoff and net settlements<br>▪ Evaluate return premiums<br>▪ Evaluate assumed reinsurance premium | | | | |
| Evaluate reinsurance transactions:<br>▪ Treaties and facultative certificates<br>▪ Setoffs improperly taken<br>▪ Ceded reinsurance premium payable | | | | |
| ***Other Assets*** | | | | |
| Identify, review and evaluate the following:<br>▪ All funds held by others<br>▪ Deposits | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ▪ Prepaid deposits<br>▪ Prepaid taxes<br>▪ IRS taxes<br>▪ State taxes<br>▪ Local taxes<br>▪ Unearned revenue<br>▪ Prepaid insurance premiums<br>▪ Retainers for professional services | | | | |
| Obtain listings of all retainers and advance deposits. Notice holders of the funds and recover as appropriate:<br>▪ Valuation of assets resident in subsidiaries<br>▪ Overall value of companies<br>▪ Initial capitalization of subsidiaries; return of investment | | | | |


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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Liabilities and Other Claims*** | | | | |
| Identify, review and evaluate:<br>▪ Accounts payable<br>▪ Notes payable<br>▪ Loss and LAE<br>▪ Funds held for others<br>▪ Lease obligations<br>▪ Mortgage obligations<br>▪ Unearned proceeds<br>▪ Inter-company payables<br>▪ Reinsurance not ceded<br>▪ Professional services<br>▪ Audit/pre-receivership billings<br>▪ Federal home Loan Bank Advance or Funding Agreements<br>▪ Other | | | | |
| ***Unclaimed Property Reports*** | | | | |
| Consult with insurer personnel to determine if unclaimed property reports have been filed with the respective states and if they are current. | | | | |
| Secure most recently filed unclaimed property reports. | | | | |
| Prepare listing of state reports required and due dates. | | | | |
| Determine whether appropriate support is available to complete future unclaimed property reports. This includes outstanding checklists for all active and closed bank accounts and other information such as check issue date, payee address and type of expense. | | | | |
| Determine if there are any separate accounts established strictly for unclaimed property purposes that eventually will be turned over to the states. | | | | |



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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Investigation*** | | | | |
| Review corporate and committee minutes of the insurer and its subsidiaries and summarize items of significance, noting:<br>▪ Financial decisions<br>▪ Approved transactions and agreements<br>▪ Resolutions<br>▪ Related parties | | | | |
| Develop a list of the insurer's officers, directors, controlling shareholders and related parties. | | | | |
| Obtain a listing of insurer employees, noting all family members and their positions within the insurer or its affiliates. | | | | |
| Obtain an ownership analysis of the insurer from Legal. | | | | |
| Document background information pertaining to subsidiaries, including:<br>▪ Business purpose<br>▪ Relationship to the insurer<br>▪ Directors and officers<br>▪ Current financial status<br>▪ Agreements/service arrangements between the companies<br>▪ Shared offices, equipment, employees, etc. | | | | |
| ***Accounting Records*** | | | | |
| Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken. | | | | |
| Determine if files at branches or outside facilities need to be returned or sent to other locations. | | | | |
| Complete ID of all accounting files. | | | | |


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| Checklist 8—Accounting | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| If required for state reporting or tax purposes, prepare current annual statement and/or quarterly statutory financial statements. Related work papers should be secured and reviewed so sheet items at date of liquidation can be properly updated for subsequent periods. | | | | |



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| Checklist 9—Tax and Compliance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Income Taxes (Federal and State)*** | | | | |
| File federal, state and municipal returns at appropriate reporting dates (income tax, premium tax, information returns, etc.) | | | | |
| Meet with company personnel responsible for filing the corporate income tax returns and obtain background information. Determine the following:<br>▪ If the returns have been filed on a consolidated basis with affiliated entities.<br>▪ The filing form used (i.e., 1120, 1120L or 1120-PC).<br>▪ If the company is current with its filings and tax payments (including current-year estimated tax payments if applicable).<br>▪ Which state income tax returns were filed.<br>▪ If there are any outstanding tax refunds or unused losses that can be utilized in the current period or carried back. If so, file appropriate return such as an amended return with net operating loss carryback claim.<br>▪ If returns are consolidated, secure a copy of the current tax sharing / tax allocation agreement. Discuss with company personnel. Verify that the companies are adhering to the provisions of the agreement, including the settling of balances due. | | | | |
| Complete and mail the Power of Attorney, Form 2848, to the IRS within 15 days of receivership. | | | | |
| File Form 56 (Notice Concerning Fiduciary Relationship) with the IRS. Enclose a certified Order of Conservation, Rehabilitation or Liquidation. Also, formally request a record of account from the IRS for at least the past three years for income and payroll taxes. | | | | |
| Obtain and review copies of most recently filed federal and state income tax returns, including any returns necessary to review if net operating losses for those years are still available. | | | | |



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| Checklist 9—Tax and Compliance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Determine and schedule the date of when the next returns are to be filed. If the deadline cannot be met, file the appropriate application for extension. | | | | |
| Secure and review tax return work papers for last year filed. Work papers should include details of adjustments from book income to taxable income. Copy relevant documents as necessary. | | | | |
| Meet with outside accounting firm and discuss company's tax situation, if applicable. Request and review tax work papers for most recently filed return. | | | | |
| Determine what sources are to be used for filing income tax returns. | | | | |
| Obtain a copy of the following documents for the period up to the date of liquidation and the previous year-end: general ledger (including a listing of all posted entries within each account), trial balance, chart of accounts and financial statements. Review general ledger for unusual items or discrepancies. Obtain backup information and discuss with company personnel as necessary to get a better understanding of financial statement items. | | | | |
| Obtain a copy of the last published annual statement and any subsequent quarterly financial statements filed. | | | | |
| Consult with company personnel to determine if any IRS or state assessments have been made, liens filed or bank accounts levied. Assessments include penalties and interest for late filing or non-filing of income tax, payroll, and information returns and/or late payment or nonpayment of the related taxes. Request an abatement of penalties for reasonable cause if not already done so. | | | | |
| Prepare a listing of government agencies (and their addresses) where income tax returns are filed so proofs of claims can be mailed. | | | | |



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| Checklist 9—Tax and Compliance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Information Returns*** | | | | |
| Meet with company personnel to determine which information returns apply. Use the current year IRS packages, Instructions to Filers of Forms 1099/1096, 1098, 5498, W-2G, W-3, 940, and 946 or Instructions for Form 5500 as a guide. | | | | |
| Prepare a listing of reports to be prepared and filing due dates. File an available application for extension of time to file the return(s), if necessary. | | | | |
| Monitor preparation and/or file various information returns required by the IRS. Common information returns for insurance companies include Forms 1099-MISC/1096 (Miscellaneous Income), 1099-R/1096 (Distribution from Pensions, Annuities, IRAs, Insurance Contracts, etc.), 5498 (Individual Retirement Information), 1098 (Mortgage Interest Statement), 5500 (Annual Return/Report of Employee Benefit Plan), W-2/W-3, 940 and 941. Coordinate efforts with the payroll department regarding the 5500s. | | | | |
| Secure copies of information returns and recent Form W-9s (Request for Taxpayer Identification Number and Certification). Review work papers or any related support and consult with company personnel and/or the third-party administrator, if applicable. | | | | |
| Determine what data sources are needed to file 1099s. If sources are computerized, coordinate with the IT Department to extract these reports. Also work with IT to transmit 1099 information to IRS electronically or via magnetic media (required if 250 or more forms.) | | | | |
| Determine whether all information needed to file returns is available. Obtain a list of names, addresses and phone numbers of vendors. If taxpayer identification numbers are not on hand, request such via mailing of Form W-9 to the appropriate parties (or obtain via phone, fax or e-mail). Use company personnel if available. | | | | |



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| Checklist 9—Tax and Compliance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***State Premium, State Franchise and Municipal Taxes*** | | | | |
| Determine if the company is current with its state and local premium tax return filings, including those required for interim periods and state franchise returns. Secure documents noting any estimated tax payments made during current tax year or prior year. | | | | |
| Determine whether there were any premium tax overpayments that have not yet been received. Also, determine if there are any unused credits available for the current period. | | | | |
| Extract statistical reports to be used for filing state premium and municipal taxes before closing down on-site operations. | | | | |
| Prepare and file premium or municipal tax returns as required. Use company personnel if available.<br>▪ Advise entities that returns are final, if appropriate<br>▪ Enclose a copy of the liquidation, rehabilitation or conservation order<br>▪ For companies in liquidation, where taxes are due, obtain a Proof of Claim form and enclose with return | | | | |
| ***Companies in Conservation or Rehabilitation*** | | | | |
| In cases when receiver is unable to file certain reports or it is deemed too costly to prepare, advise state of such. Request a waiver of filing requirement and/or any related penalties for non-compliance. | | | | |
| ***Tax and Compliance Records*** | | | | |
| Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken. | | | | |
| Determine if files at branches or outside facilities need to be returned or sent to other locations. | | | | |
| Complete ID of all tax and compliance files. | | | | |



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| Checklist 10—Claims | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Overview*** | | | | |
| Inform insurer personnel of new procedures for handling claims: if claims continue to be paid, if a moratorium was issued regarding the payment of claims (if claims will continue to be paid, note specific dollar limits), or if the insurer is in liquidation and claims need to be coordinated with guaranty associations. | | | | |
| Meet with claims manager (or appropriate personnel) to discuss the insurer's policies and procedures, managers/supervisors and their responsibilities, staffing and duties required as result of order. Document same. | | | | |
| Conduct interviews of claims department personnel to determine policies and claims processing procedures and to evaluate staff. Document same. | | | | |
| Determine whether any special technical knowledge is required for claims arising from the insurer's line of business. | | | | |
| Document the claim department's check/draft signature procedures. Coordinating with accounting, determine if new check/draft request procedures need to be established. Assist in the implementation of controls as necessary. | | | | |
| Coordinating with Accounting, secure any non-negotiated check/draft stock located in the insurer's claims department. | | | | |
| Coordinating with Accounting, obtain a listing of outstanding checks/drafts. If the check/draft will not be honored, the claim file listing must be updated to reflect the open status. | | | | |
| Obtain management reports, analyses, or other supporting memos regarding claims/underwriting matters. | | | | |
| ***Claims Records*** | | | | |
| Determine location of all claims records. | | | | |
| Secure all claim manuals. | | | | |



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| Checklist 10—Claims | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Obtain claim register. | | | | |
| Obtain list of current litigation related to claims, including:<br>▪ Bad-faith actions<br>▪ Excess exposures of the insurer<br>▪ Errors and omission claims against insurer personnel | | | | |
| Obtain list of:<br>▪ Defense counsel name and address<br>▪ All subrogation attorneys used by insurer<br>▪ Outside adjusters used by insurer<br>▪ Any independent appraisal firms used by insurer | | | | |
| Obtain list of:<br>▪ Claims handled by outside adjusters<br>▪ Open claims reserve report by claim number<br>▪ Open claims reserve report by insured<br>▪ Open claims report by residential state of the insured, so that information can be made available to appropriate guaranty associations. Update on daily basis to reflect new loss reports | | | | |
| Obtain an address listing and database of all premium finance companies, licensed agents, brokers and reinsurance intermediaries and copies of servicing agreements with agents/brokers. | | | | |
| Obtain copies of all active indemnity agreements. | | | | |
| Document the layout of claim files, noting the following:<br>▪ Claim numbering sequences/series<br>▪ Filing procedures<br>▪ Forms and form letters used by the insurer's claims department<br>▪ Other related reference material | | | | |
| Document claims department filing procedures. | | | | |



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| Checklist 10—Claims | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Identify, review and sort claim files into categories:<br>▪ OK for payment but the check/draft has not been issued<br>▪ Open<br>▪ Hardship<br>▪ Lawsuit<br>▪ Arbitration<br>▪ Subrogation<br>▪ Salvage<br>▪ Closed | | | | |
| Obtain copies of all forms used by the claims department. | | | | |
| Note any surety bonds and claims that arise from surety bonds. | | | | |
| Determine claims backlogs and establish priorities, including:<br>▪ The set-up of new loss reports<br>▪ Note the adjustor's average file counts on pending claims<br>▪ Monthly opening and closing file counts<br>▪ Review the adequacy of mail pulls, check/draft procedures, diary pulls, etc. | | | | |
| Monitor the setup of new claims. | | | | |
| Designate team member(s) to review mail received to determine quantity of correspondence, attempt to spot problems, note patterns on established procedures, etc. | | | | |
| Oversee filing of communications in claims files. | | | | |
| Consult with the Department of Insurance regarding complaints filed with the Department. | | | | |
| Obtain subrogation and salvage logs and/or diaries. | | | | |
| Salvage & subrogation – determine whether a review of closed files is required to identify maximum recoveries. | | | | |
| Initiate new procedures as to the receipt of a lawsuit, either:<br>▪ Arising from the policy defense of an insured, or<br>▪ Direct actions against the insurer | | | | |



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| Checklist 10—Claims | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Branches and Outside Facilities*** | | | | |
| Identify all branch offices and outside facilities at which claim files are housed. | | | | |
| Determine approximate number of files housed at each facility and arrange for inventory to be taken. | | | | |
| Determine if files need to be returned or sent to other locations. | | | | |
| ***HMO/Health Insurers*** | | | | |
| Obtain original or copies of all provider contracts. | | | | |
| Obtain a listing and database of all medical providers that lists tax ID numbers and contract rates. | | | | |
| Obtain a listing of disputed claims. | | | | |
| Obtain a certificate of coverage table. | | | | |
| Obtain a pay history table by subscriber/patient. | | | | |
| ***Proof of Claim*** | | | | |
| Determine what parties are to receive Proof of Claim forms and obtain listings of last known address, including:<br>▪ Guaranty associations<br>▪ Ancillaries<br>▪ Policyholders<br>▪ Loss claimants<br>▪ TPAs, MGAs, MGUs, Premium Finance Companies<br>▪ Brokers/Agents<br>▪ Intermediaries<br>▪ General creditors<br>▪ Employees<br>▪ Vendors<br>▪ Government entities<br>▪ Shareholders | | | | |



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| Checklist 10—Claims | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Coordinate with P&C Guaranty Associations*** | | | | |
| Prepare UDS worksheet or submission on all open and recently opened claims. | | | | |
| Coordinate with NCIGF to transmit UDS information to guaranty associations. | | | | |
| Inventory and forward loss files to the appropriate guaranty associations. | | | | |

| Checklist 11—Large Deductible Policies | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Overview***<br>• Meet with Manager of Large Deductible Collections (and/or other appropriate personnel) to discuss large deductible Collection procedures, personnel and responsibilities, staffing and what will be required from staff as a result of the order<br>• Conduct interviews of appropriate large deductible collection department personnel to determine policies and procedures. Document same.<br>• Establish a large deductible recoverable balance as of the receivership date | | | | |
| ***Gathering Documentation***<br>• Determine location of large deductible records – secure and inventory. This should include: | | | | |


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| | | | | |
|---|---|---|---|---|
| • All policies containing large deductible endorsements<br>• Claims files arising under such policies<br>• Correspondence files<br>• Billing records<br>  ○ Letters of credit, trust agreements, deductible reimbursement policies or other collateral<br>• For all LOCs, trust accounts, funds withheld:<br>  ○ Secure all originals<br>  ○ Notify all banks and trustees of the order | | | | |
| ***Documenting Large Deductible Collection Procedures***<br>• Review recent billings for all large deductible policies<br>• Obtain a list of large deductible payment history and determine whether insured payments have been ongoing or if payment from collateral has been required.<br>• Obtain a list of paid and unpaid bills updated after liquidation<br>• Obtain claim documentation for claims arising under large deductible policies<br>  ○ By paid loss and loss reserves and ALAE paids and reserves<br>  ○ List of claims in litigation/arbitration<br>• Review large deductible billing system; determine that all paid losses arising under large deductible policies have | | | | |



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| | | | | |
|---|---|---|---|---|
| been billed.<br><br>• Determine whether large deductible endorsements provide that losses within the deductible are limited in the aggregate<br><br>• Evaluate recovery processes and determine if new procedures are appropriate<br><br>• Determine whether collateral is held by affiliated/unaffiliated third party via large deductible reimbursement policy, trust agreement or other vehicle, and evaluate whether collateral can be transferred to the receivership<br><br>• Document insured collection disputes<br><br>• Determine which functional group handles disputes<br><br>• Interview members of each group responsible for coordinating, monitoring and controlling large deductible collection disputes<br><br>• Audit large deductible collection-specific systems. Track data from source to final product to verify billings are correct and inclusive and internal controls are adequate | | | | |



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| Checklist 12—Reinsurance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Overview*** | | | | |
| Meet with the insurer's reinsurance manager (and/or other appropriate personnel) to discuss the reinsurance procedures, managers/supervisors and their responsibilities, staffing and what will be required from their department's staff as a result of the order. | | | | |
| Conduct interviews of appropriate insurer reinsurance department personnel to determine policies and procedures. Document same. | | | | |
| Create a chart of reinsurance coverage based on interviews with reinsurance personnel, schedule F (P&C) or schedule S (L&H), and documents obtained below. See Chapter 7 – Exhibits 1 & 2. | | | | |
| Send copies of liquidation orders certified/registered mail to intermediaries (or reinsurers, if no intermediaries). | | | | |
| Establish reinsurance recoverable balance as of receivership date. | | | | |
| ***Gathering Documentation*** | | | | |
| Determine location of all reinsurance records – secure and inventory. This should include:<br>▪ Reinsurance treaties, including all endorsements or amendments<br>▪ Facultative certificates (may be in policy or claim files)<br>▪ Placement slips<br>▪ Correspondence files<br>▪ Claim files (coordinate with claims)<br>▪ Broker of record letters<br>▪ Intermediary agreements and correspondence<br>▪ Reinsurance accounting records, including computer runs and bordereaux (coordinate with Accounting)<br>▪ Letters of credit or other collateral<br>▪ Trust agreements<br>▪ Commutation agreements | | | | |



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| Checklist 12—Reinsurance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| For all LOCs, trust accounts, funds withheld:<br>▪ Secure all originals<br>▪ Notify all banks and trustees of the order | | | | |
| For all treaties and facultative contracts:<br>▪ Obtain/develop schematic (ceded, assumed, retroceded)<br>▪ Determine and document the methodology of applying losses to treaties<br>▪ Obtain security policy register for facultative policies assumed<br>▪ Obtain samples of all pertinent documentation relative to reinsurance and underwriting operations, including, but not limited to, policy wording and endorsements. | | | | |
| Obtain inventory and backup of all reinsurance PC workstations and mainframe, including file descriptions (reinsurance information is often kept on stand-alone PCs within the department). | | | | |
| Obtain copies of all system codes, lists, tables, etc., applicable to each system. | | | | |
| ***Documenting Reinsurance Procedures*** | | | | |
| Review the recent reinsurance billings for ceded and assumed reinsurance programs. | | | | |
| Obtain a list of reinsurance claims and payment history. | | | | |
| Obtain a list of paid and unpaid claims updated after liquidation. | | | | |
| Obtain claim documentation:<br>▪ Bordereaux of paid and unpaid losses and LAE figures, reserves and premiums<br>▪ List of claims in litigation/arbitration<br>▪ Facultative registers<br>▪ Claims handling procedures | | | | |
| Determine that all paid losses covered by reinsurance have been billed. | | | | |



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| Checklist 12—Reinsurance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Evaluate recovery processes and determine if new procedures are appropriate. | | | | |
| Evaluate procedures for notifying reinsurers of claims liabilities and determine any need for new procedures. | | | | |
| Determine appropriate action for continued relationships with TPAs, MGAs and intermediaries, including funds and/or LOCs held by any of these entities and records retained by them off-site. | | | | |
| Document insurer reinsurance party disputes:<br>▪ Interview all department heads and determine which functional areas are responsible for litigation, arbitration, etc.<br>▪ Interview members of each functional area responsible for coordinating, monitoring and controlling reinsurance disputes. | | | | |
| Determine if any reinsurance audits are ongoing, have been performed, or are currently scheduled, and obtain copies of reports and work papers. | | | | |
| Evaluate reinsurance-related data currently produced and that data to be stored for future use. | | | | |
| Audit reinsurance-specific systems. Track data from source to final product to verify billings are correct and inclusive. | | | | |
| ***Third-Party Dispute*** | | | | |
| Segregate third-party disputes into the following classifications:<br>▪ Reinsurance-specific issues<br>▪ Declaratory judgment actions affecting reinsurance | | | | |
| Determine if there are any appeal bonds pending the appeal of a judgment for or against the insurer in connection with any issue that might impact reinsurance. | | | | |
| Ensure that reinsurers are kept apprised of any developments. | | | | |



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| Checklist 12—Reinsurance | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| ***Intercompany Reinsurance Transactions*** | | | | |
| Obtain source documentation for intercompany relationships. | | | | |
| Analyze and document mechanics of intercompany agreement(s) including premium and loss payments, commissions, advancements, etc. | | | | |
| Compare results of agreement analysis to ensure that the accounting methodology utilized is in compliance with the contract. Document findings. | | | | |
| Determine if intercompany relationships have any bearing on other reinsurance facilities. | | | | |
| ***Reinsurance Records*** | | | | |
| Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken. | | | | |
| Determine if files at branches or outside facilities need to be returned or sent to other locations. | | | | |
| Complete ID of all reinsurance files. | | | | |



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| Checklist 13—Legal | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Coordinate preparation and filing of Petition and Order of Receivership with various responsible parties (e.g., Department of Insurance, attorney general and/or outside counsel). | | | | |
| If proceedings are agreed to by insurer:<br>▪ Obtain Corporate Resolution by insurer's board of directors or shareholder(s)<br>▪ Include Consent to Order of C-R-L<br>▪ Include Waiver of Service of Process<br>▪ Include Waiver of Right to Appear-Answer-Appeal | | | | |
| Prepare Petition/Order setting bar dates and claim filing procedures, if applicable. | | | | |
| Identify affiliates. | | | | |
| Distribute copies of the order to receiver's staff. | | | | |
| Serve certified copy of the order on:<br>▪ Insurer officers and directors<br>▪ Insurer affiliates<br>▪ Insurer attorneys<br>▪ Plaintiff attorneys<br>▪ Guaranty associations<br>▪ Other key people | | | | |
| Coordinate with Accounting to prepare letters for financial institutions for service of order. | | | | |
| Prepare any publication notice that might be required. | | | | |
| Secure corporate administrative records. | | | | |
| Secure corporate/minute books and corporate seal(s). | | | | |
| Obtain or create list of all directors, executive officers and stockholders of insurer, all subsidiaries, and, if possible, affiliates. | | | | |
| Secure contracts and agreements. | | | | |
| Secure legal records. | | | | |



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| Checklist 13—Legal | Project Assigned To | Date Completed | Completed By | Notes |
|---|---|---|---|---|
| Identify all pending litigation involving the insurer and determine appropriate actions. | | | | |
| Obtain list of lawyers representing/pursuing the insurer:<br>▪ Contact and notify of new procedures as appropriate<br>▪ Establish new reporting lines and oversight procedures | | | | |
| Review insurer's insurance policies and determine applicable contractual limitations period for filing a notice of claim. (change in control) | | | | |
| File notice of claim as appropriate. | | | | |
| Deliver notice of the receivership order's stay provision and/or other injunctive relief to litigation parties. | | | | |
| Begin preparing plan for rehabilitation/liquidation. | | | | |
| Draft Petition/Order Approving Plan of Rehabilitation/Liquidation. | | | | |
| Draft Plan for Early Access Distribution of Assets to Guaranty Associations, if appropriate. | | | | |
| Draft Petition/Order for Approval of Early Access Distribution, if appropriate. | | | | |
| File order with Recorder of Deeds as may be appropriate. | | | | |
| File lis pendens with county where real property is located. | | | | |
| ***Legal Records*** | | | | |
| Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken. | | | | |



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***Exhibit 3-1: Example of Financial Reporting Format***

**STATEMENT
OF
NET ASSETS**

**COMPANY NAME
BALANCE SHEET
DATE**

Date of Receivership:

**Unrestricted Invested Assets:**

Cash ..........................................................................................................

Short-Term Investments.....................................................................................

Bonds .........................................................................................................

Stocks.........................................................................................................
Preferred ...........................................................................
Common ...........................................................................

Investments in Subsidiaries.................................................................................
Controlled........................................................................
Affiliated Entities .............................................................

Mortgage Loans ..............................................................................................

Real Estate ...................................................................................................

Policy Loans...................................................................................................

Other Invested Assets
..........................................................................................
..........................................................................................
Total Unrestricted Invested Assets ..........................................................$ ______________

**Restricted Investment Assets:**

Statutory Deposits in This or Other States........................................................

Funds Held by or Deposited with Reinsured Companies .................................

Separate Accounts and Protected Cell Accounts ..............................................

Restricted Other ..............................................................................................

Total Restricted Invested Assets ..............................................................$ ______________

**Other Unrestricted Assets:**

Recoverable from Reinsurers on Paid Losses and LAE ...................................



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***Exhibit 3-1***

**STATEMENT
OF
NET ASSETS**

**COMPANY NAME
BALANCE SHEET
DATE**

Less: Allowance for Uncollectible Reinsurance Recoverables on Paid Losses and Loss Adjustment Expenses (LAE) ......................................................

Reinsurance Recoverables on Unpaid Losses and Unpaid Loss Adjustment Expenses (LAE) ..........................................................................................

Less: Allowance for Uncollectible Reinsurance Recoverables on Unpaid Losses and Loss Adjustment Expenses (LAE) ..........................................

Reinsurance Recoverables on Unearned Premiums and Contingent Commissions...............................................................................................

Salvage and Subrogation Recoverables ............................................................

Premiums Due and Accrued for Agents and Policyholders...............................

Receivable from Parents, Subsidiaries and Affiliates.......................................

Accrued Investment Income ..............................................................................

Receivable from Guaranty Associations – Early Access Payments ..................

Furniture, Fixtures and Equipment ....................................................................
Prepaid Expenses ...............................................................................................
Other Assets.......................................................................................................

Total Other Unrestricted Assets.......................................................................$ ______________

**Total Assets** $______________

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***Exhibit 3-1***

**STATEMENT**
**OF**
**NET LIABILITIES**

**COMPANY NAME**
**BALANCE SHEET**
**DATE**

Date of Receivership:

**Liabilities**

Secured Claims........................................................................................$

Special Deposit Claims ..........................................................................$

Administrative Claims
State/Receiver...........................................................................$
Guaranty Associations..............................................................$

Loss Claims – Guaranty Associations ...................................................$
Loss Claims – Other ..............................................................................$
Loss Adjustment Expenses – Guaranty Assns. .....................................$
Loss Adjustment Expenses – Other........................................................$

Unearned and Advance Premium Claims (Non-Assessable Policies) Guaranty Associations.........................................................................................$
Unearned and Advance Premium Claims (Non-Assessable Policies) Other ..............$

Federal Govt. Claims..............................................................................$

Employee Claims....................................................................................$

General Unsecured Creditor Claims (Other than Reinsurance Related) ................$

Ceded Reinsurance Related Unsecured Claims.....................................$
Assumed Reinsurance Related Unsecured Claims................................$

State and Local Government Claims .....................................................$

Late Filed Claims ...................................................................................$

Surplus Notes .........................................................................................$

Unearned Premium Claims (Assessable Policies) – Guaranty Associations................$
Unearned Premium Claims (Assessable Policies) – Other....................................$



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***Exhibit 3-1***

**STATEMENT**
**OF**
**NET LIABILITIES**

**COMPANY NAME**
**BALANCE SHEET**
**DATE**

Shareholder Claims ......................................................................................$

Other Liabilities..........................................................................................$
.................................................................................................................$
.................................................................................................................$

| | |
|---|---|
| **Total Liabilities** | ______________ |
| **Excess (Deficiency) of Assets Over Liabilities** | ______________ |
| **Total** | $____________ |

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**NOTE:** This may not directly tie to the "Class" section prioritizing claimants in accordance with any one state's receivership statute.



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***Exhibit 3-1***

**STATEMENT**
**OF**
**CASH RECEIPTS AND DISBURSEMENTS**

| Cash Receipts from Operations | Current Period to Date | Since Date of Rehabilitation/ Liquidation |
|---|---|---|
| Premium Receipts | $ ______ | $ ______ |
| Settlements | $ ______ | $ ______ |
| Policy Loan Receipts, Cash Collected from Policy Loans | $ ______ | $ ______ |
| Proceeds from Sales of Real Estate and/or Personal Property | $ ______ | $ ______ |
| Reinsurance Recoveries | $ ______ | $ ______ |
| Salvage and Subrogation Recoveries | $ ______ | $ ______ |
| Agents Balances Received | $ ______ | $ ______ |
| Collection of Affiliate Receivables | $ ______ | $ ______ |
| Recovery of Taxes Previously Paid | $ ______ | $ ______ |
| Other Receipts | $ ______ | $ ______ |
| **Total Operational Receipts** | $ ______ | $ ______ |
| Interest and Dividends Receipts | $ ______ | $ ______ |
| **Total Cash Receipts** | $ ______ | $ ______ |

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***Exhibit 3-1***

**STATEMENT**
**OF**
**CASH RECEIPTS AND DISBURSEMENTS**

| | Current Period to Date | Since Date of Rehabilitation/ Liquidation |
|---|---|---|
| **Operational Disbursements & Distributions** | | |
| | $ | $ |
| Deputy Receiver and Consulting Fees and Expenses | | |
| Employee Salaries, Payroll Taxes, and Employee Benefits | | |
| Rent, Office and Other Facility Expenses | | |
| Legal Fees and Expenses | | |
| Accounting and Auditing Fees and Expenses | | |
| SGA – Administration Expenses other than LAE | | |
| Ancillary Administration Expenses | | |
| Other Disbursements | | |
| **Total Operational Disbursements** | | |
| Losses/Benefit Payments – SGA | | |
| Losses/Benefit Payments – Non-SGA | | |
| Losses/Benefit and LAE Payments – Special Deposits | | |
| LAE Payments – SGA | | |
| LAE Payments – Non-SGA | | |
| Early Access Payments | | |
| Reinsurance Payments | | |
| **Total Cash Distributions** | | |
| Investment Expenses | | |
| Purchases of Invested Assets | | |
| Total Disbursements for Investment Activities | | |
| **Total Cash Disbursements & Distributions** | | |
| **Net Increase (Decrease) in Cash** | | |
| **Cash at Beginning of Period** | $ | $ |
| **Cash at End of Period** | $ | $ |

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***Exhibit 3-1***

**STATEMENT
OF
CHANGES IN NET ASSETS**

**COMPANY NAME
BALANCE SHEET
DATE**

Date of Receivership:

| | Increase (Decrease) |
|---|---|
| **Unrestricted Assets:** | |
| Cash Unrestricted | |
| Short-Term Investments | |
| Bonds | |
| Stocks | |
| Preferred | |
| Common | |
| Investments in Subsidiaries | |
| Controlled | |
| Affiliated Entities | |
| Mortgage Loans | |
| Real Estate | |
| Policy Loans | |
| Other Invested Assets | |
| Reinsurance Recoverables on Paid Losses and Paid Loss Adjustment Expenses (LAE) | |
| Less: Allowance for Uncollectible Reinsurance Recoverables on Paid Losses and Loss Adjustment Expenses (LAE) | |
| Reinsurance Recoverables on Unpaid Losses and Unpaid Loss Adjustment Expenses (LAE) | |
| Less: Allowance for Uncollectible Reinsurance Recoverables on Unpaid Losses and Loss Adjustment Expenses (LAE) | |
| Reinsurance Recoverables on Unearned Premiums and Contingent Commissions | |



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***Exhibit 3-1***

**STATEMENT
OF
CHANGES IN NET ASSETS**

**COMPANY NAME
BALANCE SHEET
DATE**

| | | |
|---|---|---|
| Salvage and Subrogation Recoverables | | |
| Premiums Due and Accrued from Agents and Policyholders | | |
| Receivable from Parents, Subsidiaries and Affiliates | | |
| Accrued Investment Income | | |
| Receivable from Guaranty Associations – Early Access Payments | | |
| Furniture, Fixtures and Equipment | | |
| Prepaid Expenses | | |
| Other Assets | | |
| **Total Unrestricted Assets** | $ | ______ |
| **Restricted Assets:** | | |
| Statutory Deposits in This or Other States | | |
| Funds Held by or Deposited with Reinsured Companies | | |
| Separate Accounts and Protected Cell Accounts | | |
| Restricted Other | | |
| **Total Restricted Assets** | $ | ______ |
| **Total Assets** | | $ ______ |

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***Exhibit 3-1***

**STATEMENT**
**OF**
**CHANGES IN NET LIABILITIES**

**COMPANY NAME**
**BALANCE SHEET**
**DATE**

Date of Receivership:

| | Increase (Decrease) |
|---|---|
| **Liabilities** | |
| Secured Claims | $ |
| Special Deposit Claims | $ |
| Administrative Claims | |
| State/Receiver | $ |
| Guaranty Associations | $ |
| Loss Claims – Guaranty Associations | $ |
| Loss Claims – Other | $ |
| Loss Adjustment Expenses – Guaranty Assns. | $ |
| Loss Adjustment Expenses – Other | $ |
| Unearned and Advance Premium Claims (Non-Assessable Policies) Guaranty Associations | $ |
| Unearned and Advance Premium Claims (Non-Assessable Policies) Other | $ |
| Federal Govt. Claims | $ |
| Employee Claims | $ |
| General Unsecured Creditor Claims (Other than Reinsurance Related) | $ |
| Ceded Reinsurance Related Unsecured Claims | $ |
| Assumed Reinsurance Related Unsecured Claims | $ |
| State and Local Government Claims | $ |
| Late Filed Claims | $ |
| Surplus Notes | $ |
| Unearned Premium Claims (Assessable Policies) – Guaranty Associations | $ |
| Unearned Premium Claims (Assessable Policies) – Other | $ |



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***Exhibit 3-1***

**STATEMENT
OF
CHANGES IN NET LIABILITIES**

**COMPANY NAME
BALANCE SHEET
DATE**

Shareholder Claims ........................................................................................$

Other Liabilities..............................................................................................$
.......................................................................................................................$
.......................................................................................................................$

| | |
|---|---|
| **Total Liabilities** | ______________ |
| **Excess (Deficiency) of Assets Over Liabilities** | ______________ |
| **Total** | $____________ |

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**NOTE:** This may not directly tie to the "Class" section prioritizing claimants in accordance with state regulatory requirements.



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***Exhibit 3-2: Example of Daily Cash Flow***

Cash Activity
For the Four Week Period Ending ____________

| | ____ | ____ | ____ | ____ | Four Week Total |
|---|---|---|---|---|---|
| Beginning Cash | | | | | |
| Cash Receipts: | | | | | |
| Investment Income | | | | | |
| Premium Deposits | | | | | |
| Investment Sales | | | | | |
| Transfers In | | | | | |
| Short-Term Interest | | | | | |
| Reinsurance Receipts | | | | | |
| Other Income | | | | | |
| Total Cash Receipts | | | | | |
| Cash Disbursements: | | | | | |
| Accounts Payable | | | | | |
| Policyholder Payments | | | | | |
| Hardship Surrenders | | | | | |
| Payroll | | | | | |
| Transfers Out | | | | | |
| Tax Payments | | | | | |
| Reinsurance Payments | | | | | |
| Returned Checks/ Other Disb | | | | | |
| | | | | | |
| Ending Cash | | | | | |



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***Exhibit 3-3: Example of Budget-Projected Liquidation Expenses***

## PROJECTED LIQUIDATION EXPENSES

| | ------------------------Projected------------------------ | | | | | |
|---|---|---|---|---|---|---|
| | Since Actual Date of Rehabilitation Liquidation | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Year to Date |
| **Receipts** | | | | | | |
| Interest Income | $ | $ | $ | $ | $ | $ |
| Mortgages Interest | | | | | | |
| Reinsurance Recoveries | | | | | | |
| Rental Income | | | | | | |
| Premium Income | | | | | | |
| Return Commission | | | | | | |
| Collection of Affiliate Receivables | | | | | | |
| Principal Collections on Mortgages | | | | | | |
| Proceeds from Sale of Real Estate & PP&E | | | | | | |
| Escrow - Mortgages | | | | | | |
| Recovery of Assets | | | | | | |
| Guaranty Fund Assessment Refund | | | | | | |
| Total Receipts | | | | | | |
| **Disbursements** | $ | $ | $ | $ | $ | $ |
| Legal, Audit & Consulting Fees | | | | | | |
| Payroll, Other Taxes & Employee Benefits | | | | | | |
| Rent and Related Expenses | | | | | | |
| Equipment & Office Expense | | | | | | |
| Investment Expenses | | | | | | |
| Reinsurance Premium Ceded | | | | | | |
| Early Access Distribution | | | | | | |
| Liquidation/Rehabilitation Expenses | | | | | | |
| Establishment of Escrow | | | | | | |
| Other Distributions | | | | | | |
| Total Disbursements | | | | | | |
| **Net Increase (Decrease) in Cash** | | | | | | |
| **Cash at beginning of period** | $ | $ | $ | $ | $ | $ |
| **Cash at end of period** | $ | $ | $ | $ | $ | $ |



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**Example: Restructuring Transaction**

When placed into liquidation, Reliance was part of a three-tiered holding company structure, whereby 100% of the stock of Reliance was owned by Reliance Financial Services Corp ("RFS"). RFS, in turn, was wholly-owned by Reliance Group Holdings, Inc. ("RGH").[1] In 2003, a settlement agreement was entered into between Reliance, RFS, and RGH whereby, among other things, the parties created a new consolidated tax group for federal income tax purposes with RFS as the common parent and with Reliance as a member.

In 2015, after collection of certain assets, RFS desired to terminate its existence and dissolve. Because Reliance is part of the consolidated tax group, the dissolution of RFS could have led to a change in ownership of Reliance which, under §382 of the Internal Revenue Code of 1986, as amended ("Code"), could have adversely affected the significant net operating loss carryovers ("NOLs")[2] held by Reliance which may be used to offset future net income, thereby reducing tax liabilities. Therefore, Reliance and its advisors developed a restructuring plan and a transaction which was approved by this Court and executed as of December 31, 2016.

The transaction resulted in an ownership change of Reliance which qualified for the bankruptcy exception under §382(l)(5) of the Code. Pursuant to the plan, all of the issued Reliance common shares are now owned by 4 GAs ("Participating GAs") who paid Reliance policyholder claims and who received Reliance stock in exchange for the partial cancellation of such indebtedness. Each Participating GA has entered into a shareholder's agreement which restricts the sale, transfer, pledge or assignment of the shares, and each shareholder executed a revocable proxy granting the right to vote all the shares to the Pennsylvania Insurance Commissioner as Liquidator. The Participating GAs will receive no preference as to their claims against Reliance due to their new ownership status. Furthermore, the Reliance stock issued to the Participating GAs provides them with no additional viable claim against Reliance as assets will be insufficient for distributions to class (i) creditors (shareholders).

The transaction received a favorable private letter ruling on August 24, 2016 from the Internal Revenue Service holding that the Participating GAs would be treated as receiving the Reliance stock in their capacity as creditors of Reliance for purposes of the Code. The plan preserved the substantial NOLs for the benefit of the Reliance estate and allows Reliance to control its own future regarding tax positions and negotiations with the Internal Revenue Service. As a result of the restructuring, Reliance will become its own tax filer and will no longer be part of a consolidated tax group.[3]

---

[1] RGH and RFS jointly filed for bankruptcy in 2001 and the RGH and RFS reorganization plan was approved in 2005 with RGH converting into a liquidating trust and RFS converting into Reorganized RFS Corporation.

[2] As a result of the large losses suffered by Reliance during the final years of its independent operations and during its liquidation, in excess of $4 billion of NOLs were accumulated through 2014. Approximately $1.5 billion of that $4 billion was utilized in the 2015 consolidated tax return.

[3] For additional details, see the Liquidator's Application for Approval of Restructuring Proposal filed with the Court on October 7, 2016, which is document # 3745 on the www.reliancedocuments website.



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***Exhibit 4-1: Potential Recovery from Unrelated Third Parties Matrix of Relationships***

## Potential Recovery from Third Parties

| | Causes for Action | Offending Parties | Information Source |
|---|---|---|---|
| 1 | Breach of Fiduciary Duty | | |
| | A) Failure to Maintain Premium Trust Account | A) Managing General Agents | A) Takeover Audit |
| | B) Skimming Premiums | B) Third-Party Administrators | B) Financial Records |
| | C) Withholding Funds Without Authority | C) Other Agents/Brokers | C) Policy File Documentation |
| | D) Failure to Collect and Remit Funds When Due | D) Reinsurance Intermediaries | D) Contract/Treaty File |
| | E) Excessive Commissions and Fees | | E) Audits of MGA, etc. |
| | F) Improper Set-offs | | F) Insurance Department Files |
| | G) Broker Funding | | |
| | H) Improper Co-Mingling of Funds | | |
| 2 | Abuses Related to Risk Selection | | |
| | A) Writing Excluded Classes of Business | A) Managing General Agents | A) Takeover Audit |
| | B) Violating Territorial Limits | B) Third-Party Administrators | B) Financial Records |
| | C) Exceeding Premium and/or Product Mix Limit | C) Attorneys | C) Policyholder File Documentation |
| | D) Improper Use of Binders | D) Other Agents/Brokers | D) Contract/Treaty Files |
| | E) Overlining | E) Reinsurance Intermediaries | E) Audits of MGA, etc. |
| | F) Misrepresenting Risks | F) Policyholders | F) Insurance Department Files |
| | G) Placing Reinsurance with Unacceptable Reinsurers | G) Cedents | G) Premium Audits |
| | H) Failing to Obtain Adequate Security for Ceded Reinsurance | | H) Insurer Rating Services |
| 3 | Abuses Relating to Loss Settlements | | |
| | A) Exceeding Settlement Authority | A) Managing General Agents | A) Takeover |
| | B) Inadequate Claims Investigation | B) Third-Party Administrators | B) Financial Records |
| | C) Failure to Pursue Subrogation and/or Salvage | C) Other Agents/Brokers | C) Policyholder File Documentation |
| | D) Presenting False Claims | D) Reinsurance Intermediaries | D) Contract/Treaty Files |
| | E) Failing to Control Allocated Loss Expenses | E) Policyholders | E) Audits of MGA, etc. |
| | F) Late Reporting of Losses | F) Cedents | F) Insurance Department Files |
| | G) Third-Party Claimants | G) Direct Confirmations | |
| 4 | Abuses Related to Premium Computations | | |
| | A) Understating Premium Base | A) Managing General Agents | A) Takeover Audit |
| | B) Neglecting to Obtain Premium Audits | B) Third-Party Administrators | B) Financial Records |
| | C) Failure to Report and Remit Premium Adjustments | C) Other Agents/Brokers | C) Policyholder File Documentation |
| | D) Late Reporting of Loss Experience | D) Reinsurance Intermediaries | D) Contract/Treaty Files |
| | | E) Policyholders | E) Audits of MGA, etc. |
| | | F) Cedents | F) Direct Confirmations |
| 5 | Professional Malpractice | | |
| | A) Incomplete Work Product | A) Certified Public Accountants | A) Takeover Audit |
| | B) Insufficient Analyses | B) Consulting Actuaries | B) Financial Records |
| | C) Failure to Honor Warranty | C) Loss Reserving Specialists | C) Engagement Letters |
| | D) Failure to Meet Minimum Standards | D) Management Consultants | D) Contract Files |
| | E) Unprofessional Conduct | E) Independent Claims Adjusters | E) Service Agreements |
| | | F) Data Processing Consultants | |
| | | G) Other Service Vendors | |
| 6 | Fraud – not really a separate category. Any or all of the preceding categories could contain elements of fraud. | | |
| 7 | Collusion with Management – not really a separate category. If the apparent damage to the insurer extends over a large number of transactions or an extended period of time, collusion may have occurred. | | |



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***Exhibit 5-1: Linear Summary of Claims Administration***

LINEAR SUMMARY OF CLAIMS ADMINISTRATION

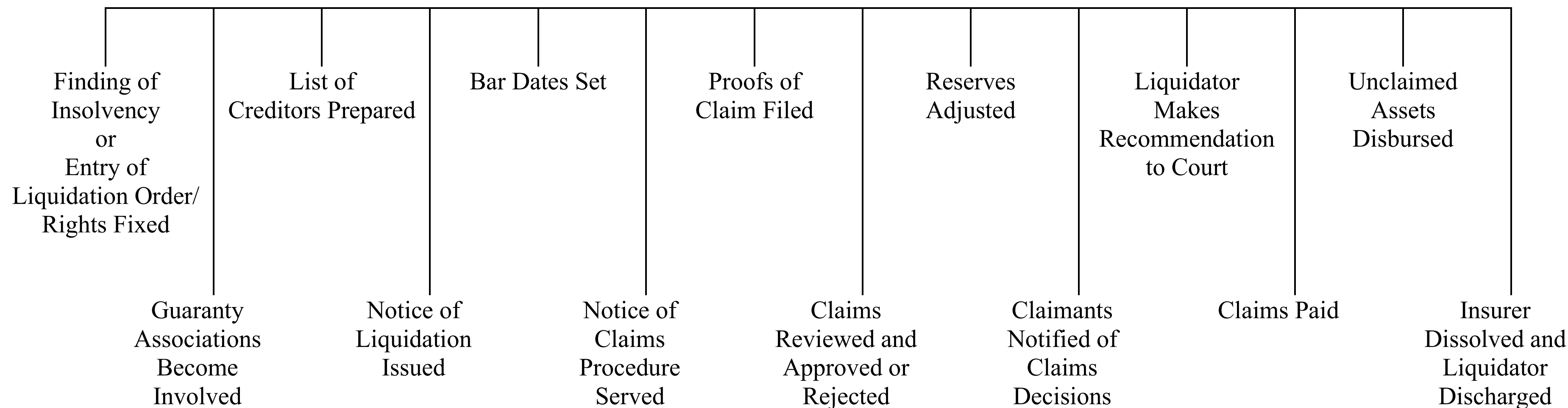




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***Exhibit 5-2: Claimant Notice via Postcard***

# CLAIMANT NOTICE VIA POSTCARD

Florida Department of Financial Services
Division of Rehabilitation and Liquidation
Post Office Box (insert box number)
Tallahassee, FL 32302-(insert 4-digits)

PRESORT
FIRST CLASS
U.S. MAIL
**PAID**
Tallahassee, FL
Permit #108

ID BARCODE
RCN <Company code>-<ID Number>-<Suffix>
<Claimant Type> <Reference #> >
<First Name> <Middle Initial> <Last Name>
<Address 1>
<Address 2>
<City>, <State> <Zip Code>
POSTAL BAR CODE

**label**

(insert company name), in Receivership

**postcard**

**front side of postcard**

**IMPORTANT CLAIMANT NOTICE**
Department of Financial Services
Receiver for (insert company name)
Toll-Free Consumer Hotline (800) 882-3054

The Florida Department of Financial Services (as Receiver) has been directed by Court Order to liquidate the above company. You have been identified as someone who might have a claim against this company. If you have no claim, please ignore this Claimant Notice. **If you have a claim, you must complete and submit a claim for each Claimant Notice (postcard) received.** Failure to complete and submit your claim(s) to the Receiver by the claim filing deadline shown below may result in your claim being denied in full or in part.

**CLAIM FILING DEADLINE: (insert claims filing deadline here)**

- To file a claim please go to the following website: (**insert web address here**)
- If you do not have access to the Internet, please place an "X" in **one** of the boxes below and return this Claimant Notice in an envelope to the return address on the front of this postcard:

☐ Please mail me a proof of claim form and instructions

☐ Please mail a proof of claim form to the updated address below (**print your information**):

Name: ________________________________________

Street Address: ________________________________________

City, State and Zip Code: ____________________________ ______ _______________

**back side of postcard**



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# Early Access Agreement

THIS EARLY ACCESS AGREEMENT (the "Agreement"), is entered into as of the _ day of ____, 20_ (the "Contract Date"), by and among the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA"), on behalf of its member state life and health insurance guaranty associations which are or become "Participating Associations" under this Agreement, and ___________, Commissioner of Insurance for the State of __________, as Liquidator (the "Liquidator") of the ___________ Insurance Company (the "Company").

WITNESSETH: RECITALS

WHEREAS, on _______ 20_ (the "Liquidation Order Date"), in the_____ Court of _____County, State of ______ (the "Liquidation Court") an "Order of Liquidation" (the "Liquidation Order") was entered as to Company, a _______ corporation, in Civil Cause Number ______; and

WHEREAS, upon entry of the Liquidation Order, Company had in force certain ________[list policies/policy types]________ ("Policies").

WHEREAS, in the __#__ jurisdictions where Company was licensed, there are life and health insurance guaranty associations (collectively, the "Affected Guaranty Associations") that, as a result of the Liquidation Order, have obligations, subject to statutory conditions and limitations on coverage and applicability, to holders of the Policies who reside within the Affected Guaranty Associations' respective jurisdictions ("Covered Obligations"). In addition, the [domiciliary state guaranty association] in certain cases may have Covered Obligations to holders of the Policies who reside in states and territories where Company was not licensed to do business prior to liquidation.

WHEREAS, the parties hereto desire to facilitate the provision of early access distributions to the Participating Associations.

AGREEMENTS:

NOW, THEREFORE, in consideration of the mutual covenants set forth in this Agreement, Liquidator, NOLHGA and the member state life and health insurance guaranty associations named on the List of Participating Associations (the form of which is attached as Exhibit A) agree as follows:

1. Duties of Liquidator:

   1.1 The Liquidator shall make pro rata to each Participating Association early access distributions of such assets of Company attributable to policies or contracts giving rise to Covered Obligations, which are not reasonably necessary for use by the Liquidator for (i) expenses of administration of the estate of Company or (ii) as a reserve for claims accorded a higher or equal priority of distribution by _______ law.


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For purposes of this Agreement, the term "cash assets of Company attributable to policies or contracts giving rise to Covered Obligations" means that proportion of the cash assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies or contracts of insurance written by the Company. The amount of the early access distribution shall be made pursuant to the priority of claims and early access provisions contained in Sections ______ and ______of the [domestic state] Insurance Code. The early access distribution each Participating Association shall receive shall be its pro-rata share of the assets reserved for each class in which it has qualifying claims. The early access distribution may not exceed the amount needed to pay each such claim in full for each class of claim.

1.2 Each Participating Association will be entitled to participate in and receive early access distributions from Company made by the Liquidator after the entry of an Order of Liquidation of Company in the same manner and to the same extent as may be provided to Participating Associations of other states.

1.3 Early access assets shall consist of funds received by the Participating Associations as distributions from the Liquidator classified as early access distributions or from any ancillary receiver or state insurance departments or from statutory or special deposits actually received by the guaranty association; provided such funds in each case are attributable to policies or contracts giving rise to Covered Obligations as defined above.

1.4 The reasonable expenses of the Participating Associations will be treated by the Liquidator as administrative expenses of the estate. These expenses will be advanced or reimbursed to the respective Participating Associations by the Liquidator based on the quarterly reporting by each Participating Association in accordance with Section (priority statute) of [domestic state] Insurance Code.

2. Duties of Participating Associations:

2.1 Each Participating Association, consistent with an accounting having been filed by the Liquidator and approved by the Court, will return within thirty days of Court approval to the Liquidator (or within 90 days if an assessment is required), (a) any amounts in excess of the amount ultimately determined by the Liquidation Court to be due the Participating Association, or (b) any amounts representing the proportional share of the assets disbursed by the Liquidator which may be required to make equivalent distribution to creditors of the same priority class as policyholders in the event that the Participating Association may have received a policyholder level disbursement of assets (including early access distributions) in excess of that available to pay all creditors of the insolvent insurer in the same class of priority as policyholders.

2.2 Each Participating Association will file a proof of claim either for itself or through NOLHGA as supplemented from time to time and in a form mutually agreed to by the Liquidator and the Participating Association, for all obligations of such Participating Association which are paid or otherwise discharged.

2.3 In addition to the accounting and reports required herein, each Participating Association will respond in good faith to reasonable requests for information from the Liquidator concerning the receipt and disbursement of all assets transferred under this Agreement.



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3. Duties of NOLHGA:

NOLHGA will advise the Liquidator within 30 days after the execution of this Agreement of the identities of the Participating Associations, as the same shall be determined pursuant to the rules, regulations and bylaws of NOLHGA, by preparation and delivery to the Liquidator of a list of Participating Associations, the form of which is attached as Exhibit A. Each Affected Guaranty Association not listed by NOLHGA as a Participating Association may elect to become a Participating Association at a later date by informing NOLHGA of its decision and by NOLHGA supplementing its list of Participating Associations.

4. Access to Records and Information:

Liquidator, NOLHGA and the Participating Associations mutually agree to provide each other with reasonable access to certain business records and information, as follows:

4.1 Liquidator will provide NOLHGA and the Participating Associations with reasonable access, during normal business hours, to the books, records and files of Company under the control of Liquidator and will respond affirmatively and in good faith to all reasonable requests from NOLHGA or the Participating Associations for information, files and documents pertaining to insurance coverage underwritten or reinsured by Company.

4.2 NOLHGA or its Participating Associations as appropriate will provide Liquidator with reasonable access, during normal business hours, to the books, records and files of Company, under the control of NOLHGA or the Participating Associations and will respond affirmatively and in good faith to all reasonable requests from Liquidator for information, files and documents pertaining to the adjudication, administration and payment of Covered Obligations.

4.3 On a quarterly basis, and within 45 days of the end of each calendar quarter, the Liquidator shall provide to NOLHGA or its Participating Associations a balance sheet and an income statement of Company which shall disclose the Liquidator's best estimate of the nature and amount of all remaining assets, the nature and amount of all known liabilities and classify these liabilities by priority classification, and the nature and amount of all income and disbursements for the quarter.

4.4 On a quarterly basis, and within 45 days of receiving the Company's balance sheet and income statement from the Liquidator, each Participating Association shall provide Liquidator a written report in a form mutually acceptable to Liquidator and such Participating Association, disclosing the status of the following items to the extent relevant during the reporting period: claims received and adjudicated; benefit payments made; open claim benefit payment reserve; subrogation recoveries, if any; and such other items as may reasonably be required by Liquidator. Reports shall be sent by each Participating Association to Liquidator physically or electronically at the address set forth in Section 7 of this Agreement or to such other address as Liquidator may from time-to-time designate in writing.

4.5 Liquidator shall give NOLHGA and its Participating Associations reasonable prior written notice of any hearing before the Liquidation Court requested by the Liquidator in connection with the liquidation of the Company. Said notice shall be considered supplemental to, and not in lieu of, the rights of NOLHGA and/or the Participating Associations to intervene or make an appearance.



5. Premiums:



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Premiums due for coverage for periods after the Liquidation Order Date shall belong to and be payable at the direction of each Participating Association, and shall not constitute early access distributions. Premiums due for coverage for periods prior to the Liquidation Order Date shall be assets of the estate, subject to the provisions of this Agreement and applicable law.

6. Audit:

The Liquidator shall, prior to and in connection with the final distribution of assets of this liquidation, be authorized to audit the financial accounts and records of the Participating Associations with respect to receipt of assets and early access distributions, and with respect to the payment or discharge of Covered Obligations.

7. Notice:

Any notice required or permitted under the terms of this Agreement to be given to the parties shall be deemed given if provided in writing and (i) if actually received by the intended recipient by facsimile or hand delivery or (ii) if posted by prepaid first class mail, or (iii) if consigned to and receipted by a commercial delivery service and addressed as follows:

i. If to Liquidator:

The __________ Insurance Company in Liquidation
____________________________
____________________________
____________________________

Attention:_________, Special Deputy Liquidator
Telephone:_______________
Fax:_____________________
E-mail: _______________________________

With a copy to:

_____________________
_____________________
_____________________
Telephone:_______________
Fax:_____________________
E-mail: _______________________________

ii. If to NOLHGA:

National Organization of Life and Health
Insurance Guaranty Associations
13873 Park Center Road, Suite 329
Herndon, VA 20171

***Exhibit 6-1***

Attention: Mr. Peter Gallanis, President
Telephone: 703-481-5206
Fax: 703-481-5209
E-mail: _______________________________



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7.3 If to Participating Associations:

For the address of each Participating Association, see Exhibit A.

7.4 Each Party shall be responsible for promptly notifying the others of any change of address or addressee which change shall become effective upon notice given in accordance with the terms of this Section 7.

iii. Merger and Choice of Law:

This Agreement merges all prior offers and agreements among the parties with respect to the subject matter herein and expresses the full and final intent of the parties. This Agreement shall be construed in accordance with the laws of ______ and shall not be modified except by an instrument in writing, executed by the authorized representatives of all the parties. In the event of any dispute between Liquidator, NOLHGA or any of the Participating Associations over (i) the legal obligations of the parties to each other under this Agreement or (ii) the construction of any term or provision of this Agreement, the parties hereby consent to the *in personam* jurisdiction of the Liquidation Court for the limited purpose of adjudicating said issues. This consent shall not extend to matters other than those expressly referenced in the previous sentence, nor to any creditor, policy owner, contract holder, or beneficiary of Company nor to any party who may be deemed a third party beneficiary of this Agreement.

This section shall not be construed to confer jurisdiction on the Liquidation Court to resolve coverage disputes between guaranty associations and those asserting claims against them resulting from the initiation of a receivership proceeding.

9. Termination:

This Agreement may be terminated by each Participating Association, with respect to that Participating Association only, by giving written notice in accordance with Section 7 to the Liquidator, with a copy to NOLHGA, and by returning to the Liquidator all assets, together with actual interest earned thereon, previously advanced to the Participating Association by the Liquidator under this Agreement.

10. Effective Date:

The effective date of this Agreement shall be the Contract Date.

IN WITNESS WHEREOF, this Agreement has been executed by the parties as of the first date written above.

NATIONAL ORGANIZATION OF LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATIONS

By. _____________
Peter Gallanis, President



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ATTEST:

_____________
(Print) _____________

__________, COMMISSIONER OF INSURANCE FOR THE STATE OF
__________, As Liquidator of the _________ Insurance Company.

By (Sign): _____________

_____________
Special Deputy Liquidator

ATTEST:

_____________
(Print) _____________


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**EXHIBIT A**

PARTICIPATING ASSOCIATIONS

(As of _______, 20)

in the

EARLY ACCESS AGREEMENT

By and between the

NATIONAL ORGANIZATION OF LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATIONS

And its Participating Member Guaranty Associations

And

The __________ Commissioner of Insurance As Liquidator of the

__________ Insurance Company in Liquidation

_____________ (Liquidator)

The National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) represents that, in accordance with its rules, regulations and bylaws, it is authorized to designate the following state life and health insurance guaranty associations as Participating Associations under that certain Early Access Agreement (Agreement) entered into with _______, Commissioner of Insurance for the State _____, as Liquidator of the ___ __________ Insurance Company in Liquidation; and that any notice required or permitted to be given under the Agreement to the Participating Associations shall be deemed to be given if delivered to the Participating Associations at the following addresses, in accordance with the requirements of Section 7 of the Agreement:

__________________________



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**<u>LIQUIDATOR'S PROPOSAL TO DISBURSE ASSETS</u>**

TO THE HONORABLE, THE JUDGES OF SAID COURT:

Petitioner, [NAME], Insurance Commissioner of [JURISDICTION], in her capacity as Liquidator ("Liquidator") of [INSOLVENT INSURER] (COMPANY) by her attorney, respectfully represents and proposes as follows:

1. By order dated [DATE], and effective [DATE], COMPANY was ordered liquidated, and the Insurance Commissioner of [JURISDICTION] and her successors in office were directed to take possession of the COMPANY'S property and to liquidate its business and affairs.

2. The Liquidator makes this proposal in accordance with the provisions of Section __ of the [STATUTORY REFERENCE] ("Act").

3. The purpose of this proposal is to provide to the guaranty associations and funds of the states and other jurisdictions (hereinafter "SGAs") prompt access to the assets of the COMPANY pursuant to the Act.

4. The Liquidator shall determine the market value of available liquid assets marshaled at the time of a proposed disbursement. Available liquid assets include cash; short-term investments, including without limitation U.S. Treasury bills and notes; and any other securities which are readily marketable and in the opinion of the Liquidator could be liquidated for a price deemed reasonable, and without material adverse economic impact. Available liquid assets do not include any amounts in the custody of an ancillary receiver in another jurisdiction, or any other amounts held on deposit in another jurisdiction. The Liquidator will continue to pursue reasonable efforts to marshal the assets of the COMPANY, and to invest the proceeds in a prudent manner in assets which shall constitute available liquid assets.



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[WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING] The liquid assets available as of [DATE] total $______.

5. The Liquidator shall reserve amounts for the payment in full of the estimated expenses of administration through conclusion of the liquidation of the COMPANY. To the extent deemed feasible and reasonably prudent by the Liquidator, a portion of such reserves may be provided for out of non-liquid assets. [WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING]. Such reserves as of [DATE] are $______ of which $______ constitutes non-liquid assets.

6. The Liquidator shall reserve amounts for the payment in full of claims falling within the priorities established in Section ____ of the Act for claims higher than the priority for policyholder claims. To the extent deemed feasible and reasonably prudent by the Liquidator, a portion of such reserve may be provided for out of non-liquid assets. [WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING]. Such reserves as of [DATE] are $____ of which $_______ constitutes non-liquid assets.

7. The Liquidator shall reserve amounts for the payment of the estimated percentage distribution on claims falling within the priority established by Section ___ of the Act for policy claims, other than amounts for the payment of claims of SGAs. To the extent deemed feasible and reasonably prudent, a portion of such reserves may be provided for out of non-liquid assets. [WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING]. Such reserves as of [DATE] are $____ of which $______ constitutes non-liquid assets.



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8. The Liquidator shall disburse to SGAs amounts equal to the payments made or to be made by the SGAs for which the SGAs could assert claims against the Liquidator, including claims on account of claims payments and administrative expenses, provided that if assets available for disbursement to SGAs

from time to time do not equal the amounts of such payments made or to be made by the SGAs, then disbursements shall be in the amount of liquid assets available after providing for reserves pursuant to Sections 5, 6 and 7 above. The Liquidator proposes to make an initial disbursement to SGAs on or about [DATE]. The Liquidator shall make additional disbursements to SGAs from time to time as assets become available but not less frequently than annually.

9. The amount determined pursuant to Section 8 above shall be disbursed among the SGAs as follows:

I. Administrative expense payments reported by each SGA to the liquidator will be paid in full.

II. The amount to be disbursed pursuant to Section 9 i. Above shall be deducted from the amount determined pursuant to Section 8 above, and the balance shall be disbursed as follows:

   i. The total amount of loss payments reported to the Liquidator by the SGAs shall be determined.

   ii. The loss payments reported to the Liquidator by each SGA shall be determined.

   iii. From the amounts reported in Section 9 II.ii. above shall be subtracted any amounts recovered (or projected to be recovered) by

   such SGA from salvage, subrogation and second injury funds, attributable to the payments reported in Section 9 II.ii. above.



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iv. From the amounts determined in Section 9 II.ii. above shall be subtracted any amounts previously paid to such SGA from the liquidation of deposits or other assets of the COMPANY located in the jurisdiction of such SGA.

v. A distribution percentage will be determined for each SGA by dividing:

(x) the excess (if any) of the amount in Section 9 II.ii. over the amounts in Sections 9 II.iii. and 9 II.iv. for each SGA, by

(y) the sum of the amounts determined in (x) above for all SGAs.

vi. Each SGA's share of the disbursement shall be determined by applying the percentages expressed in Section 9 II.v. above, to the amount calculated in Section 8 above.

10. Prior to receiving any disbursement from the Liquidator, an SGA will be required to execute a refunding agreement in the form of Exhibit A hereto agreeing to return to the Liquidator any funds received as described above in Section 9 in excess of such SGA's share of the assets of the COMPANY under the Act as finally determined. WHEREFORE, the Liquidator prays your Honorable Court that:

1. The SGAs in and the Commissioner of Insurance of each of the states be served with notice of this Liquidator's Proposal to Disburse Assets and attached Refunding Agreement.



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2. The Court set a date more than __ days after the date of this petition for a hearing on this petition and that after such hearing the Court approve the Liquidator's Proposal and attached Refunding Agreement.

3. The Liquidator be authorized to distribute [amount] to the SGAs pursuant to the Liquidator's Proposal To Disburse Assets upon the execution of a Refunding Agreement by the SGA receiving a disbursement.

Respectfully submitted,

_______________________________

Liquidator of __________________



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**REFUNDING AGREEMENT**

This Refunding Agreement ("Agreement") is entered into this _____ day of _________, ____, by and between ________, Insurance Commissioner of [JURISDICTION] (the "Commissioner") in her capacity as Liquidator (the "Liquidator") of _____________ ("COMPANY") and the undersigned insurance guaranty association or fund (hereinafter "SGA"):

**RECITALS**

A. On _________, the ________ court (the "court") entered an order of liquidation (the "liquidation order") of the COMPANY declaring the COMPANY insolvent and directing that the COMPANY be liquidated. The Court also appointed the commissioner and her successors in office, the liquidator of the COMPANY.

B. By reason of the Liquidation Order subject to the provisions of the statute under which it is organized, the SGA has certain obligations with respect to certain claims arising under certain policies issued by the COMPANY.

C. On ______, the Liquidator filed with the court her proposal to disburse assets ("Liquidator's Proposal"), which contained the Liquidator's request for authorization to make disbursements to various state insurance guaranty associations and funds from assets of the COMPANY. This form of Agreement was referenced in the Liquidator's Proposal. The Liquidator's Proposal and this form of Agreement were approved by the court on ______.



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***Exhibit 6-3***

## AGREEMENTS

The Liquidator and the SGA, in consideration of the mutual benefits and promises received by the parties hereto and the mutual covenants and agreements contained herein, and intending to be legally bound hereby agree that the recitals set forth above are hereby adopted and made a part of this Agreement and further agree to the following terms and conditions:

1. Any disbursements made by the Liquidator pursuant to the Liquidator's Proposal will be treated as disbursements to the SGA in accordance with Section ___ of the Act.

2. The SGA will be entitled to receive in accordance with Section ___ of the Act, any disbursement from the COMPANY'S assets made by the Liquidator in the same manner and to the same extent as may be provided to insurance guaranty associations or funds of other jurisdictions, provided, however, that nothing in this paragraph 2 shall be construed to indicate that a subrogation collection or deductible reimbursement amount related to a covered claim paid by the SGA is a disbursement pursuant to such Section.

3. The Liquidator and the SGA agree to provide each other with reasonable access to certain business records and information, as follows:

The Liquidator will provide the SGA with access, during normal business hours, to the books, records and files of the COMPANY held by the Liquidator and will respond affirmatively and in good faith to all reasonable requests from the SGA for information, files and documents pertaining to the SGA's performance of its statutory obligations including information, files and documents pertaining to insurance coverages issued by the COMPANY, claims against the COMPANY and unearned premiums on each in-force policy of the COMPANY.


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The SGA will provide the Liquidator with access, during normal business hours, to the books, records and files of the COMPANY held by the SGA and will respond affirmatively and in good faith to all reasonable requests from the Liquidator for information, files and documents pertaining to the adjudication, administration and payment of covered claims by the SGA. At least once each quarter, the SGA will provide the Liquidator with management reports in accordance with the UDS reporting format and such other information as may reasonably be requested by the Liquidator. Reports shall be provided by the SGA to the Liquidator at the address set forth in section 10 of this Agreement or to such other address as the Liquidator may from time to time designate in writing.

4. All rights of the COMPANY in net salvage and subrogation recovery and collection in connection with losses paid by the SGA to the extent such rights exist, will be retained and accounted for by the SGA. Any portion of salvage and subrogation received by the SGA in connection with losses paid by the COMPANY prior to the date of the Liquidation Order shall be sent by the SGA to the Liquidator on a quarterly basis.

5. The SGA will, within 30 days after receipt of a written request from the Liquidator, or within ninety (90) days after such request is made if it is necessary for the SGA to make an assessment, return to the Liquidator any disbursements made pursuant to the Liquidator's Proposal (a) in excess of the amount finally determined to be due the SGA from the assets of the COMPANY, (b) if necessary to pay claims of secured creditors or claims of a higher priority than or equal to the SGA's claims under Section ___ of the Act.

6. The SGA will be permitted to file with the Liquidator an omnibus proof of claim, as supplemented from time to time and in a form mutually agreed to by the Liquidator and the SGA, for all amounts paid or to be paid by the SGA.


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7. The Liquidator and the SGA shall cooperate in making arrangement for the final disposition of the information, files and documents received by the SGA from the COMPANY or the Liquidator.

8. This Agreement shall be governed by and construed in accordance with the law of [JURISDICTION], but without regard to its choice of law rules. The SGA agrees to submit to the exclusive jurisdiction of the court solely with respect to the enforcement of this Agreement or any issue or dispute arising out of this Agreement. However, nothing in this Agreement or the Liquidator's Proposal is intended to affect the proper venue or forum for any action arising out of or relating to any other matter or controversy, nor shall the fact that the SGA agreed to the Liquidator's Proposal or executed this Agreement be used for purposes of arguing the proper venue or forum of any such action.

9. Any notices and all other matters of communications from the Liquidator to the SGA concerning this Agreement shall be sent by first-class United States mail, postage prepaid, or by overnight delivery service or facsimile transmission to the SGA addressed as follows:

[address]

10. Any notices and all other matters of communication from the SGA to the Liquidator concerning this Agreement shall be sent by first-class United States mail, postage prepaid, or by overnight delivery service or by facsimile transmission to the Liquidator addressed as follows:

[address]

11. Each party shall pay all of its own costs, fees and expenses incurred in negotiating and preparing this Agreement and in closing and carrying out the transactions contemplated by this Agreement, provided, however, that the expenses of the SGA shall be treated by the Liquidator as administrative expenses.

***Exhibit 6-3***



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12. This Agreement merges all prior offers and agreements of every kind and expresses the full and final intent of the parties. This Agreement shall not be modified except by an instrument in writing, executed by the authorized representatives of each of the parties.

13. The execution of this Agreement by the SGA, and the acceptance by the SGA of any amount distributed pursuant to the Liquidator's Proposal, shall be without prejudice to the SGA's rights with respect to final or other distributions from the estate of the COMPANY. Without limiting the generality of the foregoing, the SGA reserves its rights to assert whatever claim the SGA deems appropriate with respect to the composition of and priority to be afforded to the SGA's claim for its payment of losses, expenses or other amounts, and its rights with respect to any issues relating to what assets constitute the assets of the estate or otherwise relating to the COMPANY.

WHEREFORE, this Agreement is executed by the parties' duly authorized representatives as of the day first written above.

______________________________

[Liquidator]

By: ___________________________

______________________________

SGA

By: ___________________________



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## LARGE DEDUCTIBLE—SAMPLE STATE CODES

***Please note, these examples were current at the time of writing this Handbook. As codes are constantly changing, you should confirm the current version.***

**Illinois Insurance Code**
REGULATION ... CHAPTER 215 INSURANCE ... ACT 5. ILLINOIS INSURANCE CODE
Article XIII—REHABILITATION, LIQUIDATION, CONSERVATION AND DISSOLUTION OF COMPANIES
215 ILCS 5/205.1
Policyholder collateral, deductible reimbursements and other policyholder obligations.

(a) Any collateral held by, for the benefit of, or assigned to the insurer or the Director as rehabilitator or liquidator to secure the obligations of a policyholder under a deductible agreement shall not be considered an asset of the estate and shall be maintained and administered by the Director as rehabilitator or liquidator as provided in this Section and notwithstanding any other provision of law or contract to the contrary.

(b) If the collateral is being held by, for the benefit of, or assigned to the insurer or subsequently the Director as rehabilitator or liquidator to secure obligations under a deductible agreement with a policyholder, subject to the provisions of this Section, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association or the Illinois Insurance Guaranty Fund and the policyholder is unwilling or unable to take over the handling and payment of the noncovered claims, the Director as rehabilitator or liquidator shall adjust and pay the noncovered claims utilizing the collateral but only to the extent the available collateral after allocation under subsection (d), is sufficient to pay all outstanding and anticipated claims. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all reasonable means of collection against the insured have been exhausted, the Director's obligation to pay such claims from the collateral as the rehabilitator or liquidator terminates, and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions in this Article for the filing and allowance of such claims. When the liquidator determines that the collateral is insufficient to pay all additional and anticipated claims, the liquidator may file a plan for equitably allocating the collateral among claimants, subject to court approval.

(d) To the extent that the Director as rehabilitator or liquidator is holding collateral provided by a policyholder that was obtained to secure a deductible agreement and to secure other obligations of the policyholder to pay the insurer directly or indirectly, amounts that become assets of the estate, such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the Director as rehabilitator or liquidator shall equitably allocate the collateral among such obligations and administer the collateral allocated to the deductible agreement pursuant to this Section. With respect to the collateral allocated to obligations under the deductible agreement, if the


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collateral secured reimbursement obligations under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The Director as rehabilitator or liquidator shall inform the guaranty association or the Illinois Insurance Guaranty Fund that is or may be obligated for claims against the insurer of the method and details of all the foregoing allocations.

(e) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement, either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third party administrator who administers the claims, the Director as rehabilitator or liquidator shall allow such funding arrangement to continue and, where applicable, will enforce such arrangements to the fullest extent possible. The funding of such claims by the policyholder within the deductible amount will act as a bar to any claim for such amount in the liquidation proceeding, including, but not limited to, any such claim by the policyholder or the third party claimant. The funding will extinguish both the obligation, if any, of any guaranty association or the Illinois Insurance Guaranty Fund to pay such claims within the deductible amount, as well as the obligations, if any, of the policyholder or third party administrator to reimburse the guaranty association or the Illinois Insurance Guaranty Fund. No charge of any kind shall be made by the Director as rehabilitator or liquidator against any guaranty association or the Illinois Insurance Guaranty Fund on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subsection.

(f) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association or the Illinois Insurance Guaranty Fund is required by applicable state law to pay any claims for which the insurer would be or would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by a policyholder or third party, the Director as rehabilitator or liquidator shall promptly bill the policyholder for such reimbursement and the policyholder will be obligated to pay such amount to the Director as rehabilitator or liquidator for the benefit of the guaranty association or the Illinois Insurance Guaranty Fund that paid such claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, shall be a defense to the policyholder's reimbursement obligation under the deductible agreement. When the policyholder reimbursements are collected, the Director as rehabilitator or liquidator shall promptly reimburse the guaranty association or the Illinois Insurance Guaranty Fund for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within 60 days after such bill for such reimbursements is due, the Director as rehabilitator or liquidator shall use the collateral to the extent necessary to reimburse the guaranty association or the Illinois Insurance Guaranty Fund, and at the same time, may pursue other collections efforts against the policyholder. If more than one guaranty association or the Illinois Insurance Guaranty Fund has a claim against the same collateral and the available collateral (after allocation under subsection (d)), along with billing and collection efforts, are together insufficient to pay each guaranty association or the Illinois Insurance Guaranty Fund in full, then the Director as rehabilitator or liquidator will pro-rate payments to each guaranty association or the Illinois Insurance Guaranty Fund based upon the relationship the amount of claims each guaranty association or the Illinois Insurance Guaranty Fund has paid bears to the total of all claims paid by such guaranty association or the Illinois Insurance Guaranty Fund.

***Exhibit 6-4***

(g) Director's duties and powers as rehabilitator or liquidator.



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(1) The Director as rehabilitator or liquidator is entitled to deduct from reimbursements owed to guaranty associations or the Illinois Insurance Guaranty Fund or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this provision, not to exceed 3% of the collateral or the total deductible reimbursements actually collected by the Director as rehabilitator or liquidator.

(2) With respect to claim payments made by any guaranty association or the Illinois Insurance Guaranty Fund, the Director as rehabilitator or liquidator shall promptly provide the court with a copy of the guaranty associations, or the Illinois Insurance Guaranty Fund with a complete report of the Director's deductible billing and collection activities as rehabilitator or liquidator including copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each policyholder and any proration of payments when it occurs. If the Director as rehabilitator or liquidator fails to make a good faith effort within 120 days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations or the Illinois Insurance Guaranty Fund, then after such 120 day period such guaranty associations or the Illinois Insurance Guaranty Fund may pursue collection from the policyholders directly on the same basis as the Director as rehabilitator or liquidator, and with the same rights and remedies, and will report any amounts so collected from each policyholder to the Director as rehabilitator, liquidator, or conservator. To the extent that guaranty associations or the Illinois Insurance Guaranty Fund pay claims within the deductible amount, but are not reimbursed by either the Director as rehabilitator, liquidator, or conservator under this Section or by policyholder payments from the guaranty associations' or the Illinois Insurance Guaranty Fund's own collection efforts, the guaranty association or the Illinois Insurance Guaranty Fund shall have a claim in the insolvent insurer's estate for such unreimbursed claims payments.

(3) The Director as rehabilitator or liquidator shall periodically adjust the collateral being held as the claims subject to the deductible agreement are run-off, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and the Director as rehabilitator or liquidator shall not be required to adjust the collateral more than once a year. The guaranty associations or the Illinois Insurance Guaranty Fund shall be informed of all such collateral reviews including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the Director as rehabilitator or liquidator is satisfied that no new claims can be presented, the Director as rehabilitator or liquidator will release any remaining collateral to the policyholder.

(h) The Illinois Circuit Court having jurisdiction over the liquidation proceedings shall have jurisdiction to resolve disputes arising under this provision.

(i) Nothing in this section is intended to limit or adversely affect any right the guaranty associations or the Illinois Insurance Guaranty Fund may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by such guaranty associations or the Illinois Insurance Guaranty Fund under policies of the insolvent insurer, or for related expenses that the guaranty associations or the Illinois Insurance Guaranty Fund incur.

***Exhibit 6-4***



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(j) This section applies to all receivership proceedings under Article XIII* that either (1) commence on or after the effective date of this amendatory Act of the 93rd General Assembly or (2) are on file or open on the effective date of this amendatory Act of the 93rd General Assembly and in which an Order of Liquidation is entered on or after May 1, 2004. However, this Section applies to rehabilitation proceedings only to the extent that guaranty associations are required to pay claims and does not apply to receivership proceedings in which an order of conservation has been entered.

(k) For purposes of this section, a "deductible agreement" is any combination of one or more policies, endorsements, contracts, or security agreements, which provide for the policyholder to bear the risk of loss within a specified amount per claim or occurrence covered under a policy of insurance, and may be subject to the aggregate limit of policyholder reimbursement obligations. This section shall not apply to first party claims, or to claims funded by a guaranty association or the Illinois Insurance Guaranty Fund in excess of the deductible unless subsection (e) above applies. The term "non-covered claim" shall mean a claim that is subject to a deductible agreement and is not covered by a guaranty association or the Illinois Insurance Guaranty Fund.

*215 ILCS 5/187 et seq.



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**Pennsylvania Insurance Code**

BOOK I. UNCONSOLIDATED STATUTES ... TITLE 40—INSURANCE ... Chapter 11—REHABILITATION AND LIQUIDATION ... Part 4. Formal Proceedings: Liquidation—Powers and Duties of Liquidators and Others
40-11-405.1
Deductible reimbursement agreements; collateral; obligations of policyholders and receivers

(a) Collateral shall not be considered an asset of the estate and shall be maintained and administered by the receiver as provided in this section, notwithstanding any other provision of law or contract to the contrary.

(b) Subject to the provisions of this section, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association and the policyholder is unwilling or unable to take over the handling and payment of the non-covered claims, the receiver shall adjust and pay the non-covered claims utilizing the collateral but only to the extent the available collateral, after allocation under subsection (d), is sufficient to pay all outstanding and anticipated claims. A claim against the collateral by a third-party claimant is not a claim against the insolvent insurer's estate for the purposes of releasing the policyholder to the extent of applicable policy coverage. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all collection means against the insured have been exhausted, the receiver's obligation to pay such claims from the collateral terminates and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions of this article for the filing and allowance of claims. When the liquidator determines that the collateral provided by the insured is insufficient to pay all additional and anticipated claims against the insured, the liquidator may file a plan for equitably allocating the collateral among claimants of the insured which provided the collateral, subject to court approval.

(d) To the extent that the receiver is holding collateral that secures other obligations of the policyholder to pay the insurer directly or indirectly amounts that will become assets of the estate, such as reinsurance obligations under a captive reinsurance program or premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the receiver shall equitably allocate the collateral among such obligations and administer the collateral allocated to the deductible agreement pursuant to this section. With respect to the collateral allocated to obligations under the deductible agreement, if the collateral secured reimbursement obligations are under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The receiver shall inform the guaranty associations of the method and details of all the foregoing allocations.

(e) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement, either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third party administrator who administers the claims, the receiver shall allow such funding arrangement to continue and, where applicable, will enforce such arrangements to the fullest


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extent possible. The funding of such claims by the policyholder within the deductible amount will act as a bar to a claim for such amount in the liquidation proceeding including, but not limited to, a claim by the policyholder or the third party claimant. The funding will extinguish both the obligation, if any, of any guaranty association to pay such claims within the deductible amount, as well as the obligation, if any, of the policyholder or the third-party administrator to reimburse the guaranty association. No charge of any kind shall be made against a guaranty association on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subsection.

(f) (1) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall promptly bill the policyholder for such reimbursement and the policyholder will be obligated to pay such amount to the receiver for the benefit of the guaranty associations who paid such claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, shall be a defense to the policyholder's reimbursements obligation under the deductible agreement. When the policyholder reimbursements are collected, the receiver shall promptly reimburse such guaranty association for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within 60 days after such bill for reimbursements is due, the receiver shall use the collateral to the extent necessary to reimburse the guaranty association, and, at the same time, may pursue other collections efforts against the policyholder. If the policyholder reimbursements are not collected due to the reduction in such reimbursements as provided in paragraph (2), the receiver shall nonetheless reimburse such guaranty association as if such reimbursements had been collected. The receiver will obtain funds to reimburse a guaranty association claim affected by paragraph (2) by subtracting from funds collected by the receiver for other policyholder claim reimbursements under this paragraph amounts sufficient to reimburse the guaranty association affected by the application of paragraph (2). Subtraction of funds shall be made against all guaranty associations, including the guaranty association affected by paragraph (2) on the basis of the ratio stated in paragraph (3). If more than one guaranty association has a claim against the same collateral and the available collateral, after allocation under subsection (d), along with billing and collection efforts, are together insufficient to pay each guaranty association in full, then the receiver will prorate payments to each guaranty association based upon the proportion of the amount of claims each guaranty association has paid bears to the total of all claims paid by such guaranty associations.

(2) The obligation of a policyholder arising solely from a deductible agreement to reimburse the receiver for the benefit of one or more guaranty associations under paragraph (1) for losses paid by one or more guaranty associations shall be reduced by the amount of premium paid by or on behalf of the policyholder for one or more policies issued by a wholly owned affiliate or subsidiary of the insurer, which affiliate or subsidiary was either licensed to do business in this Commonwealth or was an eligible surplus lines insurer under Article XVI of the act of May 17, 1921 (P.L. 682, No. 284), known as "The Insurance Company Law of 1921," at the time of the issuance of such policies, where such policies were purchased to fund the policyholder's obligation to reimburse the insurer for deductibles under the deductible agreement, but in no event shall the reduction in liability be less than 90% of the total premiums paid to the insurer

***Exhibit 6-4***



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and such affiliate or subsidiary for such policies and coverage provided under the related deductible agreement, provided that the policyholder's reimbursement obligation shall be reduced only if: (i) the wholly owned affiliate or subsidiary was merged into the insurer that was a party to the deductible agreement before the entry of a liquidation order against the insurer; (ii) the merger was approved by the commissioner; and (iii) the merger took place before the enactment of this section.

(3) The reduction as a result of paragraph (2) in the amount of deductible reimbursements that one or more guaranty associations would have been entitled to claim from a policyholder of the insurer under paragraph (1) shall be allocated by the receiver pursuant to this paragraph pro rata among all guaranty associations receiving deductible reimbursements under paragraph (1). The pro rata allocation among guaranty associations shall be based upon the ratio of:

(i) claims paid and to be paid as estimated by each guaranty association that are referred to in paragraph (1) to (ii) the total amount of claims paid and to be paid estimated by all the guaranty associations that are referred to in paragraph (1). Amounts used for the pro rata allocation shall be determined after giving effect to the provisions referred to in subsection (k) relating to insured net worth.

(4) Any claim of the policyholder under one or more policies issued by the affiliate or subsidiary as described in paragraph (2) is hereby waived except for those claims under policies that are not paid by a guaranty association as a covered claim or amounts the policyholder has reimbursed a guaranty association under Article XVIII of "The Insurance Company Law of 1921" or similar laws in other states.

(g) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall first make a good faith attempt to recover reimbursements or collateral under the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall by payable to the guaranty associations to the extent of claims paid within the deductible. To the extent the receiver is unable in whole or in part to recover first under the deductible reimbursement policy for claims paid by the guaranty associations, the receiver shall promptly bill the policyholder for the reimbursement and the policyholder will be obligated to pay the amount to the receiver for the benefit of the guaranty associations who paid the claims. The policyholder shall retain any and all defenses that may be asserted in connection with the receiver's efforts to collect reimbursements from the policyholder.

(h) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present and if a guaranty association is not paying claims for any reason for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy, to the extent claims covered under a deductible reimbursement policy have been paid by the policyholder and sufficient information on the payments has been provided by the policyholder to the receiver for purposes of billing under the deductible reimbursement policy, the receiver shall make a good faith attempt to recover reimbursements or collateral under the deductible



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reimbursement policy from the insurer of the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall be payable to the policyholder.

(i) Receiver's duties and powers:

(1) The receiver is entitled to deduct from reimbursements owed to guaranty associations and/or policyholders under this section or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this provision, not to exceed three per centum of the collateral or the total deductible reimbursements actually collected by the receiver.

(2) With respect to claim payments made by any guaranty associations, the receiver shall promptly provide the guaranty associations with a complete accounting of the receiver's deductible billing and collection activities, including, but not limited to, copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each account, and any proration of payments when it occurs. The receiver's costs of accounting shall be included with expenses referred to under this subsection and, together with other reasonable actual expenses, be subject to the overall limit called for by this subsection. If the receiver fails to make a good faith effort within one hundred twenty days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations, then after such one hundred twenty day period such guaranty associations may pursue collection from the policyholders directly on the same basis as the receiver, and with the same rights and remedies, and will report any amounts so collected from each policyholder to the receiver. To the extent that guaranty associations pay claims within the deductible amount, but are not reimbursed by either the receiver under this section or by policyholder payments from the guaranty association's own collection efforts, the guaranty association shall have a claim in the insolvent insurer's estate for such unreimbursed claims payments.

(3) The receiver shall periodically adjust the collateral being held while the claims subject to the deductible agreement are run off, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and the receiver shall not be required to adjust the collateral more than once a year. The guaranty associations and the policyholder shall be informed of all such collateral reviews, including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims can be presented, the receiver will release any remaining collateral to the policyholder.

(j) The Commonwealth Court shall have jurisdiction to resolve disputes arising under this section.

(k) Nothing in this section is intended to limit or adversely affect any right the guaranty associations may have under applicable State law to obtain reimbursement from certain classes of policyholders for claims payments made by such guaranty associations under policies of the insolvent insurer, or for related expenses the guaranty associations incur.

(l) This provision will apply to all delinquency proceedings which are open and pending as of the effective date of this provision.

***Exhibit 6-4***



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(m) This section shall not apply to first party claims, or to claims funded by a guaranty association net of the deductible unless subsection (e) applies.

(n) For purposes of this section, the following terms shall have the meanings given to them in this subsection:

> "Collateral" shall mean collateral held by, for the benefit of or assigned to the insurer or subsequently to the receiver in order to secure the obligations of a policyholder under a deductible agreement and also any collateral recovered or held by the receiver that secured the obligations of a policyholder under a deductible reimbursement policy.
>
> "Deductible agreement" shall include any combination of one or more policies, endorsements, contracts or security agreements which provide for the policyholder to bear the risk of loss within a specified amount per each claim or occurrence covered under a policy of insurance and may be subject to aggregate limit of policyholder reimbursement obligations as set forth in an endorsement to a policy or in a program agreement.
>
> "Deductible reimbursement policy" shall mean a policy other than one referred to in subsection (f)(2), purchased by the policyholder to secure the policyholder's obligation to reimburse the insurer for deductibles under the deductible agreement.
>
> "Non-covered claims" shall mean a claim that is subject to a deductible agreement, may be secured by collateral and is not covered by a guaranty association.



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**California Insurance Code**

1033.5. (a) The purpose of this section is to clarify the rights and obligations of policyholders, claimants, guaranty funds, including the California Insurance Guarantee Association, and the liquidator with respect to a deductible agreement entered into between a policyholder and an insurer subject to liquidation proceedings under this article. These arrangements are commonly referred to as "large deductible" policies or programs, even though the actual amount of the deductible can vary significantly and may not be in fact large in amount. Deductible amounts under these arrangements may vary from as little as $5,000 to as much as $1,000,000 or more. This section shall be construed such that the claim payment obligations of the guaranty associations, including the California Insurance Guarantee Association, in total arising from deductible agreements will be substantially equivalent to those of the insurer, except as provided otherwise in each guaranty association's enabling statute, including that of the California Insurance Guarantee Association, had the insurer continued in business and not become subject to a liquidation proceeding.

(b) Notwithstanding any other provision of law or contract to the contrary, any collateral held by or for the benefit of, or assigned to, the insurer or the liquidator to secure the obligations of a policyholder under a deductible agreement and any reimbursement payments to the liquidator under a deductible agreement shall be considered property of the liquidated company, but shall not be general assets of the liquidated company. The liquidator shall maintain, administer and distribute all such collateral and deductible reimbursement payments only as provided in this section.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by a guaranty association or the California Insurance Guarantee Association and the policyholder is unwilling or unable to take over the handling and payment of the noncovered claims, the liquidator shall adjust and pay the noncovered claims utilizing the collateral, but only to the extent the available collateral, after allocation under subdivision (d), is sufficient to pay all outstanding and anticipated claims. If the collateral is exhausted and the policyholder is not able to provide funds to pay the remaining claims within the deductible after all reasonable means of collection against the policyholder have been exhausted, the remaining claims shall be claims against the insurer's estate, subject to the other provisions of this article regarding the filing and allowance of claims. When the liquidator determines that the collateral is insufficient to pay all additional and anticipated claims, the liquidator may file a plan for equitably allocating the collateral among claimants, subject to court approval.

(d) (1) To the extent that the liquidator holds collateral provided by a policyholder that was obtained to secure a deductible agreement and to secure other obligations of the policyholder to pay the insurer, directly or indirectly, amounts that become assets of the estate, such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy or where the premium due is subject to adjustment based upon actual loss experience, the liquidator shall equitably allocate the collateral among those obligations and administer the collateral allocated to the deductible agreement pursuant to this section.

(2) With respect to the collateral allocated to obligations under the deductible agreement, if the collateral secured reimbursement obligations under more than one line of insurance, then the



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collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line.

(3) The liquidator shall inform the guaranty associations or the California Insurance Guarantee Association that is or may be obligated for claims against the insurer of the method and details of each allocation made pursuant to this subdivision.

(4) The liquidator shall be entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements under this section.

(e) (1) Regardless of whether there is collateral, if the insolvent insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement, either through the policyholder's own administration of its claims or through its provision of funds directly to a third-party administrator who administers the claims, the liquidator shall allow the funding arrangement to continue and, where applicable, shall enforce the arrangement to the fullest extent possible. The funding of any of these claims by the policyholder within the deductible amount, including, but not limited to, any of these claims by the policyholder or the third-party claimant, shall bar a claim for that amount in the liquidation proceeding.

(2) The funding of claims pursuant to paragraph (1) shall extinguish the obligation, if any, of a guaranty association or the California Insurance Guarantee Association to pay the claims within the deductible amount, as well as the obligation, if any, of the policyholder or third-party administrator to reimburse the guaranty association or the California Insurance Guarantee Association. No charge of any kind shall be made by the liquidator against any guaranty association or the California Insurance Guarantee Association on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subdivision. The funding of these claims by the policyholders shall not limit or prejudice any right the guaranty association or the California Insurance Guarantee Association may have with respect to these claims under state law. Any policyholder that funds its own claims under the provisions of this subdivision shall provide to the guaranty association or to the California Insurance Guarantee Association all relevant information concerning the claim whenever the policyholder's reserved liability for the claim equals or exceeds 50 percent of the deductible amount on the claim.

(f) (1) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association or the California Insurance Guarantee Association is required by applicable state law to pay any claims for which the insurer would be or would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement, and to the extent the claims have not been paid by a policyholder or third party, the liquidator shall promptly bill the policyholder for the reimbursement. The policyholder shall pay that amount to the liquidator for the benefit of the California Insurance Guarantee Association or the guaranty association that paid the claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, shall be a defense to the policyholder's reimbursement obligation under the deductible agreement.

***Exhibit 6-4***



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(2) When the policyholder reimbursements pursuant to paragraph (1) are collected, the liquidator shall promptly reimburse the guaranty association or the California Insurance Guarantee Association for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within 60 days after the bill for the reimbursements is due, the liquidator shall use the collateral to the extent necessary to reimburse the guaranty association or the California Insurance Guarantee Association, and, at the same time, may pursue other collections efforts against the policyholder. If more than one guaranty association or the California Insurance Guarantee Association has a claim against the same collateral, and the available collateral, after allocation under subdivision (d), along with billing and collection efforts, are together insufficient to pay each guaranty association or the California Insurance Guarantee Association in full, then the liquidator shall prorate payments to each guaranty association or the California Insurance Guarantee Association based upon the relationship the amount of claims each guaranty association or the California Insurance Guarantee Association has paid bears to the total of all claims paid by the guaranty association or the California Insurance Guarantee Association.

(g) (1) With respect to claim payments made by any guaranty association or the California Insurance Guarantee Association, the liquidator shall promptly provide the court with a copy to the guaranty association or the California Insurance Guarantee Association, with a complete report of the liquidator's deductible billing and collection activities, including copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each policyholder and any proration of payments when it occurs. If the liquidator fails to make a good faith effort, within 120 days of receiving a claims payment report, to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations or the California Insurance Guarantee Association, then the guaranty association or the California Insurance Guarantee Association may pursue collection from the policyholders directly on the same basis as the liquidator, and with the same rights and remedies, and shall report any amounts so collected from each policyholder to the liquidator. To the extent that the guaranty association or the California Insurance Guarantee Association pays claims within the deductible amount, but is not reimbursed by the liquidator under this section or by policyholder payments from the collection efforts of the guaranty association or the California Insurance Guarantee Association, the guaranty association or the California Insurance Guarantee Association shall have a claim against the insolvent insurer's estate for the unreimbursed claims payments.

(2) The liquidator shall periodically adjust the collateral being held as the claims subject to the deductible agreement are satisfied, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and provided further that the liquidator shall not be required to adjust the collateral more than once a year. The guaranty associations or the California Insurance Guarantee Association shall be informed of any collateral adjustment, including but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the liquidator is satisfied that no new claims can be presented, the liquidator shall release any remaining collateral to the policyholder.

***Exhibit 6-4***



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(h) The court having jurisdiction over the liquidation proceedings shall have jurisdiction to resolve disputes arising under this provision.

(i) Nothing in this section is intended to limit or adversely affect any right a guaranty association or the California Insurance Guarantee Association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association or the California Insurance Guarantee Association under policies of the insolvent insurer, or for related expenses the guaranty association or the California Insurance Guarantee Association incur.

(j) This section shall apply only with respect to insolvencies occurring on or after January 1, 2006.

(k) For purposes of this section, the following definitions apply:

(1) "Collateral" means any form of security held to secure the obligations of a policyholder under a deductible agreement with an insurer subject to an order of liquidation under this article.

(2) "Deductible agreement" means any policy, endorsement, contract, or security agreement, or a combination of any of those items, that provides for the policyholder to bear the risk of loss within a specified amount per claim or occurrence covered under a policy of insurance, and may be subject to the aggregate limit of policyholder reimbursement obligations.

(3) "Noncovered claim" means a claim that is subject to a deductible agreement and is not covered by a guaranty association or the California Insurance Guarantee Association.

(l) This section shall apply to claims funded by a guaranty association or the California Insurance Guarantee Association in excess of the deductible only if subdivision (e) is applicable.



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**Texas Insurance Code**

§ 443.213. Administration of Deductible Agreements and Policyholder Collateral

(a) Any collateral held to secure the obligations of a policyholder under a deductible agreement with an insurer subject to a delinquency proceeding under this chapter must be maintained and administered as provided in this section. For purposes of this section, a "deductible agreement" is any combination of one or more policies, endorsements, contracts, or security agreements that:

(1) provide for the policyholder to bear the risk of loss within a specified amount per claim or occurrence covered under a policy of insurance; and

(2) may be subject to an aggregate limit of policyholder reimbursement obligations.

(b) This section applies to any collateral described by Subsection (a), regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer under a deductible agreement. The collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payments within the agreed deductible amount, subject to this section.

(c) If the contract between the policyholder and the insurer allows the policyholder to fund claims within the deductible amount through a third-party administrator or otherwise, the receiver shall allow that funding arrangement to continue, except as prohibited by Title 5, Labor Code. If a policyholder funds claims within the deductible amount, the receiver or any guaranty association has no obligation to pay claims for the amount funded by the policyholder, and the policyholder or its third-party administrator is not obligated to reimburse a guaranty association for any amount funded. A charge of any kind may not be made against a guaranty association based on the funding of claims payments by a policyholder under this subsection.

(d) If the receiver is holding collateral provided by a policyholder to secure both a deductible agreement and other obligations of the policyholder, the receiver shall:

(1) allocate the collateral among these obligations in accordance with the deductible agreement; or

(2) in the absence of an allocation provision in the deductible agreement and with the approval of the receivership court, allocate the collateral equitably among these obligations.

(e) If, under Subsection (d), the collateral secures reimbursement obligations under more than one line of insurance, the receiver shall equitably allocate the collateral among the various lines based on the estimated ultimate exposure within the deductible amount for each line.

(f) If a guaranty association is obligated to pay claims under a policy under Subsection (d), the receiver shall give notice to the guaranty associations of any allocation under this section.

(g) Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims may be presented, the receiver shall release any remaining collateral to the policyholder in accordance with the provisions of the contract and of this chapter.

(h) To the extent a guaranty association is required by applicable law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder, the following provisions apply:



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(1) The receiver shall promptly invoice the policyholder for the reimbursement due under the agreement, and the policyholder is obligated to pay the amount invoiced to the receiver for the benefit of the guaranty associations that paid the claims. Neither the insolvency of the insurer nor the insurer's inability to perform any obligations under the deductible agreement is a defense to the policyholder's reimbursement obligation under the deductible agreement. At the time the policyholder reimbursements are collected, the receiver shall promptly forward those amounts to the guaranty association, based on the claims paid by the guaranty association that were subject to the deductible.

(2) If the collateral is insufficient to reimburse the guaranty association for claims paid within the deductible, the receiver shall use any existing collateral to make a partial reimbursement to the guaranty association, subject to any allocation under Subsection (d), (e),or (f). If more than one guaranty association has a claim against the same collateral, the receiver shall prorate payments to each guaranty association based on the amount of the claims each guaranty association has paid.

(3) The receiver is entitled to deduct from reimbursements owed to a guaranty association or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the receiver's responsibilities under this section. Expenses incurred to collect reimbursements for the benefit of a guaranty association are subject to the approval of the guaranty association. Any remaining expenses that are not deducted from the reimbursements are payable subject to Section 443.015.

(4) The receiver shall provide any affected guaranty associations with a complete accounting of the receiver's deductible billing and collection activities on a quarterly basis, or at other intervals as may be agreed to between the receiver and the guaranty associations. Accountings under this subdivision must include copies of the policyholder billings, the reimbursements collected, the available amounts and use of collateral for each account, and any prorating of payments.

(5) If the receiver fails to make a good faith effort to collect reimbursements due from a policyholder under a deductible agreement within 120 days of receipt of claims payment reports from a guaranty association, the guaranty association may, after notice to the receiver, collect the reimbursements that are due, and, in so doing, the guaranty association shall have the same rights and remedies as the receiver. A guaranty association shall report any amounts collected under this subdivision and expenses incurred in collecting those amounts to the receiver.

(6) The receiver shall periodically adjust the collateral held as the claims subject to the deductible agreement are paid, provided that adequate collateral is maintained. The receiver is not required to adjust the collateral more than once a year. The receiver shall inform the guaranty associations of all collateral reviews, including the basis for the adjustment.

(7) Reimbursements received or collected by a guaranty association under this section may not be considered a distribution of the insurer's assets. A guaranty association shall provide the receiver with an accounting of any amounts it has received or collected under this section and any expenses incurred in connection with that receipt or collection. The amounts received, net of any expenses incurred in connection with collection of the amounts, must be set off against the guaranty association's claim filed under Section 443.251 for the payments that were reimbursed.

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(8) To the extent that a guaranty association pays a claim within the deductible amount that is not reimbursed by either the receiver or by policyholder payments, the guaranty association has a claim for those amounts in the delinquency proceeding in accordance with Section 443.251.

(9) Nothing in this section limits any rights of a guaranty association under applicable law to obtain reimbursement for claims payments made by the guaranty association under policies of the insurer or for the association's related expenses.

(i) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association, the following provisions apply:

(1) The receiver is entitled to retain as an asset of the estate any collateral or deductible reimbursements obtained by the receiver.

(2) If a policyholder fails to assume an obligation under a deductible agreement to pay a claim, the receiver shall use the collateral to adjust and pay the claim to the extent that the available collateral, after any allocation under Subsection (d), (e), or (f), is sufficient to pay all outstanding and anticipated claims within the deductible. If the collateral is exhausted and all reasonable means of collection against the insured have been exhausted, the remaining claims shall be subject to the provisions of Sections 443.251 and 443.301.

(3) The receiver is entitled to deduct from collateral reasonable actual expenses incurred in fulfilling the receiver's responsibilities under this section. Any remaining expenses that are not deducted from the reimbursements are payable subject to Section 443.0.



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## Michigan Insurance Code

§ 500.8133a. Deductible agreement; collateral as asset maintained and administered by receiver; jurisdiction of circuit court; rights of guaranty association or foreign guaranty association; applicability to delinquency proceedings; applicability to first party claims; definitions.

Sec. 8133a. (1) Notwithstanding any other law or contract to the contrary, any collateral held by or for the benefit of or assigned to the insurer or subsequently the receiver in order to secure the obligations of a policyholder under a deductible agreement shall not be considered an asset of the estate and shall be maintained and administered by the receiver as provided in this section.

(2) If collateral is being held by or for the benefit of or assigned to the insurer or subsequently the receiver to secure obligations under a deductible agreement with a policyholder, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount as provided in this section.

(3) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association or foreign guaranty association and the policyholder is unwilling or unable to take over the handling and payment of the noncovered claims, the receiver shall adjust and pay the noncovered claims using the collateral but only to the extent the available collateral after allocation under subsection (4) is sufficient to pay all outstanding and anticipated claims. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all reasonable means of collection against the insured have been exhausted, the receiver's obligation to pay the claims from the collateral terminates and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions in this chapter for the filing and allowance of those claims. If the liquidator determines that the collateral is insufficient to pay all additional and anticipated claims, the liquidator may file a plan, subject to court approval, for equitably allocating the collateral among claimants.

(4) To the extent that the receiver is holding collateral provided by a policyholder that was obtained to secure a deductible agreement and to secure other obligations of the policyholder to pay the insurer directly or indirectly amounts that become assets of the estate, such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the receiver shall equitably allocate the collateral among those obligations and administer the collateral allocated to the deductible agreement as provided in this section. For collateral allocated to obligations under the deductible agreement, if the collateral secured reimbursement obligation under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The receiver shall inform the guaranty associations and foreign guaranty associations of the method and details of all the foregoing allocations.

(5) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible


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agreement, either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third party administrator who administers the claims, the receiver shall allow this funding arrangement to continue and, where applicable, will enforce the arrangement to the fullest extent possible. The funding of these claims by the policyholder within the deductible amount will act as a bar to any claim for such amount in the liquidation proceeding, including, but not limited to, any claim by the policyholder or the third party claimant. This funding arrangement extinguishes both the obligation, if any, of any guaranty association to pay those claims within the deductible amount, as well as the obligations, if any, of the policyholder or third party administrator to reimburse the guaranty association. If a policyholder has entered into an agreement to which this subsection applies and is prevented from funding its own claims due to any proceeding under 11 USC 101 to 1330 and 1501 to 1532, then the guaranty funds that would otherwise be obligated to pay the claims shall pay the claims to the extent required by applicable state law and, in addition to any other rights of recovery arising from payment of the claims, shall have the full benefit of all collateral and other rights of reimbursement and recovery under this section from the bankruptcy court, liquidator, or receiver. No charge of any kind shall be made against any guaranty association on the basis of the policyholder funding of claim payments made pursuant to an arrangement described in this subsection.

(6) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association or foreign guaranty association is required by applicable state law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by a policyholder or third party, the receiver shall promptly bill the policyholder for reimbursement and the policyholder is obligated to pay the reimbursement amount to the receiver for the benefit of the guaranty association or foreign guaranty associations who paid the claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, is a defense to the policyholder's reimbursement obligation under the deductible agreement. The receiver shall promptly reimburse the guaranty association or foreign guaranty association for claims paid that were subject to the deductible when the policyholder reimbursements are collected. If the policyholder fails to pay the amounts due within 60 days after the bill for the reimbursement is due, the receiver shall use the collateral to the extent necessary to reimburse the guaranty association or foreign guaranty associations, and, at the same time, may pursue other collections efforts against the policyholder. If more than one guaranty association or foreign guaranty association has a claim against the same collateral and the available collateral, after allocation under subsection (4), along with billing and collection efforts, are together insufficient to pay each guaranty association and foreign guaranty association in full, then the receiver will prorate payments to each guaranty association and foreign guaranty association based upon the relationship the amount of claims each guaranty association and foreign guaranty association has paid bears to the total of all claims paid by the guaranty association and foreign guaranty associations.

(7) The receiver is entitled to deduct from reimbursements owed to a guaranty association or foreign guaranty association or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this section, not to exceed 3% of the

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collateral or the total deductible reimbursements actually collected by the receiver. For claim payments made by a guaranty association or foreign guaranty association, the receiver shall promptly provide the guaranty association or foreign guaranty association with a complete accounting of the receiver's deductible billing and collection activities, including copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each account, and any proration of payments when it occurs. If the receiver fails to make a good faith effort within 120 days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by the guaranty association or foreign guaranty association, the guaranty association or foreign guaranty association may pursue collection from the policyholders directly on the same basis as the receiver, and with the same rights and remedies, and shall report any amounts collected from each policyholder to the receiver. To the extent that a guaranty association or foreign guaranty association pays claims within the deductible amount, but is not reimbursed by either the receiver under this section or by policyholder payments from the guaranty association's or foreign guaranty association's own collection efforts, the guaranty association or foreign guaranty association shall have a claim in the insolvent insurer's estate for unreimbursed claims payments.

(8) The receiver shall adjust the collateral being held as the claims subject to the deductible agreement are run off, so long as adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor. The receiver shall make these adjustments periodically, but is not required to adjust the collateral more than once a year. The guaranty association and any foreign guaranty association shall be informed of all such collateral reviews, including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims can be presented, the receiver will release any remaining collateral to the policyholder.

(9) The Ingham county circuit court having jurisdiction over the liquidation proceedings shall have jurisdiction to resolve disputes arising under this section.

(10) This section does not limit or adversely affect any right a guaranty association or foreign guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association or foreign guaranty association under policies of the insolvent insurer or for related expenses the guaranty association or foreign guaranty association incurs.

(11) This section applies to all delinquency proceedings that are open and pending on the effective date of this section.

(12) This section does not apply to first party claims or to claims funded by a guaranty association or foreign guaranty association net of the deductible unless subsection (5) applies.

(13) As used in this section:

(a) "Deductible agreement" means any combination of one or more policies, endorsements, contracts, or security agreements that provide for the policyholder to bear the risk

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of loss within a specified amount per claim or occurrence covered under a policy of insurance and may be subject to aggregate limit of policyholder reimbursement obligations.

(b) "Noncovered claim" means a claim that is subject to a deductible agreement, may be secured by collateral, and is not covered by a guaranty association or foreign guaranty association.



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**Utah Insurance Code**

31A-27a-612. Administration of deductible policies and insured collateral.

(1) As used in this section:

(a) "Collateral" means any of the following that secures an insured's obligation to pay or to reimburse the insurer for deductible claim payments and to reimburse or pay to the insurer other secured obligations:

(i) cash;

(ii) a letter of credit of the insured;

(iii) a surety bond posted by the insured; or

(iv) any other form of security posted by the insured.

(b) "Deductible claim" means a claim, including a loss or allocated loss adjustment expense, under a deductible policy within the insured's obligation to pay a portion of a claim or claim expense that the insurer is obligated to pay to a person other than the insured by the deductible policy or by operation of law.

(c) (i) "Deductible limit" means a limit on an amount to be paid or reimbursed by the insured under a deductible policy that is equal to or greater than $5,000.

(ii) A deductible limit may be any amount of the risk exposure before the insurer agrees to become liable for the insurance risk without a right of recoupment from the insured for the insurer's payment of claims or expenses related to a claim under the deductible policy.

(d) (i) "Deductible policy" means any combination of one or more policies, endorsements, contracts, or security agreements in which the insured agrees with the insurer to:

(A) pay directly:

(I) the initial portion of a claim under the policy, endorsement, contract, or agreement up to a specified dollar amount; or

(II) the expenses related to a claim; or

(B) reimburse the insurer for the insurer's payment of:

(I) a claim under the policy, endorsement, contract, or agreement up to a specified dollar amount; or

(II) the expenses related to a claim.



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(ii) "Deductible policy" includes a policy, endorsement, contract, or agreement that contains an aggregate limit on the insured's liability for all deductible claims in addition to a deductible limit for each claim.

(iii) "Deductible policy" does not include:

(A) a policy, endorsement, contract, or agreement that provides that the initial portion of a covered claim shall be self-insured and the insurer has no payment obligation within the self-insured retention;

(B) a policy, endorsement, contract, or agreement that provides for retrospectively rated premium payments by the insured; or

(C) a reinsurance arrangement or agreement.

(e) "Other secured obligation" means an obligation, such as a reinsurance or retrospective premium obligation, that is:

(i) payable by the insured to the insurer; and

(ii) secured by collateral that also secures a deductible obligation.

(f) "Uncovered claim" means a deductible claim that is secured by collateral but that:

(i) is not defined as a covered claim under any relevant guaranty association statute;
(ii) the insured fails to fund or pay; and

(iii) is filed with the receiver pursuant to the receivership proof of claim process.

(2) (a) If an insurer agrees to allow an insured to fund or pay deductible claims directly or through a third party administrator, except as prohibited by applicable workers' compensation insurance law:

(i) the insured shall fulfill the insured's obligations notwithstanding a delinquency proceeding; and

(ii) the receiver shall allow the funding or payment agreements to continue notwithstanding a delinquency proceeding.

(b) To the extent the insured funds or pays a deductible claim, the insured's funding or payment of a deductible claim:

(i) bars any deductible claim in a delinquency proceeding including a claim by the insured or third party claimant; and

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(ii) extinguishes the obligation, if any, of the receiver or an affected guaranty association to pay the deductible claim.

(c) The insured is responsible for providing timely notice to the receiver and to all affected guaranty associations for any claim that may exceed the deductible limit.

(d) A charge of any kind may not be made against a receiver or an affected guaranty association on the basis of an insured's funding or payment of a deductible claim.

(e) The failure of an insured to fulfill the insured's obligation pursuant to a funding agreement entitles the following to the full benefit of all collateral and other rights of recovery and reimbursement under the other provisions of this section:

(i) the receiver that pays a deductible claim; or

(ii) pursuant to Subsection (6)(b), an affected guaranty association that pays a deductible claim.

(3) Any reimbursement owed to an insurer under a deductible policy issued by an insurer subject to a delinquency proceeding shall be administered as follows:

(a) (i) A reimbursement from an insured for the payment of a deductible claim is a general asset of the estate to the extent that:

(A) the insolvent insurer is owed reimbursement for deductible payments made before the entry of a final order of liquidation; or

(B) the receiver is owed reimbursement for a deductible payment.

(ii) The receiver shall determine if a reimbursement is a general asset of the estate in accordance with this section.

(b) The receiver shall bill an insured for reimbursement of a deductible claim:

(i) paid by the insurer before the commencement of delinquency proceedings;

(ii) paid by an affected guaranty association upon receipt of notice of a reimbursable payment; or

(iii) paid or allowed by the receiver.

(c) The receiver may take all commercially reasonable actions necessary to collect a reimbursement owed if the insured does not make payment within:

(i) the time specified in the deductible policy; or

(ii) within 60 days after the day of billing if no time is specified in the deductible policy.

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(d) The following is not a defense to the insured's reimbursement obligation under a deductible policy:

(i) the insolvency of the insurer;

(ii) the insurer's inability to perform any of the insurer's obligations under a deductible policy; or

(iii) an allegation of improper handling or payment of a deductible claim by:

(A) the insurer;

(B) the receiver;

(C) an affected guaranty association; or

(D) any combination of Subsections (3)(d)(iii)(A) through (C).

(4) The receiver shall adjust and pay uncovered claims as provided in Subsection (5). The receiver's obligation under this Subsection (4) terminates once all available collateral is exhausted. Once all available collateral is exhausted, any unpaid uncovered claims shall continue to be handled as a proof of claim in the receivership estate.

(5) (a) (i) Except where a deductible policy or other agreement conflicts with this section, any collateral held by an insurer subject to a delinquency proceeding under this chapter held under a deductible policy issued by the insurer, held for other secured obligations, or held under both shall be maintained and administered in accordance with:

(A) the deductible policy;

(B) any applicable security agreement;

(C) any agreement regarding other secured obligations; or

(D) any applicable combination of the deductible policy and other agreement.

(ii) This Subsection (5) applies to collateral regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer under a deductible policy, agreement, or other secured obligation.

(b) (i) Subject to this Subsection (5), collateral shall be used to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations under Subsection (8).

(ii) Collateral shall be considered as property of the receivership estate solely for the purpose of the receiver administering and handling the collateral.

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(iii) Collateral may not be considered as a general asset of the estate, except as provided in Subsections (5)(c) and (8).

(c) (i) Subject to Subsection (5)(c)(ii), collateral held to secure the insured's performance of obligations is a general asset of the estate to the extent that:

(A) the insurer pays or has paid a deductible claim before the day on which a final order of liquidation is entered and the deductible is not reimbursed by the insured;

(B) the receiver pays or has paid a deductible claim; or

(C) the insured fails to pay or reimburse to the insurer other secured obligations to the extent the payment or reimbursement is due or payable before the day on which a final order of liquidation is entered and remains unpaid.

(ii) The receiver shall determine the extent that collateral described in this Subsection (5)(c) is a general asset.

(d) The receiver shall draw down collateral to the extent necessary if the insured f ails to:

(i) perform the insured's funding or payment obligations under any deductible policy;

(ii) pay deductible reimbursements within:

(A) the time specified in the deductible policy; or

(B) 60 days after the date of the billing if no time is specified in the deductible policy;

(iii) timely fund any other secured obligation; or

(iv) timely pay expenses defined in Subsection (8).

(e) (i) The receiver shall first apply or reserve collateral to the insured's obligations referenced in Subsections (5)(c)(i)(A) and (C).

(ii) The receiver shall use any collateral remaining after the application of Subsection (5)(e)(i) to:

(A) reimburse deductible claims submitted by an affected guaranty association;

(B) adjust and pay uncovered claims allowed by the liquidator;

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(C) pay other secured obligations of the insured that become due and payable after the date of liquidation; or

(D) pay expenses as defined in Subsection (8).

(iii) The receiver shall:

(A) use collateral under Subsection (5)(e)(ii) in the order that the deductible claims or charges against the collateral listed in Subsection (5)(e)(ii) are received and accepted by the receiver; and

(B) continue until all valid deductible claims or charges are fully reimbursed or paid or the collateral is exhausted.

(iv) If there are amounts payable or reimbursable under this Subsection (5)(e) and the receiver for any reason has been precluded from drawing the collateral, the receiver may establish a reserve against the collateral for those amounts. Only the collateral exceeding the reserve shall be considered remaining collateral under this Subsection (5)(e).

(f) Once all claims, other secured obligations, or expenses under Subsection (8) covered by collateral have been paid and the receiver is satisfied that no new claims, other secured obligations, or expenses under Subsection (5)(e) may be presented, the receiver shall release any remaining collateral to the insured in accordance with the deductible policy or agreement relating to other secured obligations.

(6) To the extent an affected guaranty association pays a deductible claim for which the insurer would have been entitled to reimbursement from the insured, the following provisions apply:

(a) (i) When an affected guaranty association pays a deductible claim, the affected guaranty association shall report the claim to the receiver.

(ii) The receiver shall collect from the insured all deductible amounts due as reimbursement. Subject to Subsection (8), when the insured reimbursements are collected, the receiver shall reimburse the affected guaranty association for deductible claims.

(iii) A reimbursement paid to the affected guaranty association pursuant to this Subsection (6)(a) may not be treated as a distribution under Section 31A-27a-703 or as an early access payment under Section 31A-27a-704.

(iv) If an affected guaranty association pays a deductible claim that is also subject to reimbursement under statutory net worth provisions, the affected guaranty association shall:

(A) bill the insured directly;

(B) notify the insurer of the payment; and



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(C) notify the receiver of any receipt of a reimbursement under net worth provisions, which shall be credited against the insured's deductible reimbursement obligations to the extent that the reimbursement applies to deductible claims.

(b) (i) This Subsection (6)(b) applies if:

(A) the receiver declines to seek reimbursement from the insured or from any available collateral;

(B) the receiver is unsuccessful in obtaining reimbursement from the insured or from any available collateral; or

(C) the receiver fails to take available commercially reasonable actions to collect a reimbursement owed.

(ii) The receiver shall notify an affected guaranty association if the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured or from any available collateral.

(iii) If a condition described in Subsection (6)(b)(i) exists, notwithstanding whether the affected guaranty association receives the notice required by Subsection (6)(b)(ii), an affected guaranty association:

(A) may, after notice to the receiver, collect a reimbursement due from the insured for the deductible claims the affected guaranty association has paid:

(I) on the same basis as the receiver; and

(II) with the same rights and remedies; and

(B) shall report any amounts collected under Subsection (6)(b)(iii)(A) from each insured to the receiver.

(iv) The receiver shall provide an affected guaranty association with available information needed to collect a reimbursement due from the insured.

(v) When an affected guaranty association undertakes to collect reimbursements from the insured, the affected guaranty association shall notify all other guaranty associations who have paid deductible claims on behalf of the same insured that this action is being taken.

(vi) An amount collected by the affected guaranty association pursuant to this Subsection (6)(b) may not be treated as a distribution under Section 31A-27a-703 or as an early access payment under Section 31A-27a-704.

(vii) An affected guaranty association may net an expense incurred in collecting a reimbursement against that reimbursement.

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(c) The receiver shall provide any affected guaranty associations with periodic reports concerning the receiver's activities in discharging responsibilities under this section, which shall include an accounting for the receiver's deductible billing and collection activities.

(d) To the extent that an affected guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, the affected guaranty association has a claim for those amounts in the delinquency proceeding. Any claim by an affected guaranty association shall be reduced by reimbursed or unreimbursed expenses described in Subsection (8) incurred by the receiver.

(e) (i) If any collateral is held under a deductible policy at the time the receiver files an application to terminate the delinquency proceeding, and it appears that an additional deductible claim may be payable by an affected guaranty association under the deductible policy, the receiver shall:

(A) transfer to an affected guaranty association the portion of the collateral that is reasonably estimated to be necessary to pay the deductible claim; and

(B) release any remaining portion of the collateral to the insured.

(ii) An affected guaranty association shall handle any collateral transferred from the receiver as provided in this section.

(f) Nothing in this Subsection (6) limits any rights of the receiver or an affected guaranty association under applicable statutory law to obtain reimbursement from an insured for a claims payment made by the affected guaranty association under a policy of the insurer or for the affected guaranty association's related expenses.

(7) (a) The receiver shall periodically adjust the collateral being held using accepted actuarial principles and practices.

(b) The receiver may impose a discretionary safety margin for collateral maintained.

(c) The receiver may not be required to review collateral more than once a year.

(d) The receiver shall inform any affected guaranty association and the insured of any collateral reviews, including the basis for any proposed adjustment.

(8) The receiver may do the following in relation to reasonable expenses incurred in fulfilling the receiver's responsibilities under this section:

(a) deduct the expense from reimbursements;

(b) deduct the expense from the collateral; or

(c) recover the expense through billings to the insured.

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(9) (a) A receiver shall meet the receiver's obligations under this section in a timely manner.

(b) If an affected guaranty association believes that a receiver is not meeting an obligation under this section in a timely manner, upon motion by an affected guaranty association, a receivership court may grant relief to the affected guaranty association if the receivership court finds that the receiver is not meeting an obligation under this section in a timely manner.

(10) This section modifies Subsection 31A-22-1010(2)(b) to the extent necessary to permit an insured to participate in the payment of the insurance claims and losses by reimbursement of a receiver or affected guaranty association as provided in this section.


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***Exhibit 7-1: Treaty Master Abstract***

# TREATY MASTER ABSTRACT

Ceding Co.: ______________________ Source Co/MGA: ________

Title: __________________________ Date:____________________________________

Status: [ ] New [ ] Renew [ ] Endorse [ ] Cancellation [ ] Reactive

Treaty No.: ____________________

Binder Change (Status "New")
Activity No.: _________

Assuming Co: _________________

Contract Type ________________ Ceding Co. ____________ Broker Code: ____________________ Source Proportional Co.: _____ Non-Proportional

Participation %: ____________________________ Broker Reference No.: _______________

Dates

Contract Eff : ____/___/_____ Contract Exp: ___/___/_____ Cont (Y/N): ____/___/_____

Anniversary: ____/___/_____ Review Mos: ____/___/_____ Endorsement: ____/___/_____

Actual Can Date: ____/___/______ Basis: __________________ Provisions: _______________

Territory of Risk: _________________________ Underwriter: _________________________

Line of Business

| ASL | % | | % | | % | | % | | |
|---|---|---|---|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

| LPC | CUR | % 100 | Limit of Liab | Retention | Comment |
|---|---|---|---|---|---|
| _____ | _____ | | __________ | __________ | __________ |
| _____ | _____ | | __________ | __________ | __________ |
| _____ | _____ | | __________ | __________ | __________ |
| _____ | _____ | | __________ | __________ | __________ |

Class of Bus: ____ % Long Tail: _________________________________

Risk Attach Method: _______________ Loss Attach Basis: ____ Sub To Cat: _______ Cat % Sub Cat _______________

| | EAP Type | Cur | 100% Amount |
|---|---|---|---|
| | EAP | ______________ | _______________ |
| Prem Basis | Flat | ______________ | _______________ |
| G/N ___ W/E ___ | Min | ______________ | _______________ |
| | Dep | ______________ | _______________ |
| | M&D | ______________ | _______________ |

| | Cur | Provisional | Minimum | Flat or Max |
|---|---|---|---|---|
| Rates: | __________________ | ___________________ | ___________________ | ___________________ |

Subject Prem: _________________ Cur:_________________ Amount: _________________
Rating Basis: _________________ Adjustment (Y/N): _____________ As Of: __/__/__ Due: ________
Premium Comment: ______________________________________________________________________



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***Exhibit 7-1***

Commission % __ W/E: _______ Brokerage % _______ W/E: ____ G/N: _______

Profit Commission Formula Code: ______ % ___ MTG%: ________

#Yrs Deficit C/F: ____________ Basis of Adj: __________ 1st Calc Day: __/__/__ 1st Due Date: __/__/__

Sliding Scale Commission Minimum %: ___________ Pro%: _________ Max %: ____________

Loss Ratio — Max: ____________ Prov: __________ Min: ______________

SSC Basis: _____________________ Adjustment Due Date: __/__/__

# Yrs Carry Forward Credit: _______________________ Deficit: ____________________________

Commission Comment: ______________________________________________________________

Portfolio Premium In (Y/N): _____ Out (Y/N): _____ Loss In (Y/N): _____ Out (N/Y): _____

Accounts: Freq ________ 1st Pd Start __/__/__ End ________ Due __________

Report Lag (in days) __________ Payment Lag (in days): P ____ L ____

Reinstatement: Type Code: _____ Brokerage _____ Comment _____

Loss Exp. Method: _______________ Cas Loss Amt 100%: _______________ Cur: ____________

Type of Bus.: _________________________ Accommodation Bus (Y/N): ____________________

IBNR: __________________________

COMMENTS

1)________________________________________________________________________________

2)________________________________________________________________________________

3)________________________________________________________________________________

4)________________________________________________________________________________

5)________________________________________________________________________________

6)________________________________________________________________________________

7)________________________________________________________________________________

Priority Ceded Contract Year Retro% Start Stop W/E G/N %O/R

QUAKE WIND FLOOD

Zones Cur Amount

PH L %

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| | | | | | | |



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***Exhibit 7-2: Reinsurance Matrix***

ABC INSURANCE COMPANY

REINSURANCE MATRIX

LINE OF BUSINESS: PROPERTY AND CASUALTY

| LIMITS | 4/01/87 - 3/31/88 | 4/01/88 - 3/31/89 | 4/01/89 - 3/31/90 | LIMITS |
|---|---|---|---|---|
| 100,0000 | RETENTION | RETENTION | RETENTION | 100,000 |
| 500,000 | Contract 1<br>1st Multi-Line XOL<br>400,000<br>XS<br>100,000<br>(Prop & Cas) | Contract 4<br>1st Multi-Line XOL<br>400,000<br>XS<br>100,000<br>(Prop & Cas) | Contract 7<br>1st Multi-Line XOL<br>400,000<br>XS<br>100,000<br>(1,200,000 Agg Prop Only)<br>30% Canceled Cut-off<br>(Prop, Cas. Wkrs Comp) | 500,000 |
| 1,000,000 | Contract 2<br>2nd Multi-Line XOL<br>500,000<br>xs<br>500,000<br>(Prop & Cas) | Contract 5<br>2nd Multi-Line XOL<br>500,000<br>XS<br>500,000<br>(Prop & Cas) | Contract 8<br>2nd Multi-Line XOL<br>500,000<br>XS<br>500,000<br>25% Canceled Cut-off<br>(Prop & Cas) | 1,000,000 |
| 2,000,000 | Contract 3<br>1st Casualty Cat XOL<br>1,000,000<br>XS<br>1,000,000<br>(2,000,000 Agg)<br>(Casualty) | Contract 6<br>1st Casualty Cat XOL<br>1,000,000<br>XS<br>1,000,000<br>(2,000,000 Agg)<br>(Casualty) | Contract 9<br>1st Casualty Cat XOL<br>1,500,000<br>XS<br>1,000,000<br>(3,000,000 Agg)<br>(Casualty) | 2,000,000<br>------------<br>2,500,000 |
| 2,500,000<br>------------<br>3,000,000<br>------------<br>5,000,000 | NO REINSURANCE IN PLACE | | Contract 10<br>2nd Casualty Cat XOL<br>2,500,000<br>XS<br>2,500,000<br>(Casualty) | 3,000,000<br>------------<br>5,000,000 |



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***Exhibit 9-1: NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers***

NAIC PROPOSED GUIDELINES
RELATING TO THE REPORTING OF LOSS INFORMATION TO REINSURERS

- The parties to reinsurance agreements involving a U.S. ceding insurance company are presumed to know the role of guaranty associations in a domestic liquidation.

- Liquidators have the obligation for loss reporting to reinsurers in accordance with the terms of the insolvent insurance company's reinsurance agreements.

- Liquidators should promptly advise the guaranty associations of the loss reporting requirements of applicable reinsurance agreements and what additional information is needed from the guaranty associations.

- Guaranty associations should acknowledge the responsibility to furnish timely and adequate information to liquidators so that the liquidators may meet their loss reporting obligations to reinsurers.

- Reinsurers should request from liquidators only that information to which the reinsurers are entitled under the reinsurance agreement.

- Reinsurers should not contact guaranty associations directly. Upon consultation with each guaranty association, liquidators should permit and initiate arrangements for reinsurers to review the claims handling practices of guaranty associations and to examine claim files in which reinsurers have an interest. Guaranty associations should acknowledge their obligation to permit such reasonable review by representatives of liquidators or reinsurers; liquidators should acknowledge their obligation to timely advise guaranty associations of such requests of reinsurers to examine claim files and to verify the scope of such review. Reinsurers are encouraged to provide a summary of their findings to liquidators, who will then provide a copy to the appropriate guaranty association.

- Unless otherwise determined by the liquidator, guaranty associations should promptly report the following loss information to liquidators; liquidators should promptly provide this information to reinsurers to, among other things, provide reinsurers an opportunity to elect to participate in the defense and to establish the reinsurers' own reserves:

    - Initial reports on each claim arising after liquidation.

    - Narrative description of each claim arising after liquidation.

    - Regular reporting of payments and notification of closing, updated at least on a quarterly basis.

    - Regular reporting of reserve information, including reports of changes in reserves, updated at least on a quarterly basis; also included with such reports should be projected loss exposures regardless of the guaranty association's maximum statutory liability (cap), or in the alternative immediate notification of any claim that is reserved at or near the cap.



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* Interim reporting of information to liquidators with respect to bodily injury, personal injury and/or property damage claims of a catastrophic nature as well as environmental, toxic pollution, hazardous waste, des, asbestos-related, agent orange and other product liability claims and major losses; major losses should be defined in each insolvency by agreement between the liquidator and the guaranty associations.

* Interim reporting of known trial dates and settlement conferences on specified types of claims as agreed between liquidators and guaranty associations.

* Interim reporting of significant changes in the status of claims, reserve changes and loss or expense payments; the liquidators should promptly advise the guaranty associations of the reporting requirements with respect to each book of business.

Provision by guaranty associations of the above-listed information in a sufficiently detailed, uniform format utilizing electronic data processing capabilities is desired.

- In claims arising out of policies with aggregate coverage limits, it is the responsibility of liquidators to monitor the cumulative payments and/or allowances (pre- and post-liquidation) and to promptly advise guaranty associations of policies having aggregate limits and the amount remaining available under each such limit. Guaranty associations should consult with the liquidator on all claims involving an aggregate limit prior to entering into any settlement or issuing any payment. Liquidators should furnish such aggregate status information to reinsurers upon request.

- Liquidators and reinsurers should accept determinations of "covered claims," as defined under the applicable guaranty association statutes, and the amount of "covered claim" payments made by guaranty associations unless an extraordinary fact situation exists, or an applicable law justifies a challenge.

- Under reinsurance agreements, salvage and subrogation recoveries may belong to the reinsurers rather than liquidators; thus, the guaranty associations and liquidators should consult and cooperate with each other concerning the handling and disposition of salvage and subrogation recoveries.

- In the absence of prejudice, the payment of loss due under a reinsurance agreement by a reinsurer should not be withheld solely on the basis of time limits of the liquidator's reporting of that loss where the liquidator can show reasonable compliance with the applicable loss reporting requirements under the agreement.

- Guaranty associations should recognize liquidators' requirements to receive original closed claims files. Liquidators should recognize guaranty associations' requirements to retain closed claim files through an audit cycle. Liquidators should consult with the reinsurers and guaranty associations concerning the establishment of appropriate document retention/destruction procedures, subject to the liquidation court's approval.

- Guaranty associations should recognize liquidators' requirements, from time to time, to have reproduced some or all open and closed claim files; liquidators will be reasonable in such requests and shall consult with guaranty associations regarding the manner and timing of payment of reproduction costs.



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- Liquidators and reinsurers should transmit information through reinsurance intermediaries when provided for in the applicable reinsurance agreements, unless there has been agreement by all concerned that the information should be transmitted directly between the reinsurers and the liquidator.

- Numerous reinsurers may have an interest in an individual claim. It is incumbent upon the liquidators and reinsurance intermediaries to develop procedures to efficiently match and respond to reinsurers' inquiries in a reasonable and practicable manner and to avoid requesting duplicate data from guaranty associations.


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**<u>Considerations for Separate Accounts – Receivers' Checklist</u>**

This receiver's checklist accompanies Chapter 9: Legal Considerations – III. H. General Guidance for Receivers in a Future Receivership of a Troubled Insurer that Issued SEC Registered Products. The checklist is intended to assist with issue spotting and identifying areas where receivers should be in communications with the U.S. Securities and Exchange Commission (SEC). Receivers should be aware that insurers' registered products are constantly evolving, and that the issues that might be encountered in a receivership of an insurer that issued registered products are likely to be different than those in prior receiverships due to the different product mixes. Receivers encountering SEC registered products in a receivership should early in the proceedings retain experienced legal counsel qualified to provide advice on the federal securities laws the rules under those laws and compliance issues, and on how state receivership laws and federal securities laws might interact in a receivership.

1. Immediately identify the types of insurance products to be administered during receivership.
2. Immediately determine whether or not products are registered with the SEC. Registered products include:
   - Variable Products (variable annuities or variable life insurance policies).
       - If there are registered variable products, then any separate account supporting those Variable Products will also be subject to registration under the Investment Company Act of 1940 (1940 Act) and be subject to additional compliance requirements under the 1940 Act.
   - Other SEC Registered Products (e.g., certain fixed annuities with market value adjustments or index-based adjustments to value).
3. Receivers should identify other interested federal regulators and establish lines of communication with them.
4. Receivers of an insurer with Managed Separate Accounts should communicate with the board of directors of that Managed Separate Account since any action taken may require board approval.

   If the insurer has registered products, immediately contact SEC staff to establish lines of communication and identify contact points for coordination.

   - The SEC's website contains contact numbers for SEC offices in Washington and for SEC's regional offices: *www.sec.gov*.
   - Information regarding the SEC Division of Investment Management and how to contact these SEC staff may be located at: *www.sec.gov/investment*.
5. Immediately focus on SEC registered products. The federal securities laws applicable because of the insurer's registered products vary depending on the type of product.
   - Review and evaluate the impact of and compliance with the applicable state receivership laws and the federal securities laws applicable to the insurer and its registered products, in particular if the registered products are variable products with separate accounts.

   <u>For variable products,</u>

   - Determine types of separate accounts supporting the variable products and whether any existing separate account was, or was required to be, registered under the 1940 Act as either:
       - Unit Investment Trust (UIT).
       - Managed Separate Account.

- Determine if variable product is backed by insulated separate account not registered under the 1940 Act (Exempt SAs).



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- Obtain and review available 1933 Act and 1940 Act registration statements and other filings.
  - Obtain complete set of all SEC filings, looking for:
    - Insurer's "Plan of Operations" or similar documentation for operation of separate account (may not be filed with the SEC).
    - Obtain all agreements with reinsurers, distributors, third-party credit support providers, guarantors, administrative service providers, custodians and investment advisors/managers involved with insurer's maintenance of separate accounts
- Obtain and review Rule 38a-1 written compliance policies and procedures and annual compliance reports.
- Obtain copies of any significant SEC orders or other relief applicable to the separate account that modifies the regulatory regime governing the account.
- Determine the types of variable products and amount of the insurer's net financial exposure.
  - Locate and review all prospectuses filed with SEC and all variable product forms insurer issued.
- Determine all guarantees provided with registered products, such as:
  - Expense charge guarantees.
  - Mortality guarantees.
  - Optional guaranteed benefits, such as guaranteed death benefits (GMDBs), and guaranteed living benefits such as guaranteed minimum withdrawal benefits (GMWBs), guaranteed minimum accumulation benefits (GMABs) and guaranteed minimum income benefits (GMIBs).
- Determine the standards governing the guarantees.
  - Based upon or determined from guaranteed return of premium, guaranteed annual interest rate return, or highest anniversary value.
- Determine insurer's financial risk not supported by separate accounts.
  - Review all actuarial memoranda and analysis.
- Determine insurer's financial hedging transactions to support obligations under variable products.
  - Evaluate whether hedging programs are adequate.

<u>For other SEC Registered products</u>,

- Determine if SEC registered product is backed by an insulated separate account that is not registered under the 1940 Act (such as registered MVA, and registered index-linked variable annuities).
- Obtain and review available 1933 Act registration statements and other filings and all 1934 Act reports (Form 10-K, 10-Q and 8-K), if applicable.
  - Obtain complete set of all SEC filings, looking for:
    - Insurer's "plan of operations" or similar documentation for operation of separate account (may not be filed with the SEC).
    - Obtain all agreements with reinsurers, distributors, third-party credit support providers, guarantors, administrative service providers, custodians, and investment advisors/managers involved with insurer's maintenance of separate accounts
  - Determine the types of other SEC registered products and amount of the insurer's net financial exposure.
    - Locate and review all prospectuses filed with SEC and all product forms insurer issued.



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***Exhibit 9-2***

- Determine all guarantees provided with other SEC registered products, such as:
    - Expense charge guarantees.
    - Mortality guarantees.
    - Optional guaranteed benefits, such as guaranteed death benefits (GMDBs), and guaranteed living benefits such as guaranteed minimum withdrawal benefits (GMWBs), guaranteed minimum accumulation benefits (GMABs) and guaranteed minimum income benefits (GMIBs).
- Determine the standards governing the guarantees.
    - Based upon or determined from guaranteed return of premium, guaranteed annual interest rate return, or highest anniversary value.
- Determine insurer's financial risk not supported by separate accounts.
    - Review all actuarial memoranda and analysis.
- Determine insurer's financial hedging transactions to support obligations under variable products.
    - Evaluate whether hedging programs are adequate.

6. Determine whether from an operations standpoint the receiver should maintain the insurer's infrastructure, compliance procedures, administrative procedures, technology, fund managers, etc.
    - Obtain and review all documentation, contracts, licenses, etc., pertaining to these matters.
7. Life Guaranty System
    - Collaborate with guaranty associations (through the NOLHGA in multi-state insolvency) as soon as practical regarding registered products that may be eligible for guaranty association coverage, including the assessment of (i) what securities laws might apply to covered registered products and any related separate accounts and (ii) compliance and operational issues with respect to the possible continuation of covered registered products, including whether the receiver should maintain the insurer's infrastructure, technology, product administration, fund managers and other relevant operational mechanisms
8. Explore sale of insurer's book of business (assumption reinsurance transaction)
    - Communicate with SEC staff and legal counsel regarding plans to transfer registered products book of business.
9. Securities Laws Compliance Considerations
    - Separate accounts supporting variable products
        - Properly established, insulated separate accounts supporting registered products must be preserved.
        - Assets in the separate account are insulated and ear-marked and are thus protected from the claims of general creditors in the insurer's receivership.

- General Account Guarantees regarding SEC Registered and variable products.
    - Insurer's general account guarantees are subject to claims paying ability of the insurer.
    - Claims associated with the insurer's guarantee of the variable product are claims against the general assets of the insurer.
- SEC Registered Products with Guarantees.
    - Guarantees are subject to claims paying ability of the insurer.



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- Disclosure Requirements.
  - Initiation of receivership proceedings and other actions taken during receivership will likely necessitate filings with the SEC and disclosure to owners of the registered products. The receiver should seek advice from legal counsel regarding what events need to be disclosed under the federal securities laws and the manner and timing of such disclosures.
- Registration Statements and Prospectus Disclosure Requirements – Supplementation Requirements.
  - Receivers may seek guidance from SEC staff and legal counsel on the need to keep product registration statements and prospectuses current at different stages of receivership.
  - Suspension of Sales & New Premium.
    - Consult with SEC staff and legal counsel as soon as possible in the receivership process if receiver decides it cannot comply with any federal securities law requirements, since commencement of a receivership does not terminate the registration of any contracts registered as securities under the 1933 Act or of any separate account registered as an "investment company" under the 1940 Act.
    - Consult with legal counsel regarding the need to obtain a no action letter from SEC staff regarding not issuing updated prospectuses.
    - Suspending new premiums on in-force SEC Registered Products could be problematic and should be discussed with SEC staff before implementation.
  - Transferring Registered Variable Product Business.
    - Communicate with SEC staff and legal counsel regarding plans to transfer a book of business to an assuming solvent insurer.
    - No Action relief should be sought in connection with such a transfer and change in control issues arising from the liquidation.
  - Restructuring Registered Product Contracts.
    - Communicate with SEC staff and legal counsel regarding plans to restructure insurer's registered product contacts, and should seek necessary approvals from SEC staff.
  - Continuing to "Evergreen" Prospectuses and File Required Reports.
    - Keep prospectuses up to date if the insurer continues to sell registered products or receive premiums in receivership.
  - Continue to comply with periodic reporting obligations of the 1934 Act.
- Redeemability
  - Communicate with SEC staff and legal counsel about any anticipated disruptions in payments or processing redemptions funded by any separate account registered under the 1940 Act.
  - Resolutions of Blocks of Business.
    - Where a "pre-packaged receivership" that results in the immediate sale/transfer of the registered product business is not possible, consideration should be given to:
      - Restructuring the registered product contracts and cease accepting premiums.
      - Offering an exchange of the insurer's registered product contract.
      - Offering to buy back the insurer's registered product contracts.
    - Consult with SEC staff and legal counsel regarding above implementation of above considerations.



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***Exhibit 10-1: Interim Liquidating Balance Sheet***

## ABC LIFE INSURANCE COMPANY
### INTERIM LIQUIDATING BALANCE SHEET
### AS OF DECEMBER 31, 2008

| | | 12/31/2008 STATEMENT VALUE | ADJUSTMENTS | ADJUSTED VALUE | CLASS 1 ADMIN. | CLASS 2 | CLASS 3 | CLASS 4 & HIGHER |
|---|---|---|---|---|---|---|---|---|
| | ASSETS | | | | | | | |
| | BONDS | 872,142 | 10,282 | 882,424 | | | 882,424 | |
| | CASH IN OFFICE | 100 | | 100 | | | 100 | |
| | CASH ON DEPOSIT | 15,275 | | 15,275 | | | 15,275 | |
| | SHORT-TERM INVESTMENTS | 2,580,915 | | 2,580,915 | 331,888 | 769,841 | 1,479,186 | |
| | OTHER INVESTED ASSETS | 85,415 | | 85,415 | | | 85,415 | |
| | PREMIUM TAX REFUNDS | 10,038 | | 10,038 | | | 10,038 | |
| (1) | EARLY ACCESS (ESTATE ASSETS) | 0 | 34,785 | 34,785 | | | 34,785 | |
| | INVESTMENT INCOME DUE | 19,672 | | 19,672 | | | 19,672 | |
| | AGGREGATE WRITE-INS | 26,795 | (9,734) | 17,061 | | | 17,061 | |
| | TOTAL ASSETS | 3,610,352 | 35,333 | 3,645,685 | 331,888 | 769,841 | 2,543,956 | 0 |
| | LIABILITIES | | | | | | | |
| | POLICY & CONTRACT CLAIMS (LIFE) | 201,047 | | 201,047 | | | 201,047 | |
| | POLICY & CONTRACT CLAIMS (A&H) | 355,209 | | 355,209 | | | 355,209 | |
| | SURRENDERS | 43,722 | | 43,722 | | | 43,722 | |
| (1) | ACCOUNTS PAYABLE GUARANTY FUND | 3,671,806 | 34,785 | 3,706,591 | | 769,841 | 2,936,750 | |
| | COMMISSIONS DUE & UNPAID | 76,285 | | 76,285 | | | | 76,285 |
| | GENERAL EXPENSES DUE & UNPAID | 152,685 | | 152,685 | | | | 152,685 |
| | TAXES,LICENSES AND FEES | 21,875 | | 21,875 | | | | 21,875 |
| | AMOUNTS HELD AS AGENT | 102,698 | | 102,698 | | | | 102,698 |
| | REMITTANCES NOT ALLOCATED | 10,815 | | 10,815 | | | | 10,815 |
| | PHASE III TAX | 726,892 | | 726,892 | | | | 726,892 |
| | ADMINISTRATION EXPENSE | 136,729 | 195,159 | 331,888 | 331,888 | | | |
| | TOTAL LIABILITIES | 5,499,763 | 229,944 | 5,729,707 | 331,888 | 769,841 | 3,536,728 | 1,091,250 |
| | % OF DISTRIBUTION | | | | 100.00% | 100.00% | 71.93% | 0.00% |
| | DOLLAR DISTRIBUTION | | | | | | | |

(1) Net Policyholder liabilities conveyed via assumption agreement less estate assets



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***Exhibit 10-2: Closing Liquidating Balance Sheet***

## ABC LIFE INSURANCE COMPANY
### CLOSING LIQUIDATING BALANCE SHEET
### AS OF DECEMBER 31, 2008

| | | 12/31/2008 STATEMENT VALUE | ADJUSTMENTS | ADJUSTED VALUE | CLASS 1 ADMIN. | CLASS 2 | CLASS 3 | CLASS 4 & HIGHER |
|---|---|---|---|---|---|---|---|---|
| | **ASSETS** | | | | | | | |
| | CASH ON DEPOSIT | 15,275 | | 15,275 | | | 15,275 | |
| | SHORT-TERM INVESTMENTS | 1,850,915 | | 1,850,915 | 28,624 | 769,841 | 1,052,450 | |
| | PREMIUM TAX REFUNDS | 10,038 | | 10,038 | | | 10,038 | |
| (1) | EARLY ACCESS (ESTATE ASSETS) | 0 | 34,785 | 34,785 | | | 34,785 | |
| (2) | EARLY ACCESS (CASH) | 0 | 1,500,000 | 1,500,000 | | | 1,500,000 | |
| | TOTAL ASSETS | 1,876,228 | 1,534,785 | 3,411,013 | 28,624 | 769,841 | 2,612,548 | 0 |
| | **LIABILITIES** | | | | | | | |
| | POLICY & CONTRACT CLAIMS (LIFE) | 10,000 | | 10,000 | | | 10,000 | |
| | POLICY & CONTRACT CLAIMS (A&H) | 105,646 | | 105,646 | | | 105,646 | |
| | SURRENDERS | 33,947 | | 33,947 | | | 33,947 | |
| (1,2) | ACCOUNTS PAYABLE GUARANTY FUND | 2,622,191 | 1,534,785 | 4,156,976 | | 769,841 | 3,387,135 | |
| | COMMISSIONS DUE & UNPAID | 76,285 | | 76,285 | | | | 76,285 |
| | GENERAL EXPENSES DUE & UNPAID | 152,685 | | 152,685 | | | | 152,685 |
| | TAXES, LICENSES AND FEES | 21,875 | | 21,875 | | | | 21,875 |
| | AMOUNTS HELD AS AGENT | 102,698 | | 102,698 | | | | 102,698 |
| | REMITTANCES NOT ALLOCATED | 10,815 | | 10,815 | | | | 10,815 |
| | PHASE III TAX | 726,892 | | 726,892 | | | | 726,892 |
| | ADMINISTRATION EXPENSE | 15,872 | 12,752 | 28,624 | 28,624 | | | |
| | TOTAL LIABILITIES | 3,878,906 | 1,547,537 | 5,426,443 | 28,624 | 769,841 | 3,536,728 | 1,091,250 |
| | % OF DISTRIBUTION | | | | 100.00% | 100.00% | 73.87% | 0.00% |
| | DOLLAR DISTRIBUTION | | | | | | | |

(1) Net Policyholder liabilities conveyed via assumption agreement less estate assets
(2) Represents cash distribution on November 20, 2008



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***Exhibit 11-A: Initiation of Orderly Liquidation of Insurance Company Under Dodd-Frank***

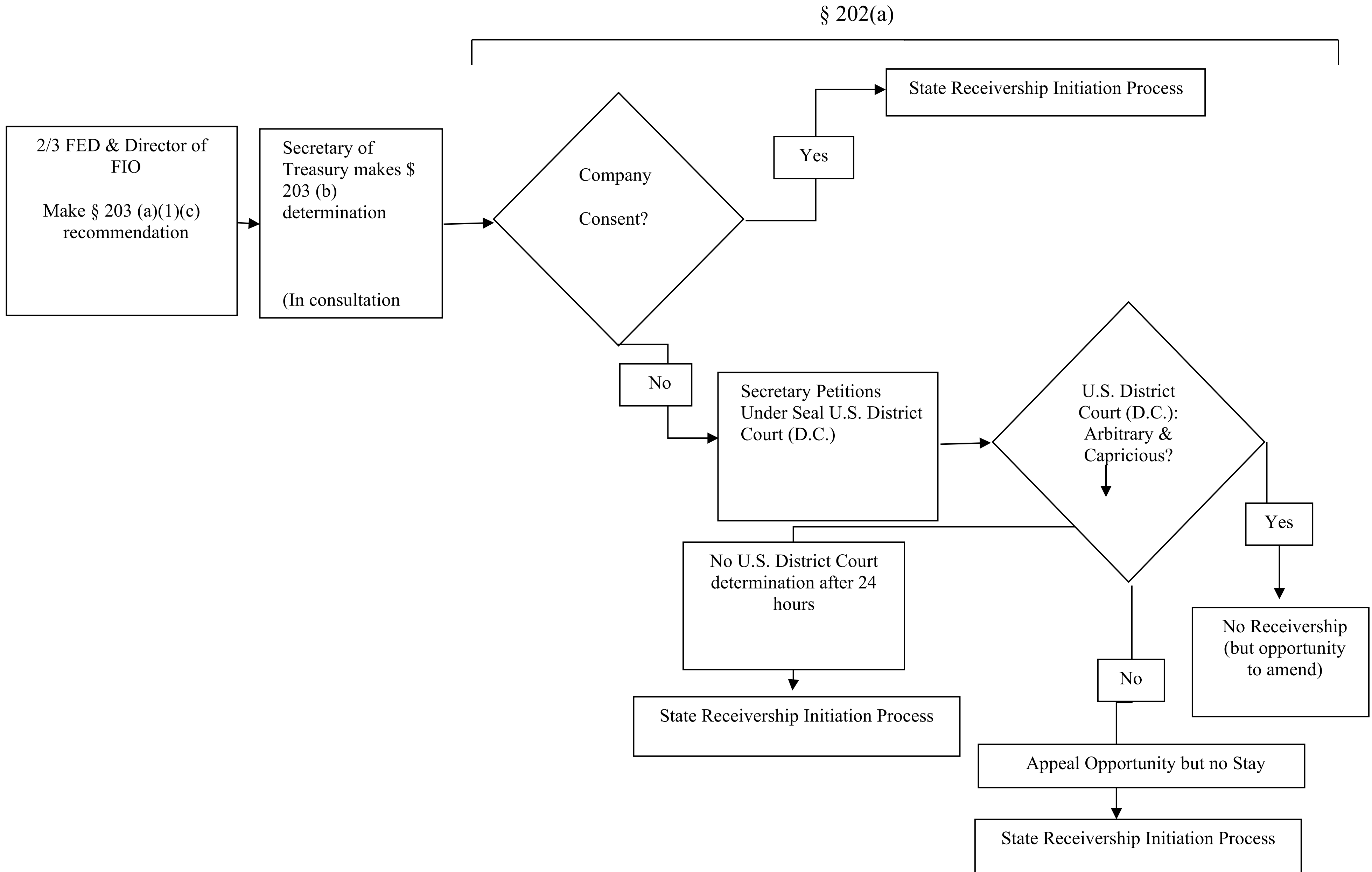




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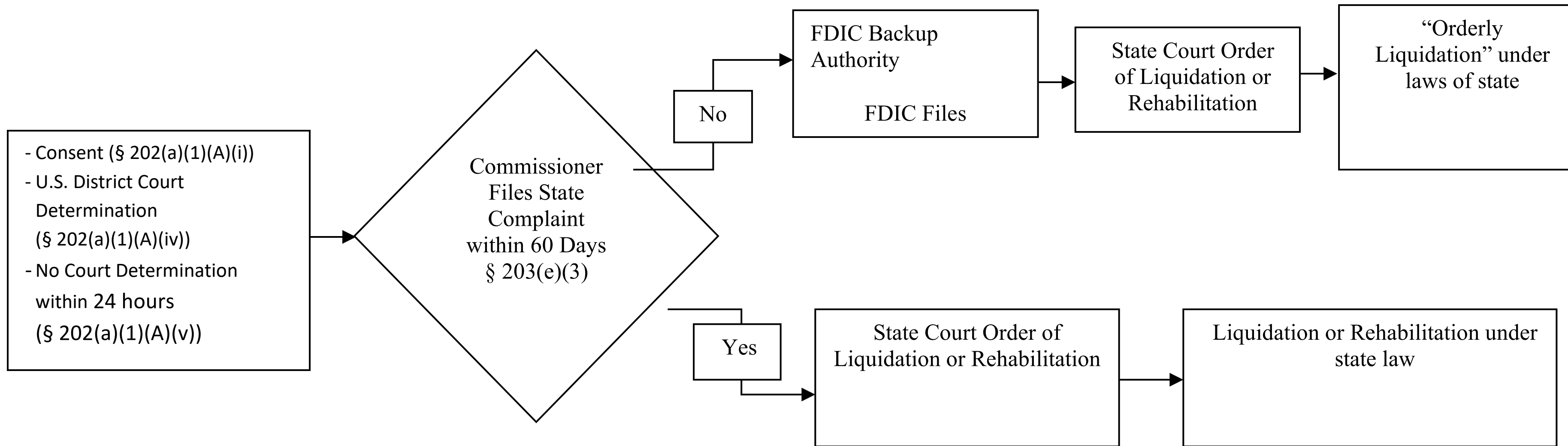
***Exhibit 11-B: State Receivership Initiation Process***

STATE RECEIVERSHIP INITIATION PROCESS



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GUIDELINE FOR IMPLEMENTATION
OF STATE ORDERLY LIQUIDATION AUTHORITY

**Drafting Note:** Title II of Dodd-Frank, Pub. L. No. 111-203, provides for the orderly liquidation of certain financial companies, including qualifying insurance companies, with the FDIC generally seeking the appointment as receiver. However, in the case of qualifying insurance companies, the liquidation or rehabilitation of such a financial company will be conducted as provided under state law pursuant to 12 U.S.C. § 5383(e). If, at the end of the 60-day period provided for under 12 U.S.C. § 5383(e)(3), the commissioner (or other appropriate regulatory agency) has not filed the appropriate state judicial action to place the insurer into orderly liquidation, the FDIC shall have the authority to stand in the place of the commissioner and file the appropriate judicial action in the appropriate state court to place the insurer into orderly liquidation under the laws and requirements of the state. The following statutory language is not an amendment to the NAIC receivership models, but is intended as a Guideline for use by those states seeking to review their authority under existing state law for purposes of initiating rehabilitation or liquidation proceedings in accordance with the federal statute:

**[ ] Orderly Liquidation Authority**

In accordance with Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 with respect to an insurance company that is a covered financial company, as that term is defined under 12 U.S.C. § 5381:

A. The commissioner may file in the [insert proper court] court of this state a petition for an order of rehabilitation or liquidation on any of the following grounds:

   1) Upon a determination and notification given by the Secretary of Treasury (in consultation with the President) that the insurance company is a financial company satisfying the requirements of 12 U.S.C. § 5383(b), and the board of directors (or body performing similar functions) of the insurance company acquiesces or consents to the appointment of a receiver pursuant to 12 U.S.C. § 5382(a)(1)(A)(i), with such consent to be considered as consent to an order of rehabilitation or liquidation; or

   2) Upon an order of the United States District Court for the District of Columbia under 12 U.S.C. § 5382(a)(1)(A)(iv)(I) granting the petition of the Secretary of the Treasury concerning the insurance company under 12 U.S.C. § 5382(a)(1)(A)(i); or

   3) A petition by the Secretary of the Treasury concerning the insurance company is granted by operation of law under 12 U.S.C. § 5382(a)(1)(A)(v).

B. Notwithstanding any other provision in this Act or other law, after notice to the insurance company, the receivership court may grant a petition for rehabilitation or liquidation within 24 hours of the filing of a petition pursuant to this section.

C. If the court does not make a determination on the petition for rehabilitation or liquidation filed pursuant to this section within 24 hours after the filing of the petition, it shall be deemed granted by operation of law upon the expiration of the 24-hour period. At the time that an order is deemed granted under this section, the provisions of [cite to applicable state law addressing rehabilitation or liquidation] shall be deemed to be in effect, and the receiver shall be deemed to be appointed [optional: affirmed] and have all of the applicable powers provided by [refer to applicable state law addressing rehabilitation or liquidation], regardless of whether an order has been entered. The receivership court shall expeditiously enter an order of rehabilitation or liquidation that:



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1) Is effective as of the date that it is deemed granted by operation of law; and

2) Conforms to [cite to applicable state law addressing rehabilitation or liquidation], as applicable.

D. Any order of rehabilitation or liquidation made pursuant to this section shall not be subject to any stay or injunction pending appeal.

E. Nothing in this section shall be construed to supersede or impair any other power or authority of the commissioner or state courts under this Act.



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