RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force Dec. 2, 2023, Minutes
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  - Model #540 Amendments Combined Comment Letters (Attachment One-F)
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  - Chapters 9, 10, and 11 and Appendices of the Receiver's Handbook (Attachment Two-D)
- Revisions to the Receiver's Handbook (Attachment Three)

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Draft Pending Adoption

Draft: 12/7/23

Receivership and Insolvency (E) Task Force
Orlando, Florida
December 2, 2023

The Receivership and Insolvency (E) Task Force met Dec. 2, 2023. The following Task Force members participated: James J. Donelon, Chair (LA); Glen Mulready, Vice Chair, represented by Donna Wilson and Jamin Dawes (OK); Mark Fowler represented by Ryan Donaldson (AL); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jane Callahan and William Arfanis (CT); Doug Ommen represented by Daniel Mathis (IA); Dana Popish Severinghaus represented by Jacob Stuckey (IL); Vicki Schmidt represented by Philip Michael (KS); Sharon P. Clark represented by Vicki Lloyd (KY); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Troy Downing represented by Kari Leonard (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Andrea Johnson (NE); Justin Zimmerman represented by David Wolf (NJ); Judith L. French represented by Matt Walsh (OH); Andrew R. Stolfi represented by Brian Fjeldheim (OR); Michael Humphreys represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Michael Wise (SC); Cassie Brown represented by Brian Riewe (TX); Mike Kreidler represented by Charles Malone and John Haworth (WA); and Nathan Houdek represented by Mark McNabb (WI). Also participating was: Miriam Victorian (FL).

1. <u>Adopted its Oct. 2 Meeting Minutes</u>

The Task Force met Oct. 2 and took the following actions: 1) adopted its Summer National Meeting minutes; 2) adopted its 2024 proposed charges; 3) adopted a U.S. Resolution Template into the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook) and a referral to the Financial Analysis (E) Working Group to include the template in the *Troubled Insurance Company Handbook* (regulator-only publication); 4) discussed comments received and adopted amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) that address guaranty fund coverage of policies subject to restructuring mechanisms, specifically, insurance business transfers (IBTs) and corporate divisions (CDs), as well as revisions related to clarifying guaranty fund coverage for cybersecurity insurance; and 5) heard an update on the receivership tabletop scheduled for Nov. 29, in Orlando, FL.

Gendron made a motion, seconded by Joyce, to adopt the Task Force's Oct. 2 minutes (Attachment One). The motion passed unanimously.

2. <u>Adopted the Report of the Receivership Financial Analysis (E) Working Group</u>

Wilson said the Receivership Financial Analysis (E) Working Group will meet Dec. 2 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership and related topics.

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

3. <u>Adopted the Report of the Receiver's Handbook (E) Subgroup</u>

Victorian said the Receiver's Handbook (E) Subgroup met in open session Nov. 9, Oct. 5, and Aug. 18, during which the Subgroup exposed revisions for public comment, discussed comments received, and adopted Chapters 6, 7, 8, 9, 10, 11, and certain exhibits of the Receiver's Handbook. She said each chapter of the Receiver's Handbook

was updated to make it more user-friendly and concise without losing the value it provides to both seasoned and new receivers. Each chapter was sent from the drafting groups to the Subgroup for public exposure and comment. She said the Subgroup has completed its charge and can be disbanded upon the Task Force's adoption of the Handbook revisions.

Donaldson made a motion, seconded by Stuckey, to adopt the report of the Receiver's Handbook (E) Subgroup (Attachment Two). The motion passed unanimously.

4. Adopted Revisions to the *Receiver's Handbook for Insurance Company Insolvencies*

Commissioner Donelon said the Receiver's Handbook (E) Subgroup has completed the review and adopted updates to the Receiver's Handbook. All of the revisions have been through a public exposure period. The cover page of Attachment Three details which chapters were revised and when the Subgroup adopted those revisions. Upon adoption, the Receiver's Handbook will be published on the NAIC's publications web page, and certain exhibits will be made available in Word format on the Task Force web page for easier use.

Lloyd made a motion, seconded by Fischer, to adopt the revisions to all chapters and certain exhibits of the Receiver's Handbook (Attachment Three). The motion passed unanimously.

5. Heard an Update on International Resolution Activities

Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group has completed edits to the issues paper on policyholder protection schemes, which will be sent to its IAIS parent committee for consideration. The Resolution Working Group is beginning a review and rewrite of Insurance Core Principles (ICPs) related to recovery and resolution. There have been some drafting issues. For example, the term "planning" is viewed by some reviewers as confusing, as it may refer to a formal resolution plan. He said the Resolution Working Group is also working on reorganizing the resolution powers in the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) to be more coherent and easier to understand when evaluating jurisdictions' observance without lowering the bar. He said the U.S. completed responses to the Financial Stability Board's (FSB's) questionnaire on resolution powers and resolution planning.

6. Heard an Update on the UDS Project

Slaymaker said the new Uniform Data Standards (UDS) version 3.0 will use a new language and format that will be more user-friendly and flexible than the current 2.0 version. For example, certain data fields will have no restrictions on what data can be input, such as long names, email addresses, and phone numbers. The new system can convert from the prior system with no required immediate upgrades. She said the new 3.0 version will be rolled out at the UDS technical support group meeting Dec. 12.

7. Heard Feedback on the Receivership Tabletop Exercise

Commissioner Donelon said a receivership tabletop exercise, facilitated by the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF), was held Nov. 29. There were over 100 attendees from 34 state insurance departments, including 11 state insurance commissioners and guaranty fund representatives.

Roger Schmelzer (NCIGF) said he feels a lot of progress was made at the tabletop, but there is also a lot to do. He said all seem to agree that guaranty funds should be involved earlier in the insolvency process at the right time and place. The right time and place are unknown, and NCIGF is excited to work with state insurance regulators to figure it out. He said this is a real change in state insurance regulation and is going to protect consumers at a

higher level. He said NCIGF is committed to being a resource to state insurance regulators and receivers. He said he plans to follow up on the tabletop and looks forward to working with the Task Force on what they can do next. He also said the Receiver's Handbook that was adopted is important, and NCIGF looks forward to implementing it.

Katherine Wade (NOLHGA) said she appreciated all of the participation in the tabletop. She said it was valuable for the administrators at both NOLHGA and NCIGF, and they want feedback on how they can do the next iteration of the tabletop. She said she looks forward to continued collaboration.

Commissioner Donelon said it was valuable beyond what he had hoped for and will be valuable if continued on an ongoing basis. He said exposing the state insurance department regulators in attendance to how the receivership process works and what best practices could be implemented to improve the process, as well as introducing each other to face-to-face relationships, is invaluable.

Haworth said what he enjoyed about the session was that everyone was brainstorming and collectively trying to figure out the underlying issues of the scenario exercise and what steps to take to mitigate those issues. He said he thought it was invaluable and hopes there will be more training and more people can participate.

8. Discussed Adoption of Model Amendments

Wilson said 15 states have adopted the 2021 amendments related to receivership in the *Insurance Holding Company System Model Act* (#440). She encouraged states to consider the amendments in upcoming legislative sessions.

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

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Draft: 10/23/23

Receivership and Insolvency (E) Task Force
Virtual Meeting
October 2, 2023

The Receivership and Insolvency (E) Task Force met Oct. 2, 2023. The following Task Force members participated: James J. Donelon, Chair (LA); Glen Mulready, Vice Chair, represented by Donna Wilson (OK); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Lorenzo Alexander (AL); Andrew N. Mais represented by Jared Kosky (CT); Doug Ommen represented by Kim Cross (IA); Dana Popish Severinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Philip Michael (KS); Sharon P. Clark represented by Russ Coy (KY); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Troy Downing represented by Kari Leonard (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning (NE); Justin Zimmerman represented by David Wolf (NJ); Judith L. French represented by Matt Walsh (OH); Michael Humphreys represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer (RI); Michael Wise represented by Tom Baldwin (SC); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Brian Riewe (TX); Mike Kreidler represented by Charles Malone (WA); and Nathan Houdek represented by Amy Malm (WI). Also participating were: Miriam Victorian (FL); and Doug Stolte (VA).

1. Adopted its Summer National Meeting Minutes

Kevin Baldwin made a motion, seconded by Director Dunning, to adopt the Task Force's Aug. 14 minutes (*see NAIC Proceedings – Summer 2023, Receivership and Insolvency (E) Task Force*). The motion passed unanimously.

2. Adopted its 2024 Proposed Charges

Wilson made a motion, seconded by Slaymaker, to adopt the 2024 proposed charges of the Task Force and its Working Group, which includes disbanding the Receiver's Handbook (E) Subgroup (Attachment One-A). The motion passed unanimously.

3. Adopted a U.S. Resolution Template and Referral to the Financial Analysis (E) Working Group

Commissioner Donelon said the Task Force released a draft U.S. Resolution Template for a 30-day public comment period that ended Sept. 14, 2023. Comments and proposed edits were received from Maine (Attachment One-B) and a joint letter from the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and National Conference of Insurance Guaranty Funds (NCIGF) (Attachment One-C).

Jane Koenigsman (NAIC) said the recommended edits from the commenters were added to the draft. In a few instances where commenters both proposed edits to the same paragraph and the edits appeared substantively the same, NAIC staff chose one set of edits. Koenigsman highlighted a few subsequent editorial changes that were proposed prior to this meeting by NOLHGA and NCIGF (Attachment One-D). Wake recommended that where the draft refers to orders of supervision, the supervision should be characterized as a delinquency action rather than a resolution action. Commissioner Donelon agreed.

Wake made a motion, seconded by Superintendent Dwyer, to amend the draft U.S. Resolution Template with the edits proposed during the meeting. The motion passed unanimously.

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Slaymaker made a motion, seconded by Director Dunning, to adopt the U.S. Resolution Template into the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook) and to refer the template to the Financial Analysis (E) Working Group for consideration in the *Troubled Insurance Company Handbook* (regulator only publication) (Attachment One-E). The motion passed unanimously.

4. Adopted the Model #540 Amendments

The Task Force previously exposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) for a 30-day comment period that ended Sept. 14. The amendments relate to coverage of policies that are subject to restructuring mechanisms, specifically insurance business transfers (IBTs) and corporate divisions (CDs), as well as revisions related to clarifying coverage for cybersecurity insurance.

Commissioner Donelon said comments were received from Maine, Virginia, Patrick Cantilo (Cantilo & Bennett, LLP), and the NCIGF (Attachment One-F).

Cantilo said the charge to the Receivership Law (E) Working Group was to evaluate whether amendments to Model #540 would be necessary to assure that IBT and CD transactions would not result in the loss of policyholder guaranty association coverage following the completion of the transaction. He said he supports the goal and offers a simple amendment to Model #540 to make that clear, although it could be argued that even without the amendment, Model #540 already did that. He said the Working Group went further and is suggesting reversing the 2009 decision to provide guaranty association coverage for assumed claims transactions, which are transactions in which a licensed member insurer becomes responsible for the losses and policy benefits under a policy originally issued by someone that was not a licensed member insurer. Cantilo said his letter provides the history of the change in 2009. He said there is no need to reverse the 2009 decision to include assumed claims coverage to ensure that guaranty association protection is not lost in an IBT or CD transaction. To achieve this purpose, it would have been simple. The complexity and the debate that has occurred are because the Working Group went beyond the charge and, without fairly stating it, added an additional goal of its work, eliminating or providing for the elimination of the coverage adopted in 2009.

Cantilo said that to assure continued protection for policyholders and IBT and CD transactions, there are four lines he proposed in his comment letter. His comments on the matter that policyholders should retain guaranty association protection following an assumed claim transaction are based on the experience with Reciprocal of America, which was to provide workers' compensation insurance throughout the southeast of the country. It was placed into rehabilitation and then liquidation in 2003. There was opposition to providing guaranty association coverage to worker's compensation benefits where the policy had originally been issued by non-member insurers but was assumed by a member insurer. One case was a mother who had lost her worker's compensation benefits as a result and was forced out of her apartment with her kids and had to live out of her car. He said he was able to persuade our receivership court to reverse that. He said there is no public policy reason to support eliminating the guaranty association coverage for an assumed claims transaction simply to assure that it exists for an IBT and CD transaction.

Victorian asked if adopting Cantilo's proposed amendment would preserve guaranty association coverage for IBT and CD transactions. Cantilo said it would. Kevin Baldwin said with regard to whether either Cantilo's proposed amendment or the Working Group's adopted amendment would preserve guaranty association coverage for IBT and CD transactions, there was a lot of discussion in the Working Group. Kevin Baldwin said Cantillo raised his comments at the Working Group level. The amendments that the Working Group adopted and sent to the Task Force are a consensus product that included the input of many state insurance regulators and interested stakeholders.

Kevin Baldwin said for the Working Group's draft, the Working Group wanted to address the issue of guaranty fund coverage in the definition of a covered claim as opposed to addressing it in the definition of assumed claims transaction. He said the definition of a covered claim is the first place someone would go to see if a policy is covered by the guaranty fund. He said 47 states do not have a definition of assumed claim transaction because states have not adopted the 2009 language. He said there has been a lot of opposition to that language from various stakeholders. He said the Working Group's draft is a consensus approach that received buy-in from interested stakeholders, and it seemed to be the clearest and most concise place to revise the definition.

Slaymaker said the version before the Task Force gives two avenues for state insurance departments when requesting legislative changes. One approach is to pass both Section 5G(2) and the optional language in Section 5G(3), if possible. If it is not possible to pass both, states still pass the language that will address the IBT and CD coverage issues in 5G(2).

Wake said one issue that is not addressed by the base version of the Cantilo amendment is the situation where the domiciliary state transfers the policies to an insurer that is not licensed in this state at the time of the transfer. There are many scenarios in which this could happen. He said Cantilo acknowledged this and included some optional language in some of the versions he submitted, but the base version of his amendments requires an insolvent insurer. An insolvent insurer is defined to be a member insurer at the time the policy is transferred, which might not happen for a variety of reasons. He said claimants should not be punished for what happened when the policy was involuntarily transferred by the domiciliary regulator. He said guaranty fund coverage should be preserved.

Cantilo said his changes are all in the definition of covered claims. He said Wake is correct that he offered alternatives for an event that he finds unlikely—that regulators want to approve IBT or CD transactions of a non-member unlicensed insurer. Even if that were the case, only three or four lines of amendments are needed in the covered claims definition, which he has proposed to the Working Group, to accomplish the same result instead of the 278-line complicated Working Group proposal.

Wake said most of the 278 lines are deletions of language that some would characterize as complicated. He said the best answer is to not let the policy get transferred to a non-member insurer. He said this state has no choice over that unless it is the domiciliary state. Wake said that is why other language is needed to make sure the coverage is preserved, unless states want to be compelled to license what the domiciliary state might approve that might be contrary to this state's judgment.

Cantilo said he agreed with Wake's comments, but Cantilo is suggesting that can be done without deleting the 2009 assumed claims language.

Barbara Cox (Barbara Cox LLP) said she believes only three states have adopted the 2009 language on assumed claims transactions. She said with Cantilo's proposed amendment, there could be a situation where there is one set of rules for IBT and CD and a different set of rules for older, assumed claims transactions because the definition of novation and related requirements are still included in the draft. She said the charge that originated in the Restructuring Mechanisms (E) Working Group called for coverage neutrality, meaning that coverage should not be changed, and that is footnoted in one of NCIGF's comment letters. Cox stated that the way she read Cantilo's proposal is that none of these four options would provide for cover neutrality. She said she believes all of them call for a transaction that originated from a non-member of a guaranty fund transfer to a member would retain that coverage, so that is not the charge of the Restructuring Mechanisms (E) Working Group. She said this discussion has taken a year, and she said she thinks everyone has been heard. She said the proposal before the

Task Force is a simple solution that affords coverage for a broad range of transactions. She said NCIGF supports Section 5G(2), which is coverage neutrality member-to-member and member-to-non-member. NCIGF does not support 5G(3), which is non-member-to-member transactions, However, she said she respects the state insurance regulator's wish to make that available to state policymakers.

Cox stressed the urgency of the situation as there are 12 states that have adopted either IBT or CD provisions, and now they are using them. These laws do affect workers' compensation and other personal lines. The way the laws are read that exist in most states, there would not be guaranty fund coverage. If there are a lot of those transactions, that would mean a number of injured workers would not get the assistance they need, along with other homeowners, etc. She said NCIGF urges the NAIC to bring this process to a conclusion as expeditiously as possible.

Stolte said Virginia had a receivership to 2003, Reciprocal of America, where Virginia had to litigate this issue. Virginia supported the 2009 assumed claims amendment for the benefit of policyholders. Virginia believes that the Working Group exceeded its charge and is trying to make this optional. Virginia believes this would put the state at a distinct disadvantage. He said Virginia is opposed to making it optional.

Greg E. Mitchell (Global Regulatory Risk & Compliance PLLC) said he is speaking in his individual capacity. He said he was involved with the Reciprocal of America receivership, representing a number of claimants that had claims that had been assumed by Reciprocal of America. He said that public policy decision-making should be carefully considered as part of the amendments. He said in a situation where a regulated entity has had reserves and assets transferred through an approved transaction that would have constituted a novation and then have an insolvency with no guaranty fund coverage, the use of those assets should be carefully weighed and considered.

Commissioner Donelon said an exhaustive amount of time, energy, and effort has been put into this endeavor over the past year. He said he would like to refer the Model #540 amendments to the Financial Condition (E) Committee as soon as possible with the goal in mind of accomplishing a resolution to the disagreements. He said he is moved by the comments from Virginia relative to its experience with Reciprocal of America.

Wake said he submitted a comment but would like to discuss the layers of potential claims. First is what is covered by the existing laws in 47 states. Everybody wants to cover those. Second is IBTs and CDs, which the charge to the Working Group is to cover. When there is a disagreement between this state and the domiciliary state over whether that company qualifies for licensure or maybe even the resulting company does not seek licensure in this state, the result is that there might be a non-member transferee despite the state insurance regulator's best efforts.

Wake said the third layer on which he and the majority of the Working Group agree is that there are a number of scenarios in the 2009 amendments, like traditional assumption reinsurance, that should be covered. The Working Group version does that, and this is what has created the complaints that the amendments are supposedly outside of scope. There are also some other gaps that neither the 2009 amendments, the Cantilo proposal, nor the existing law cover. Common law novation is one.

Wake said all of these four together is what the base version of the Working Group's amendments with Section 5G(2) will cover. Because with the amendment uses a broad rule it automatically includes common law novation and assumption reinsurance without stating those specifically. He said he does not believe there is any good public policy reason to say the charge was too narrow, and to exclude these people and then come back with another amendment to fix that.

Wake said the Working Group understands that there are some states that think that there is a need for coverage in certain situations where a non-member transfers claims to a member insurer in a situation where it is not clear whether the member insurer issued a replacement policy. This issue is what the Task Force is arguing over, what state legislatures have disagreed about, and why the 2009 amendments are a hard sell in the legislature. Wake said the base version of the Working Group's model amendments does not cover this, but the optional Section 5G(3) does. If a state adopts optional Section 5G(3), it will cover everything that the 2009 amendments cover, plus everything else state insurance regulators want to cover. If they do not want to adopt Section 5G(3), then they will at least cover everything that is in the existing laws in the other 47 states, and every transfer from a member insurer that previously had guaranty fund coverage is preserved.

Commissioner Donelon asked which three states have adopted the 2009 assumed claims transaction language. Cox said Nevada, Oklahoma, and Rhode Island have adopted the 2009 amendments for assumed claims transactions. Stolte said Virginia probably adopted the 2009 amendments early rather than waiting for their adoption. Cantilo said in a lot of states, no change was necessary in order for that coverage to continue, which is perhaps why there were no changes made. Wake said he agrees that because the situation is that coverage is wanted, there are situations where the new insurer actually issued a replacement policy, and that is what the receivership court in Virginia found after litigation.

Superintendent Dwyer made a motion, seconded by Wake, to adopt the amendments to Model #540 (Attachment One-G). The motion passed unanimously.

5. Heard an Update on a Receivership Tabletop Exercise

Koenigsman said she distributed an announcement to state insurance regulators for the receivership tabletop exercise that NOLHGA and NCIGF will be presenting on Nov. 29 at the Fall National Meeting. Learning objections include opportunities for early planning, information, and operational needs for planning for receivership, unique issues that might arise in receivership, and understanding the timing and decision points in receivership. The session is intended for state insurance regulators and guaranty fund representatives. The session will not be listed in the Fall National Meeting agenda. Therefore, Fall National Meeting registration is not required. However, for planning purposes, those intending to attend should send an RSVP to NAIC staff by Nov. 3.

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

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Draft: 9/15/23
Adopted by the Executive (EX) Committee and Plenary, ___ __, 2023
Adopted by the Financial Condition (E) Committee, ___ __, 2023
Adopted by the Receivership and Insolvency (E) Task Force, ___ __, 2023

2024 Proposed Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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

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

~~4. The **Receiver's Handbook (E) Subgroup** will:~~

~~A. Complete the review the Receiver's Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver's Handbook. Complete by the 2023 Fall National Meeting.~~

NAIC Support Staff: Jane Koenigsman

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EDITORIAL SUGGESTIONS BY ROBERT ALAN WAKE (MAINE BUREAU OF INSURANCE)
AUGUST 22, 2023

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

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

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

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

TRIGGERS FOR RESOLUTION

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

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

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

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

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

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

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APPENDIX —SAMPLE DESCRIPTION OF U.S. RECEIVERSHIP REGIME

IMPACT OF FAILURE ON POLICYHOLDER PROTECTION

While the laws governing state insurance guaranty associations vary, most states 'have laws are patterned after the [Insert appliable Model: *Life and Health Insurance Guaranty Association Model Act (#520)* , or and the *Property and Casualty Insurance Guaranty Association Model Act (#540)*] adopted by the National Association of Insurance Commissioners (NAIC). Under the Model Act, a state's guaranty association generally must cover resident claims of an insolvent insurer (placed into liquidation). For life and health insurers, the guaranty association may cover resident claims of an impaired insurer (placed into rehabilitation and not an insolvent insurer). Benefit limits vary by state. This means that usually, the guaranty association of the claimant's state of residence is responsible for paying policyholder protection claims, subject to that state's laws, regardless of where the insurer is domiciled. If a claimant is not fully covered -by the applicable guaranty association, the claimant's rights against the estate of the insurer would be governed by the receivership laws of the insurer's domiciliary jurisdiction, as discussed more fully below.

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

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

Aggregate limits and other rules may apply.

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

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

High net worth exclusions and other rules may apply.

[Describe any material differences between the state guaranty association act(s) and the two NAIC Model Acts.]

OVERVIEW OF A RESOLUTION REGIME

[
If multiple legal entity insurers are within scope of the resolution plan, insert a comment that "rReceivership actions would be independent for each individual insurance legal entity and would be conducted by their respective domiciliary jurisdictions. Factors would be considered independently such as, minimum capital requirements or RBC levels in determining whether it should be placed into any receivership proceeding. An insolvency at the holding company level would be outside the scope of state

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Commented [RAW1]: This is not placeholder text so it shouldn't be bracketed. Most states have versions of both model acts, or similar related legislation, so it's "and," not "or."

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Commented [RAW2]: This is not obvious to non-US readers, so it bears emphasis.

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Commented [RAW3]: Don't we need to say something about this? Is a single paragraph enough?

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insurance receivership laws and would be within the jurisdiction of the federal Bankruptcy Courts. Insurance regulators would coordinate to avoid contagion in the event of "]the insolvency or threatened insolvency of [Insurance Holding Company Name] [or its parent(s) or affiliate(s)].

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[Modify or eliminate the above paragraph if there is only one insurance legal entity within scope of the resolution plan, if there is no holding company subject to federal bankruptcy jurisdiction, or if the holding company is within scope of the Dodd-Frank Act.]

Commented [RAW4]: Unless I am missing something, this is a highly unusual situation for an insurer that would be subject to resolution planning.

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

Commented [RAW5]: There will often be more than one lead-state domestic insurer in a group that is subject to resolution planning.

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

Timelines to complete a receivership depend on factors such as size and complexity of the insurer, ability to sell assets including selling books of business and affiliated assets, legal issues including handling affiliated or third-party agreements, stays and injunctions, and coordination with other states and jurisdictions where the insurer has business. Therefore, any receivership action is difficult to predict and may take years to complete.

The [other state insurance department(s)] would handle any resolution of [affiliated insurance entit~~y~~(ies) domiciled in another state(s)]. [Other state]'s receivership scheme would be similar to [this state]'s scheme in that any receivership would be overseen by the local court. (For simplicity the District of Columbia is referred to here as a state.) *[Omit last sentence if group does not do business in DC. Add additional explanatory material if group has operations in territories and possessions, or has subsidiaries domiciled outside the US or foreign branches that might be subject to foreign resolution laws.]*

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

	Insurer #1	Insurer #2	Insurer #3
General Account Assets			
(Separate Account Assets for L/H or Protected Cell Assets for P&C)			
Total Assets			
General Account Liabilities			
Separate Account Liabilities for L/H or Protected Cell Liabilities for P&C)			

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Total Liabilities			
Total Policyholder Surplus			
Total (Direct/Net) Premiums			
Largest Line of Business			
Net Income or Loss			
ACL Risk-Based Capital %			

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

[Insurance Code] provides the Commissioner several regulatory actions when insurance companies experience financial difficulties. Regulatory action is taken when insurance companies trigger any of the hazardous financial condition standards delineated in [Insurance Code], including ~~if the company triggers action under~~ RBC standards as developed by the NAIC and adopted by [this state], which give the Commissioner authority to take action before a company is insolvent. Failure to meet RBC requirements ~~have absolute~~requires specific prescribed actions that must be taken ~~given the reported~~based upon the RBC level of the reporting entity; the required actions escalate with each RBC threshold that is breached. The hazardous condition ~~requirements~~ criteria are much broader in nature and include qualitative as well as quantitative standards ~~give the Commissioner authority to take action before a company is insolvent~~. [*Specify the regulatory actions*] within [Insurance Code] require a court order and oversight.

Commented [RAW6]: This applies to RBC as well as HFC – that's the whole point of the RBC thresholds, after all.

Commented [RAW7]: Hazardous operation isn't "required"

- Supervision is an order from the Commissioner that orders the insurance company to take certain actions to abate the hazardous conditions. Supervision is frequently used as the first step in a process to resolve financial issues within the insurer.
- If the issue is significant and needs immediate action to protect policyholders the Commissioner may decide Conservation, Seizure, Rehabilitation or Liquidation are appropriate, and petition the court.

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

RESOLUTION DIFFERENCES

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

General Account vs. Separate Account

[This state] differentiates between the resolution of [the insurer's] general account business and its separate account business. A separate account refers to an investment account used to

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manage policyholder funds placed in variable insurance products. This account is maintained separately from the general account, and distinctions are important in this context.

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

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

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

Pursuant to [Insurance Code], policies or contracts of reinsurance are not covered by the guaranty association unless the assuming insurer has assumed the ceding insurer's entire obligation ~~assumption certificates have been issued to the~~ directly to the insured parties on the underlying policies.

Commented [RAW8]: The language that included the "assumption certificate" exception is an accurate quote from 520, but I don't think it's easily accessible to the reader who doesn't already know this. 540 doesn't even expressly exclude reinsurance, but the effect of both the existing language and the proposed amendments is similar; however, neither version mentions anything called an "assumption certificate."

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

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

RESOLUTION ACTIONS

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

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

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

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

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

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

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Liquidation
An order of Liquidation is sought when the receiver determines there is no possibility to rehabilitate the insurer, and the best option to protect policyholders and creditors is to liquidate the insurer. In a Liquidation, all new and renewal business ceases. Again, the receiver receives authority to marshal and take title to all assets of the insurer's estate. The liquidation order would also place a temporary stay on any litigation. The Board of Director's powers would be suspended, and the receiver placed in charge of running the day-to-day operations. Some or all of the insurer's upper management could be terminated as determined by the receiver.

In all the above actions, dividends would cease, and it is likely [this state] would have stopped any dividends prior to the deterioration in financial condition to the point where regulatory action was necessary. Even in the ordinary course of business, an insurer may not pay ~~The Commissioner has broad authority to object to ordinary dividends and must prior approve any~~ extraordinary dividends without the prior approval of the Commissioner, .and the Commissioner has broad authority to object to ordinary dividends for cause.

ANALYSIS OF RESOLUTION ACTIONS

The following summarizes key elements of each of the resolution actions available in [this state]. Notwithstanding the following, each receivership situation and cause is often unique to the insolvent

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entity. An analysis must be quickly made, and a plan developed for dealing with any event. The plan must also be continually reviewed and adjusted as events unfold.

1. ORDER OF SUPERVISION

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

Commented [RAW9]: e.g.???

<u>The Order</u>

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

<u>Operations of a Supervision</u>

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

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Confidentiality and Notification/Communication

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

Commented [RAW10]: The insurer itself might have the right to waive confidentiality in whole or part.

Oversight of Supervision

- In a Supervision, the Commissioner generally designates an internal or external party as supervisor (referred to as "Supervisor" in this section) to oversee and monitor the company's progress in developing and implementing corrective actions necessary to abate the hazardous financial conditions. The Supervisor interacts with company management and provides the Commissioner and interested parties with progress reports.
- The Commissioner may hire an external Supervisor to monitor and oversee the Supervision. [*Insert the state's rule on compensation, such as "The amount of compensation would be dependent on the expertise and experience of the external Supervisor. The Commissioner may appoint an internal supervisor and those costs would be covered within the Department's budget."]*

Commented [RAW11]: We started using this term earlier – consider reordering?

2. ORDER OF SEIZURE OR CONSERVATION

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

The Order

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

Commented [RAW12]: Might there be readers who don't know what "ex parte" means?

Operations of a Seizure

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

Confidentiality and Notification/Communication

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

Oversight of Seizure

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

3. ORDER OF REHABILITATION

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~~After Supervision and Seizure [*or Conservation*],~~ Rehabilitation is the ~~next~~ most ~~severe~~ stringent delinquency proceeding short of Liquidation. Rehabilitation is designed to generate a Rehabilitation plan that will either correct the difficulties that led to the insurer being placed in receivership and restore the company's financial condition to sound basis or transition the company's policyholder liabilities to financially sound insurers. The ~~Deputy~~ Rehabilitator~~(s)~~ may determine the company cannot be rehabilitated. If that is the determination, then a petition for Liquidation will be filed with the court.

Commented [RAW13]: We don't mention the Deputy(ies) until the end of the next page, and I don't think we need to do it here.

The Order

- [Insurance Code] allows the Commissioner to petition the Court for an order of Rehabilitation based on one or more of the criteria listed above including, but not limited to, the concern that allowing the company to transact business would be hazardous to policyholders, creditors and the public.
- Rehabilitation orders are public documents and are subject to judicial oversight by [Name of Court].
- The Rehabilitation order vests authority to marshal and take title of all assets of the insurer's estate with the Commissioner as Rehabilitator.
- During Rehabilitation, the receiver may look for possible buyers for the insurer or even books of business or may consider other options to restore profitability or minimize losses.
- There are a number of issues ~~that may occur~~ that can complicate a successful Rehabilitation, such as loss of essential personnel, inability to restructure non-policyholder contractual obligations, loss of asset values due to market conditions, litigation, reinsurer disputes, inability to find

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insurers to reinsure company policies on an satisfactory basis, unexpected liabilities under derivative or policy contracts, inadequate policy or claim reserves, rating downgrade due to the Rehabilitation order and inability of investment income to meet policy minimum guarantees as well as other matters.

- The length of time of a Rehabilitation is dependent on the complexity, financial condition, size of the company, and the development of a plan of rehabilitation. Rehabilitation can take multiple years to complete.

Operations of a Rehabilitation

- After the Court has issued the Rehabilitation order, the receiver would be placed in charge of running the day-to-day operations of the insurer.
- The Rehabilitation order would suspend the authority of the board of directors, managers and officers unless reappointed by the Commissioner. Some or all of the insurer's upper management could be terminated as determined by the receiver.
- All current legal proceedings and litigation against the company would be stayed for [number of days based on state's insurance code] and the Rehabilitation order would contain an injunction against filing new legal actions.
- The Rehabilitation order may include *[For this bullet suggest only including those items that may be included in the order which are material to the insurer, rather than an exhaustive list.]:*
  - Prohibit or severely limit all new business writings.
  - Require the insurer to modify or even cancel certain managing general agent ("MGA"), third-party administrator ("TPA") and general agency agreements.
  - Suspend claims payments and halt the transfer of cash or loan values on life insurance contracts.
  - Provide that reinsurance agreements may not be canceled, and that the insurer may not obtain any new reinsurance without the approval of the receiver.
  - Require recapitalization.
  - Restrict new investments or liquidate investments.
- *[Insert the state's handling in rehabilitation of any material issues or risks that are specific to the insurer, such as the following]:*
  - The Rehabilitation order would most likely include a moratorium on cash surrenders or policy loans except in defined hardship matters. If the Rehabilitator sells or ~~reinsurers~~ reinsures a block of business with another insurer, an additional moratorium may be implemented before the policyholder can change insurers.
  - Because Rehabilitation is a formal delinquency action, counterparties to the company's derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with [insurer], ~~risks that~~hedging strategies previously undertaken by [insurer] ~~had hedged~~ may disappear and expose [insurer] to adverse financial risks. [Insurer's] credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.
  - If the company has any secured ~~l~~loans outstanding, for example, ~~with~~advances of credit from ~~the~~ a Federal Home Loan Bank (FHLB), the ~~FHLB~~ lender would be able to take possession of any collateral pledged as security for the loan amounts.
  - *[Describe the handling of significant assumed reinsurance business in receivership, e.g., if the US entity is a reinsurer or a direct writer with significant assumed book of business.]*

Commented [RAW14]: If the risks disappeared, that would be a good thing. It's the disappearance of the hedges we need to worry about.

Commented [RAW15]: Does an FHLB have special rights that other secured lenders lack??? Revert to original language if it's unique to FLHBs.

Commented [RAW16]: There are multiple regional FHLBs.

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- *[This bullet applies to resolution plans involving life, annuity and health insurers.]* A Rehabilitation order against a life, annuity or health insurer such as [name(s) of insurer(s)] would trigger guaranty association involvement and coverage under the definition of "impaired" insurer contained in their statutes. The guaranty association may guarantee, assume or reinsure any or all of the impaired insurer policies, provide additional funds to assume or reinsure the impaired insurer policies, provide substitute benefits in some cases for the impaired insurer and other actions.
- Proof of claim forms would need to be sent out for unpaid pre-rehabilitation liabilities. It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in ~~that~~ their respective states.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*
- Various matters will need to be filed with the Court for approval including legal settlements, payments to pre-rehabilitation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Commented [RAW17]: Groups subject to resolution planning could often have members of both guaranty associations within the group. In some cases a single legal entity writes some cross-category business.

Oversight of a Rehabilitation

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- The Commissioner may appoint one or more Deputy Rehabilitators. The [*Specify the title of any department director of receivership or other position*] is usually appointed as Deputy Rehabilitator or manages the Rehabilitators if they are outside consultants. Given the insurer's size and complexity, the Deputy Rehabilitators would likely hire a rehabilitation team to assist in the Rehabilitation. The rehabilitation team would likely have specialists such as actuaries, investment specialists and others. *[Insert any needed specialists based on the insurer's unique risk profile.]* An investment bank may be hired to assist in identifying potential purchasers of blocks of business, merger partners or sources of capital infusion.
- The [*name of the department's Receivership or other Division*] has procedures in place for hiring outside specialists/outside Deputy Rehabilitators as well as a list of qualified vendors. The hiring of any outside consultants/specialists is subject to *[Specify state's rules on hiring and compensation such as "the Receivership procurement procedures"]* and their compensation is subject to Court approval. [*Specify the state's legal structure for handling receivership matters, such as "The Attorney General usually handles receivership matters for the Commissioner"*].
- Because of [insurer's] size and complexity, it may be necessary to hire outside legal counsel. There are a number of qualified law firms that have prior rehabilitation legal experience. Any outside legal counsel and their compensation would be subject to Court approval.
- [*Specify the state's rules on funding of compensation, such as "Payment of any outside specialists, Deputy Rehabilitators and/or legal funds would be paid out of the Rehabilitation estate funds. The (Name of the department's receivership director, if applicable) costs are funded by the Department subject to potential reimbursement by the Rehabilitation estate."]*
- The Rehabilitator or Deputy Rehabilitators and the Rehabilitation team are responsible for the day-to-day operations of the company.
- The Deputy Rehabilitator(s) and the rehabilitation team would be responsible for drafting a plan of Rehabilitation subject to the Commissioner and the Court's approval. The Rehabilitation Plan may include reorganization, reinsurance of various blocks of company business, merger or purchase or other options in order for the company to meet its obligations to policyholders and creditors. The Rehabilitation Plan will follow the creditor priorities as stated in [Insurance Code]. The Deputy Rehabilitators would seek the guaranty association input on any sale or reinsurance

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of company blocks of business. The Deputy Rehabilitators and the rehabilitation team would be responsible for communicating the plan of Rehabilitation to all interested parties.

4. ORDER OF LIQUIDATION

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

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

The Order

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

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Operations of a Liquidation

- After the Court has issued the Liquidation order all new business writings would cease.
- *[Insert applicable insurance code that describes the effect of the order of liquidation upon contracts of the insolvent insurer, i.e., continuance in force, termination or cancelation of policies:]*
  - [Insurance code] provides that upon issuance of the order, all of the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of liquidation. The Liquidation order provides notice to policyholders, terminates policies and contracts where a guarantee of insurance is provided upon [*insert termination period*].
  - *[For life, annuity and health insurers.]* Life and health insurance policies and annuities shall continue in force for such a period and under such terms provided for by the guaranty associations. Those life, health and annuity products not covered by a guaranty association would terminate [Insert termination period from state statute]. The Liquidation order would most likely include a moratorium on cash surrenders or policy loans except in defined hardship matters. If the Liquidator sells or ~~reinsurers~~ reinsures a block of business with another insurer an additional moratorium may be implemented before the policyholder can change insurers.
- *[Insert the state's handling in liquidation of any material issues or risks or unique policy types that are specific to the insurer that may require special consideration, such as the following:]*
  - Because Liquidation is a formal delinquency action, counterparties to the company's derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with [insurer], risks that [insurer] had hedged may disappear and expose [insurer] to adverse financial risks. [Insurer's] credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.

- If the company has any secured ~~l~~loans outstanding, for example, ~~with~~advances of credit from ~~the~~ a Federal Home Loan Bank (FHLB), the ~~FHLB~~ lender would be able to take possession of any collateral pledged as security for the loan amounts.
- [Insurance code] excludes [*material policy types or business not covered*] from guaranty fund coverage.
- *[Describe the handling of significant assumed reinsurance business in receivership, if the US entity is a reinsurer or a direct writer with a significant assumed book of business. e.g., exclusion from guaranty fund coverage; claims fall within general creditor class of priorities; limitations on setoffs.]*

Commented [RAW18]: Does an FHLB have special rights that other secured lenders lack??? Revert to original language if it's unique to FLHBs.

Commented [RAW19]: There are multiple regional FHLBs.

- The Liquidation order would terminate the authority of the board of directors and officers.
- A Liquidation order would trigger guaranty association involvement and coverage under the definition of "insolvent" insurer contained in their statutes.

Commented [RAW20]: Strictly speaking, the definition isn't the trigger, it's the substantive provisions that use the defined term.

- The Liquidation order would contain an injunction against filing new legal actions or pursuing current actions.
- Proof of claim forms would need to be sent out for unpaid pre-liquidation liabilities.
- It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in ~~that~~ their respective states.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*
- The Deputy Liquidators would need to discuss the transition of policyholder administration and claims adjudication processes with the effected guaranty associations.
- Various matters will need to be filed with the Court for approval including legal settlements, any distribution to liquidation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Liquidation

- The Commissioner may appoint one or several Deputy Liquidators. Given [insurer's] size and complexity, the Deputy Liquidators would likely hire temporary staff to assist them in the Liquidation. The Deputy Liquidators may hire specialists such as actuaries, investment specialists and others to evaluate certain areas of the company. *[Insert any needed specialists based on the insurer's unique risk profile.]*
- The [*Specify the title of any department director of receivership or other position*] is usually appointed as Deputy Liquidator or manages the Deputy Liquidators if they are outside consultants. The [N*ame of the department's Receivership or other Division*] has procedures in place for hiring outside specialists and outside Deputy Liquidators as well as a list of qualified vendors. The hiring of any outside consultants/specialists is subject to *[Specify state's rules on hiring and compensation such as "the Receivership procurement procedures"]* and their compensation is subject to Court approval. [*Specify the state's legal structure for handling receivership matters, such as "The Attorney General usually handles receivership matters for the Commissioner"*]. Because of [insurer's] size and complexity, it may be necessary to hire outside legal counsel. There are a number of qualified law firms that have prior liquidation legal experience. Any outside legal counsel and their compensation would be subject to Court approval. [*Specify the state's rules on funding of compensation, such as "Payment of any outside specialists, Deputy Liquidators and/or legal funds would be paid out of the Liquidation estate funds. The (Name of the department's receivership director, if applicable) costs are funded by the Department subject to potential reimbursement by the Liquidation estate."]*

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- The Deputy Liquidator(s) would be responsible for the administration of the Liquidation estate with the goal of the fair and efficient handling of all Liquidation claims and the marshalling of assets to insure the maximum distribution for the Liquidation creditors. The Deputy Liquidators would distribute assets in accordance with the creditor priorities as stated in [Insurance Code]. The Deputy Liquidators would work with the guaranty association input on any sale or reinsurance of company blocks of business.

Guaranty Associations
[Due to differences in P&C vs. L&H guaranty funds, this section should be edited for the applicable guaranty fund(s) based on the type(s) of domestic insurer)s) within the scope of the resolution plan.]

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

POLICYHOLDER PROTECTION SCHEMES (AKA., GUARANTY FUNDS)

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

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

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

Further details on the coverage and eligibility requirements for coverage by the [this state's guaranty association(s)] can be found at [*Insert name of attachment or website*]. A list of coverage and limitations of [this state's guaranty association(s)] can be found at [*Insert name of attachment or website*]. *[Customize to address the types of business conducted in this state by insurers within scope of this resolution plan.]*

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Commented [RAW21]: It would have been simpler just to say "when the insurer becomes insolvent," but there are several steps between the insurer going broke and meeting the statutory definition of "insolvent insurer" (which also contains some other conditions that aren't part of the English definition of the term).

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

IMPLEMENTATION

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

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

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

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

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

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

COMMUNICATION STRATEGY

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

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

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

Parties to which timely communication is required include the NAIC, NOLGHA or NCIGF and [this state's] guaranty association, states in which the company is licensed, state/federal/international regulatory agencies, agents, policyholders, reinsurers, creditors, management and employees, board of directors,

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and other federal agencies (as applicable), among others. *[Edit this list for this state's communication requirements].*

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

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

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

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

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**JOINT COMMENTS ON RITF EXPOSURE DRAFT
OF SAMPLE DESCRIPTION OF U.S. RESOLUTION REGIME
September 14, 2023**

Thank you for the opportunity to comment on the exposure draft of the Sample Description of U.S. Resolution Regime. The draft provides a solid description of the national state-based resolution system, including the important policy protection role of guaranty associations. We appreciate the Task Force continuing to acknowledge the importance of coordination among regulators, receivership staff, and the guaranty system in ensuring that a resolution achieves the best possible outcomes for policyholders and other creditors.

Our comments are focused primarily on the description of the guaranty system. In a few instances, we also have suggestions regarding the broader resolution description for your consideration. All those suggestions are provided in the attachment through redlines or document comments.

We are available to discuss these comments with the Task Force and staff, and look forward to continuing to contribute to the project.

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

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

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

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

TRIGGERS FOR RESOLUTION

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

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

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

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

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

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

~~IMPACT OF FAILURE ON~~ POLICYHOLDER PROTECTION SUPPORT UPON FAILURE

Policyholder protection mechanisms are in place in all U.S. states and several of its territories. These mechanisms, commonly known as "guaranty associations" or "guaranty funds", pay certain policy claims and/or continue certain policy coverages, generally upon the issuance of a liquidation order with a finding

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of insolvency by a court in the appropriate U.S. jurisdiction. The operation and obligations of guaranty associations are governed by statute. Funding to support the guaranty associations' statutory obligations comes from the remaining assets of the insolvent insurer, assessments on certain licensed insurance companies that are "members" of the guaranty associations, future premiums (if applicable), and statutory deposits collected by the states (if available).

While the laws governing state insurance guaranty associations vary somewhat, most states' laws are patterned after the [*Insert appliable Model: Life and Health Insurance Guaranty Association Model Act (#520), or the Property and Casualty Insurance Guaranty Association Model Act (#540)*] adopted by the National Association of Insurance Commissioners (NAIC). Under the Model Act, a state's guaranty association generally must cover resident claims of against an insolvent member insurer (placed into liquidation with a finding of insolvency). For life and health insurers, the guaranty associations also continue in-force policies and annuities of an insolvent insurer. Life and health guaranty associations may have discretionary authority to provide coverage or continue policies/annuities resident claimsfor policyholders of an impaired insurer (placed into rehabilitation and not an insolvent insurer). Due to concerns and challenges associated with this authority, it has not been used in multi-state insolvencies and has only rarely been used in single state cases. Benefit limits vary by state.

Additional information about the guaranty system is available on the websites for the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF).

Benefit limits are generally consistent but can vary somewhat by state. The *Life and Health Insurance Guaranty Association Model Act* proposes the following benefit limits, with respect to one life, regardless of the number of policies or contracts:

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

Aggregate limits and other rules may apply.

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

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

High net worth exclusions limitations and other rules may apply in many jurisdictions for property and casualty claims. These limitations generally exclude or call for recovery of claims by or against policyholders that have a net worth exceeding the threshold. The thresholds vary by jurisdiction but typically range from 10 million to 50 million USD.

Commented [A1]: NOLHGA notes that voluntary triggering for an impaired insurer is not a practical solution in multi-state cases and has only rarely been used in single state cases. NOLHGA suggests that this and other references to triggering for an impaired insurer be deleted. If the reference is regarded as necessary, we request the noted revisions be made here and the subsequent references be deleted as noted below.

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The coverage limits for each guaranty association and information about certain limitations on coverage can be found on NOLHGA's website and NCIGF's website.

OVERVIEW OF A RESOLUTION REGIME

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

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

A multi-state resolution will be undertaken with a high degree of national coordination under the state-based system. Senior financial regulators comprise the NAIC's Financial Analysis Working Group, which coordinates and provides peer review for the oversight of financially troubled insurers. Likewise, through the NAIC's Receivership Financial Analysis Working Group, senior resolution professionals can coordinate planning and execution of multi-state receiverships. NOLHGA and NCIGF coordinate policyholder protection for multi-state insolvencies.

Timelines to complete a receivership depend on factors such as size and complexity of the insurer, ability to sell assets including selling books of business and affiliated assets, legal issues including handling affiliated or third-party agreements, stays and injunctions, timeline for asset recovery (including through litigation), and coordination with other states and jurisdictions where the insurer has business. Therefore, the length of any receivership action is difficult to predict and may take years to complete in order to effectuate the best possible outcome for policyholders and other creditors.

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

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

	Insurer #1	**Insurer #2**	**Insurer #3**
General Account Assets			

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

Should there be an insolvency of the insurer, [this state] must coordinate its activities on the receivership with [this state's] guaranty association and the national state-based guaranty system. Attached is [Insurance Code] that provides the statutory authority of [this state's] guaranty association, and coverage limits provided by the association. The guaranty funds in all the states where the insurer ~~sold business~~was licensed would be triggered to cover ~~the~~ policyholder liabilities in accordance with the guaranty association ~~as defined by insurance~~ laws of those states. The Commissioner as receiver and [t~~T~~his state's guaranty association] would work with [~~the National Organization of Life & Health Life Guaranty Associations (~~NOLHGA~~)~~ or ~~the National Conference of Insurance Guaranty Funds (~~NCIGF~~)~~] to coordinate the efforts of all the ~~states'~~ affected guaranty ~~funds~~associations. Once triggered, guaranty associations will begin to pay claims and, for life/health insurance liquidations, continue coverage, typically without delay.

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

- Supervision is an order from the Commissioner that ~~orders~~ the insurance company ~~to~~ take certain actions to abate the hazardous conditions. Supervision is frequently used as the first step in a process to resolve financial issues within the insurer.
- If the issue is significant and needs immediate action to protect policyholders the Commissioner may decide Conservation, Seizure, Rehabilitation or Liquidation are appropriate, and petition the court.

The most appropriate action(s) to take in a resolution of the insurer will depend on the cause and magnitude of the financial issues that are prompting the need for regulatory action. *[Where applicable, note that- a temporary moratorium may be imposed on policyholder withdrawals or surrenders.]*

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APPENDIX —SAMPLE DESCRIPTION OF U.S. RECEIVERSHIP REGIME

RESOLUTION DIFFERENCES

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

General Account vs. Separate Account

[This state] differentiates between the resolution of [the insurer's] general account business and its separate account business. A separate account refers to an ~~investment~~ account established by an insurer under [insert jurisdiction's legal/statutory provisions governing the creation of separate accounts] to segregate from the insurer's general assets funds backing certain of the insurer's liabilities. A separate account must be used ~~to manage policyholder funds placed in~~for variable insurance products to provide the investment options permitted by those products. Insurers have also used separate accounts to support certain fixed products, including fixed payout annuity obligations under pension risk transfer annuities. Th~~is~~ese account~~s~~ ~~is~~ are maintained separately from the general account, and the purpose of each separate account is ~~distinctions are~~ important in this context.

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

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

> **Commented [A2]:** Note that this section seems to conflate separate accounts with variable products. While all variable products must utilize a separate account, separate accounts are also used for non-variable products where the funds in the separate account support certain liabilities but do not provide investment returns for the benefit of policyholders and are not registered with the SEC. We suggest revisions to acknowledge these other uses of separate accounts and distinguish where the text is referring only to variable product separate accounts.

> **Commented [A3]:** There are no provisions in the guaranty association statutes that discuss separate accounts and general accounts. Moreover, such accounts are not relevant to how guaranty associations determine coverage.

Reinsurance Assumed Business

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

Pursuant to [Insurance Code], policies or contracts of reinsurance are not covered by the guaranty association unless, in the case of life and health insolvencies, ~~the~~ assumption certificates have been issued by the reinsurer to the direct insureds. Property and casualty guaranty funds do not cover reinsurance in any situation.

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Unique Lines of Business or Insurance Entities in the Group

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

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

RESOLUTION ACTIONS

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

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

Administrative Supervision

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

Seizure or Conservation

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

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

Rehabilitation

An order of Rehabilitation is sought when the ~~receiver~~Commissioner wants a period of time to evaluate whether actions can be taken to restore or transform the insurer and restore financial stability. The receiver ~~receives~~ is then granted authority to marshal and take title to all assets of the insurer's estate and runs the day-to-day operations. An Order of Rehabilitation and Plan of Rehabilitation will be tailored to the specific circumstances around the rehabilitation and the goals of the receiver. In most U.S. jurisdictions, the Commissioner serves as receiver. (The appointment of deputy receivers and other consultants is discussed below.)

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Liquidation

An order of Liquidation is sought when the receiver Commissioner determines there is no possibilitythat (further) efforts to rehabilitate the insurer would be futile or increase the risk of harm to policyholders, creditors or the public, and the best option to protect policyholders and, creditors and the public is to liquidate the insurer. (An insurer can be placed in liquidation without having been in rehabilitation or any other receivership proceeding first.) In a property and casualty Liquidation, all new and renewal business ceases. However, for life insurance, health insurance (including long-term care) and annuities, policies and contracts will be continued by the guaranty associations in accordance with the terms of the policies and contracts and applicable guaranty association statutes. Again, the receiver receives is granted authority to marshal and take title to all assets of the insurer's estate. The liquidation order would also place a temporary stay on any litigation. The Board of Director's powers would be suspended, and the receiver placed in charge of running the day-to-day operations. Some or all of the insurer's upper management could be terminated as determined by the receiver.

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

ANALYSIS OF RESOLUTION ACTIONS

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

1. ORDER OF SUPERVISION

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

The Order

- [Insurance Code] allows the Commissioner to issue an order of Supervision, which allows the Commissioner to order the insurer to take actions to abate the hazardous conditions identified by the Commissioner. Under Supervision there is no judicial oversight. *[If judicial action is required in this state, replace applicable language.]*
- The Supervision order provides an [*Insert timeframe*] for the company to abate the hazardous conditions. The Commissioner may determine to extend the Supervision timeframe dependent on the company's progress in abating the hazardous conditions or, if satisfactory progress has not

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been met, place the company in a more severe delinquency proceeding (i.e., seizure, conservation, rehabilitation, liquidation). The Commissioner may also decide to suspend, revoke or limit the company's certificate of authority to do business.

- Supervision does not vest control or title of the company's assets under the Commissioner.
- Supervision typically is a confidential proceeding, allowing the Commissioner to work with the company to correct the hazardous financial conditions without raising concerns of policyholders, creditors or others.
- *[Consider other risk scenario specific comments such as for life and annuity insurers: "If confidentiality is breached it may cause a run on the bank scenario i.e., policy surrenders."].*

Operations of a Supervision (subject to specific content of an order)

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

Confidentiality and Notification/Communication

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

insurer's financial condition worsen, or the insurer does not successfully abate the conditions of the Supervision order and a more severe resolution action becomes necessary.

<u>Oversight of Supervision</u>

- In a Supervision, the Commissioner generally designates an internal or external party as supervisor (referred to as "Supervisor" in this section) to oversee and monitor the company's progress in developing and implementing corrective actions necessary to abate the hazardous financial conditions. The Supervisor interacts with company management and provides the Commissioner and interested parties with progress reports.
- The Commissioner may hire an external Supervisor to monitor and oversee the Supervision. [*Insert the state's rule on compensation, such as "The amount of compensation would be dependent on the expertise and experience of the external Supervisor. The Commissioner may appoint an internal supervisor and those costs would be covered within the Department's budget."]*

2. ORDER OF SEIZURE OR CONSERVATION

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

<u>The Order</u>

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

<u>Operations of a Seizure</u>

- Similar to Supervision, the insurer continues to write and renew business and pay claims in the ordinary course of business. General creditors and vendors are also paid in the ordinary course

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of business. The company's board of directors and present management generally remain in place. There would be no changes to policy benefits or coverage under a Seizure order.

- However, the Seizure order prohibits the insurer, its officers, managers, agents and employees from disposing of the insurer's property and transacting business except with the Commissioner's written consent or further court order.
- While there is more control of the disposal of assets under Seizure, the Seizure order does not give title of those assets to the Commissioner. The company's current contractual obligations remain in place. ~~[If confidentiality is breached it may cause a run on the bank scenario i.e., policy surrenders or withdrawals.]~~

Confidentiality and Notification/Communication

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

Commented [A4]: Please see note above about life and health guaranty association triggering for an impaired insurer. Even if the above language is retained (as revised), we do not see the need to make repeated references to an option that has rarely been exercised.

Oversight of Seizure

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

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- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*

3. ORDER OF REHABILITATION

After Supervision and Seizure [*or Conservation*], Rehabilitation is the next most severe ~~delinquency~~ resolution proceeding. Rehabilitation is designed to generate a Rehabilitation plan that will either correct the difficulties that led to the insurer being placed in receivership and restore the company's financial condition to sound basis or transition the company's policyholder liabilities to financially sound insurers. The ~~Deputy~~ Rehabilitator may determine the company cannot be rehabilitated. If that is the determination, then a petition for Liquidation will be filed with the court.

The Order

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

Operations of a Rehabilitation

- After the Court has issued the Rehabilitation order, the receiver (or a deputy receiver) would be placed in charge of running the day-to-day operations of the insurer.
- The Rehabilitation order would suspend the authority of the board of directors, managers and officers unless reappointed by the Commissioner. Some or all of the insurer's upper management could be terminated as determined by the receiver.
- All current legal proceedings and litigation against the company would be stayed for [number of days based on state's insurance code] and the Rehabilitation order would contain an injunction against filing new legal actions.

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- The Rehabilitation order may include *[For this bullet suggest only including those items that may be included in the order which are material to the insurer, rather than an exhaustive list.]:*
  - Prohibit or severely limit all new business writings.
  - Require the insurer to modify or even cancel certain managing general agent ("MGA"), third-party administrator ("TPA") and general agency agreements.
  - Suspend claims payments and halt the transfer of cash or loan values on life insurance contracts.
  - Provide that reinsurance agreements may not be canceled, and that the insurer may not obtain any new reinsurance without the approval of the receiver.
  - Require recapitalization.
  - Restrict new investments or liquidate investments.
- *[Insert the state's handling in rehabilitation of any material issues or risks that are specific to the insurer, such as the following]:*
  - The Rehabilitation order wouldmay include a temporary moratorium on cash withdrawals, surrenders or policy loans except in defined hardship matters. If the Rehabilitator sells or reinsurers a block of business with another insurer, an additional moratorium may be implemented before the policyholder can change insurers.
  - Because Rehabilitation is a formal delinquency action, counterparties to the company's derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with [insurer], risks that [insurer] had hedged may disappear and expose [insurer] to adverse financial risks. [Insurer's] credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.
  - If the company has any loans outstanding with the Federal Home Loan Bank (FHLB), the FHLB would be able to take possession of any collateral pledged as security for the loan amounts.
  - *[Describe the handling of significant assumed reinsurance business in receivershipreahhabilitation, e.g., if the US entity is a reinsurer or a direct writer with significant assumed book of business.]*
- *[This bullet applies to resolution plans involving life, annuity and health insurers.]* A Rehabilitation order would trigger guaranty association involvement and coverage under the definition of "impaired" insurer contained in their statutes. The guaranty association may guarantee, assume or reinsure any or all of the impaired insurer policies, provide additional funds to assume or reinsure the impaired insurer policies, provide substitute benefits in some cases for the impaired insurer and other actions.
- Proof of claim forms would need to be sent out for unpaid pre-rehabilitation liabilities.
- It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in that state.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].* Other state insurance departments often will seek to either revoke or suspend the company's authority to transact business in that state. The Commissioner may coordinate with those other states to ensure revocation or suspension is handled in the best interests of policyholders.

Commented [A5]: We do not recall this ever happening. Moratoriums are more thoroughly covered on the next page, and we suggest keeping that discussion rather than this sentence.

Commented [A6]: Given complexities around the topic, consider a less specific statement such as: "Treatment of derivative counterparties will be subject to [insert state law if applicable]."

Commented [A7]: Please see note above about life and health guaranty association triggering for an impaired insurer. Even if the above language is retained (as revised), we do not see the need to make repeated references to an option that has rarely been exercised.

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- Various matters will need to be filed with the Court for approval including legal settlements, payments to pre-rehabilitation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Rehabilitation

- The Commissioner may generally would appoint aone or more Deputy Rehabilitators. The [*Specify the title of any department director of receivership, or other position, or standing receivership support organization*] is usually appointed as Deputy Rehabilitator or manages the Rehabilitators rehabilitation staff if they are outside consultants. Given the insurer's size and complexity, the Deputy Rehabilitators would likely hire a rehabilitation team to assist in the Rehabilitation. The rehabilitation team would likely have specialists such as actuaries, investment specialists and others. *[Insert any needed specialists based on the insurer's unique risk profile.]* An investment bank may be hired to assist in identifying potential purchasers of blocks of business, merger partners or sources of capital infusion.
- The [*name of the department's Receivership or other Division*] has procedures in place for hiring outside specialists/outside Deputy Rehabilitators as well as a list of qualified vendors. The hiring of any outside consultants/specialists is subject to *[Specify state's rules on hiring and compensation such as "the Receivership procurement procedures"]* and their compensation is subject to Court approval. [*Specify the state's legal structure for handling receivership matters, such as "The Attorney General usually handles receivership matters for the Commissioner"*].
- Because of [insurer's] size and complexity, it may be necessary to hire outside legal counsel. There are a number of qualified law firms that have prior significant national rehabilitation legal experience. Any outside legal counsel and their compensation would be subject to Court approval.
- [*Specify the state's rules on funding of compensation, such as "Payment of any outside specialists, Deputy Rehabilitators and/or legal funds would be paid out of the Rehabilitation estate funds. The (Name of the department's receivership director, if applicable) costs are funded by the Department subject to potential reimbursement by the Rehabilitation estate."]*
- The Rehabilitator or Deputy Rehabilitators and the Rehabilitation team are responsible for the day-to-day operations of the company.
- The Deputy Rehabilitator(s) and the rehabilitation team would be responsible for drafting a plan of Rehabilitation subject to the CommissionerRehabilitator and the Court's approval. The Rehabilitation pPlan may include reorganization, reinsurance of various blocks of company business, merger or purchase or other options in order for the company to meet its obligations to policyholders and creditors. The Rehabilitator generally is required to follow the principle that no creditor should be worse off in a Rehabilitation than the creditor would be treated in a liquidation. The Rehabilitation Plan will follow the creditor priorities as stated in [Insurance Code]. The Deputy Rehabilitators would seek the guaranty association input on any sale or reinsurance of company blocks of business. The Deputy Rehabilitators and the Rrehabilitation team would be responsible for communicating the plan of Rehabilitation to all interested parties.

4. ORDER OF LIQUIDATION

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

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

The Order

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

Operations of a Liquidation

- After the Court has issued the Liquidation order all new business writings would cease.
- *[Insert applicable insurance code that describes the effect of the order of liquidation upon contracts of the insolvent insurer, i.e., continuance in force, termination or cancelation of policies:]*
  - [Insurance code] provides that upon issuance of the order, all of the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of liquidation. The Liquidation order provides notice to policyholders and, terminates policies and contracts where a guarantee of insurance is provided upon [*insert termination period*].
  - *[For life, annuity and health insurers.]* Life and health insurance policies and annuities shall continue in force for such a period and under such terms provided for by the guaranty associations. Those life, health and annuity products not covered by a guaranty association would terminate [Insert termination period from state statute]. The Liquidation order would could most likely include a temporary moratorium on cash surrenders or policy loans except in defined hardship matters. If the Liquidator sells or reinsurers a block of business with another insurer an additional moratorium may be implemented before the policyholder can change insurers.
- *[Insert the state's handling in liquidation of any material issues or risks or unique policy types that are specific to the insurer that may require special consideration, such as the following:]*
  - Because Liquidation is a formal delinquency action, counterparties to the company's derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with [insurer], risks that [insurer] had hedged may disappear and expose [insurer] to adverse financial risks. [Insurer's] credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.
  - If the company has any loans outstanding with the Federal Home Loan Bank, the Federal Home Loan Bank would be able to take possession of any collateral pledged as security for the loan amounts.
  - [Insurance code] excludes [*material policy types or business not covered*] from guaranty fund coverage.
  - *[Describe the handling of significant assumed reinsurance business in receivership, if the US entity is a reinsurer or a direct writer with a significant assumed book of business. e.g.,*

Commented [A8]: See note above regarding derivative counterparties.

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exclusion from guaranty fund coverage; claims fall within general creditor class of priorities; limitations on setoffs.]

- The Liquidation order would terminate the authority of the board of directors and officers.
- A Liquidation order with a finding of insolvency would trigger guaranty association involvement and coverage under the definition of "insolvent" insurer" contained in their statutes.
- The Liquidation order would contain an injunction against filing new legal actions or pursuing current actions.
- Proof of claim forms would need to be sent out for unpaid pre-liquidation liabilities.
- It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in that state.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*
- The Deputy Liquidators would need to discuss the transition of policyholder administration and claims adjudication processes with the effected affected guaranty associations (with such conversations happening in advance of a liquidation order being issued).
- Various matters will need to be filed with the Court for approval including legal settlements, any distribution to liquidation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Liquidation

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

Commented [A9]: Apply any changes made to Rehabilitation section

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The Deputy Liquidators would work with the guaranty association input on any sale or reinsurance of uncovered company blocks of business.

Guaranty Associations

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

- ~~Under a Liquidation order, g~~Guaranty associations are triggered ~~under certain conditions for~~when a member insurer~~s meeting~~ meets the definition of "insolvent insurers" (i.e., is placed under an order of liquidation with a finding of insolvency).
- Each guaranty association has limits on the amount of coverage they provide for each type of ~~policy benefit~~insurance as well as aggregate limits per policyholder. These amounts vary somewhat by state.
- The Deputy Liquidator~~s would work with~~ and the affected guaranty associations (through NOLHGA or NCIGF) would work together to consider the possibility of ~~to potentially~~ reinsur~~e~~inge or transferring the existing blocks of business to new insurers ~~when possible,~~ or on the run-off of remaining blocks of business. Whether in the case of a sale or run-off, guaranty association coverage is determined by the affected guaranty associations in compliance with state law.
- The life and health guaranty association may guarantee, assume or reinsure any or all of the insolvent insurer's covered policies or provide additional funds to another carrier in an assumption of the business. Also, ~~with the Commissioner's approval, the~~ guaranty associations generally have the authority ~~may~~ to issue an alternative policy, modify a current policy, implement temporary policy moratoriums, or pay policy claims subject to coverage limits, among other actions. Some of these options rarely are exercised (e.g., issuing alternative policies).
    - *[Specific to life/annuity]* The guaranty associations may be required by statute to modify guaranteed or credited interest rates on certain policies.

POLICYHOLDER PROTECTION SCHEMES (AKA., GUARANTY ~~FUNDS~~ASSOCIATIONS)

Guaranty associations provide a mechanism for the payment of covered claims under certain insurance policies, ~~or~~ and to continue life, health and ~~coverages~~annuity policies and contracts. Their purpose is to~~, aimed to~~ avoid excessive delays in the payment of claims and ~~to the extent allowed by state statute, to~~ minimize the financial loss to covered claimants or policyholders resulting from the insolvency of an insurer, and allow life, health and annuity policyholders to continue (subject to statutory limits) long duration policies that they might otherwise be unable to replace in the market.

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

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

Commented [A10]: Please see note above about life and health guaranty association triggering for an impaired insurer. Even if the above language is retained (as revised), we do not see the need to make repeated references to an option that has rarely been exercised.

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

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[this state's guaranty association] can be found at [*Insert name of attachment or website*]. Please consult the NOLHGA website [GA Laws] and NCIGF website [Laws and Law Summaries; Comparison of Laws by Provision] for information about eligibility, coverage and limitations for all guaranty associations.

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

IMPLEMENTATION

Commented [A11]: Consider referencing the Receivers Handbook generally.

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

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

Commented [A12]: We were unclear as to the referenced "program" here.

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

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

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

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

COMMUNICATION STRATEGY

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

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

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

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

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

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

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

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

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From: Hughes, Patrick D.
Sent: Friday, September 29, 2023 2:55 PM
To: Koenigsman, Jane; Wake, Robert
Cc: 'Bill O'Sullivan; Cox, Barbara
Subject: US Resolution System Template Additional Notes

Jane and Bob:

Thanks for incorporating NOLHGA and NCIGF's comments into the template. We have reviewed the additional revisions (as reflected in the comprehensive markup) and have a few suggestions for further consideration by the Task Force. We thought that outlining them below would make for more efficient consideration on the October 2 RITF call.

Page 2, second paragraph under Impact on Policyholder Protection Scheme (8th line):

There is an extra "for policies" toward the end that should be deleted.

Page 2, Comment 5:

The reference to siting coverage based on the "claimant's state of residence" should have further clarification as regards life coverage. As an example, a death benefit claimant's residence under a life policy wouldn't determine which guaranty association covers (it would be the residence of the policyholder). We suggest a small clarification by inserting "policyholder/" immediately before "claimant" in the referenced paragraph.

We also have a minor suggestion regarding placement of that added language. We suggest the best placement for the point isn't in the referenced paragraph (starting with "Benefit limits"), since that paragraph discusses coverage limits, rather than discussing which policyholders are covered. Resident coverage is addressed two paragraphs above (beginning with "While the law governing"). The template could add "regardless of where the insurer is domiciled" at the end of the sentence discussing resident coverage in the paragraph above, and/or incorporate the language added by Mr. Wake into that paragraph.

Page 3, Comment 7:

As the template notes elsewhere (and as discussed immediately above), state coverage is not based on the domiciliary state of the insolvent insurer. We would therefore suggest in this paragraph a reference to "affected states" laws rather than the domiciliary state's laws. Similarly, with respect to the model guaranty association laws, we suggest the reference should be to laws in the affected states, not just in the domestic state.

Page 16, Comment 57:

We agree with Mr. Wake's point that the phrasing could be worded more clearly. We have an additional suggestion to consider for further clarification:

"A Liquidation order with a finding of insolvency entered against a member insurer would trigger guaranty association involvement and coverage under ~~the definition of "insolvent" insurer" contained in~~ their statutes."

Page 19, Implementation:

At this spot drafters did not accept the suggestion to change from "delinquency" to "resolution", although that change was accepted elsewhere. We suggest considering the change here for consistency.

Once again, we appreciate the consideration, and can discuss further on Monday's call if helpful to the Task Force.

Pat Hughes

Patrick D. Hughes

Faegre Drinker Biddle & Reath LLP
1500 K Street, N.W., Ste. 1100
Washington, DC 20005, USA

Attachment Three

9/30/23 Update: A few additional edits in Yellow
RITF Exposure Draft with Combined Edits from Comments
(Separate Comments posted to RITF webpage)

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

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

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

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

TRIGGERS FOR RESOLUTION

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

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

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

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

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

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

IMPACT OF FAILURE ON POLICYHOLDER PROTECTION SCHEME SUPPORT UPON FAILURE

Policyholder protection mechanisms are in place in all U.S. states and several of its territories. These mechanisms, commonly known as "guaranty associations" or "guaranty funds", pay certain policy claims and/or continue certain policy coverages, generally upon the issuance of a liquidation order with a finding of insolvency by a court in the appropriate U.S. jurisdiction. The operation and obligations of guaranty associations are governed by statute. Funding to support the guaranty associations' statutory obligations comes from the remaining assets of the insolvent insurer, assessments on certain licensed insurance companies that are "members" of the guaranty associations, future premiums (if applicable), and statutory deposits collected by the states (if available).

While the laws governing state insurance guaranty associations vary somewhat, most states 'have laws are patterned after the [*Insert applicable Model: Life and Health Insurance Guaranty Association Model Act (#520)* , or and the *Property and Casualty Insurance Guaranty Association Model Act (#540)*] adopted by the National Association of Insurance Commissioners (NAIC). Under the Model Act, a state's guaranty association generally must cover resident claims ofagainst an insolvent member insurer (placed into liquidation with a finding of insolvency). For life and health insurers, the guaranty associations also continue in-force policies and annuities of an insolvent insurer. Life and health guaranty associations have discretionary authority to provide may coverage or continue policies/annuities resident claims of an impaired insurer (placed into rehabilitation and not an insolvent insurer). Due to concerns and challenges associated with this authority, it has not been used in multi-state insolvencies and has only rarely been used in single state cases. Regardless of where the insurer is domiciled, this means that usually, the guaranty association of the policyholder/claimant's state of residence is responsible for paying policyholder protection claims, subject to that state's laws, regardless of where the insurer is domiciled. If a policyholder/claimant is not fully covered by the applicable guaranty association, the policyholder/claimant's rights against the estate of the insurer would be governed by the receivership laws of the insurer's domiciliary jurisdiction, as discussed more fully below.

Additional information about the guaranty system is available on the websites for the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF).

Benefit limits are generally consistent but can vary somewhat by state. This means that usually, the guaranty association of the claimant's state of residence is responsible for paying policyholder protection claims, subject to that state's laws, regardless of where the insurer is domiciled. If a claimant is not fully covered by the applicable guaranty association, the claimant's rights against the estate of the insurer would be governed by the receivership laws of the insurer's domiciliary jurisdiction, as discussed more fully below.

Commented [Staff1]: **Staff Comment:** While NOLHGA/NCIGF recommend deleting "Impact of Failure" and adding "Support upon Failure", staff recommends Keeping "Impact on Policyholder Protection Scheme" as the title, since this the terminology used in the IAIS Application Paper on Resolution Planning.

Commented [RAW2]: This is not placeholder text so it shouldn't be bracketed. Most states have versions of both model acts, or similar related legislation, so it's "and," not "or."

Commented [Staff3R2]: Okay with edits

Commented [Staff4]: **NOLHGA/NCIGF Comment:** NOLHGA notes that voluntary triggering for an impaired insurer is not a practical solution in multi-state cases and has only rarely been used in single state cases. NOLHGA suggests that this and other references to triggering for an impaired insurer be deleted. If the reference is regarded as necessary, we request the noted revisions be made here and the subsequent references be deleted as noted below.

Commented [RAW5]: This is not obvious to non-US readers, so it bears emphasis.

Commented [Staff6R5]: Okay with edits.

Per request of NCIGF/NOLHGA, paragraph is moved and "policyholder/" added to claimant.

Commented [RAW7]: This is not obvious to non-US readers, so it bears emphasis.

Commented [Staff8R7]: Okay with edits.

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

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

Aggregate limits and other rules may apply.

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

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

High net worth limitations~~exclusions~~ and other rules ~~may~~ apply in many jurisdictions for property and casualty claims. These limitations generally exclude or call for recovery of claims by or against policyholders that have a net worth exceeding the threshold. The thresholds vary by jurisdiction but typically range from 10 million to 50 million USD.

The coverage limits for each guaranty association and information about certain limitations on coverage can be found on NOLHGA's website and NCIGF's website.

[The above reference the NAIC Model Act. For a resolution plan, modify the above to the affected state's guaranty association acts or ~~D~~describe any material differences between the affected state guaranty association act(s) and the two NAIC Model Acts.]

OVERVIEW OF A RESOLUTION REGIME

~~[~~
~~If multiple legal entity insurers are within scope of the resolution plan, insert a comment that "r~~Receivership actions would be independent for each individual insurance legal entity and would be conducted by their respective domiciliary jurisdictions. Factors would be considered independently such as, minimum capital requirements or RBC levels in determining whether it should be placed into any receivership proceeding. An insolvency at the holding company level would be outside the scope of state insurance receivership laws and would be within the jurisdiction of the federal Bankruptcy Courts. Insurance regulators would coordinate to avoid contagion in the event of ~~"]~~the insolvency or threatened insolvency of [Insurance Holding Company Name] [or its parent(s) or affiliate(s)].

Commented [Staff9]: **Staff Comment:** In addition to Maine's addition, staff recommends that this section of a resolution plan could be modified to reflect the benefits of the state's guaranty association rather than the NAIC Models.

Commented [Staff10R9]: Per NCIGF/NOLHGA, added "affected" before "state's guaranty association Acts...

Commented [RAW11]: Don't we need to say something about this? Is a single paragraph enough?

Commented [Staff12R11]: Staff: For purposes of this template, staff feels this is sufficient. States using this template may prefer to include input from federal regulators if applicable.

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[Modify or eliminate the above paragraph if there is only one insurance legal entity within scope of the resolution plan, if there is no holding company subject to federal bankruptcy jurisdiction, or if the holding company is within scope of the Dodd-Frank Act.]

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

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

A multi-state resolution will be undertaken with a high degree of national coordination under the statebased system. Senior financial regulators comprise the NAIC's Financial Analysis Working Group, which coordinates and provides peer review for the oversight of financially troubled insurers. Likewise, through the NAIC's Receivership Financial Analysis Working Group, senior resolution professionals can coordinate planning and execution of multi-state receiverships. NOLHGA and NCIGF coordinate policyholder protection for multi-state insolvencies.

Timelines to complete a receivership depend on factors such as size and complexity of the insurer, ability to sell assets including selling books of business and affiliated assets, legal issues including handling affiliated or third-party agreements, stays and injunctions, timeline for asset recovery (including through litigation), and coordination with other states and jurisdictions where the insurer has business. Therefore, the length of any receivership action is difficult to predict and may take years to complete in order to effectuate the best possible outcome for policyholders and other creditors.

The [other state insurance department(s)] would handle any resolution of [affiliated insurance entityy(ies) domiciled in another state(s)]. [Other state]'s receivership scheme would beis similar to [this state]'s scheme in that any receivership would be overseen by the local court. (For simplicity the District of Columbia is referred to here as a state.) *[Omit last sentence if group does not do business in DC. Add additional explanatory material if group has operations in territories and possessions, or has subsidiaries domiciled outside the US or foreign branches that might be subject to foreign resolution laws.]*

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

	Insurer #1	Insurer #2	Insurer #3

4

Commented [RAW13]: Unless I am missing something, this is a highly unusual situation for an insurer that would be subject to resolution planning.

Commented [Staff14R13]: Staff: deleted.

Commented [RAW15]: There will often be more than one lead-state domestic insurer in a group that is subject to resolution planning.

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

Should there be an insolvency of the insurer, [this state] must coordinate its activities on the receivership with [this state's] guaranty association and the national state-based guaranty system. Attached is [Insurance Code] that provides the statutory authority of [this state's] guaranty association, and coverage limits provided by the association. The guaranty funds in all the states where the insurer ~~sold business~~was licensed would be triggered to cover ~~the~~ policyholder liabilities in accordance with the guaranty association ~~as defined by insurance~~ laws of those states. The Commissioner as receiver and [~~T~~this state's guaranty association] would work with ~~[the National Organization of Life & Health Life Guaranty Associations (~~NOLHGA~~)~~ or ~~the National Conference of Insurance Guaranty Funds (~~NCIGF~~)]~~ to coordinate the efforts of all the ~~states'~~affected guaranty associations~~funds~~. Once triggered, guaranty association will begin to pay claims and, for life/health insurance liquidations, continue coverage, typically without delay.

[Insurance Code] provides the Commissioner several regulatory ~~actions~~ tools that can be used when insurance companies experience financial difficulties. Regulatory action is taken when insurance companies trigger any of the hazardous financial condition standards delineated in [Insurance Code], including ~~if the company triggers action under~~ RBC standards as developed by the NAIC and adopted by [this state], which give the Commissioner authority to take action before a company is insolvent. Failure to meet RBC requirements ~~have absolute~~requires specific prescribed actions that must be taken ~~given the reported~~based upon the RBC level of the reporting entity; the required actions escalate with each RBC threshold that is breached. The hazardous condition ~~requirements~~ criteria are much broader in nature and include qualitative as well as quantitative standards ~~give the Commissioner authority to take action before a company is insolvent~~. [*Specify the regulatory actions*] within [Insurance Code] require a court order and oversight.

- Supervision is an order from the Commissioner that ~~orders~~ the insurance company ~~to~~ take certain actions to abate the hazardous conditions. Supervision is frequently used as the first step in a process to resolve financial issues within the insurer.
- If the issue is significant and needs immediate action to protect policyholders the Commissioner may decide Conservation, Seizure, Rehabilitation or Liquidation are appropriate, and petition the court.

Commented [RAW16]: This applies to RBC as well as HFC – that's the whole point of the RBC thresholds, after all.

Commented [Staff17R16]: Okay with edits

Commented [Staff18]: NOLHGA/NCIGF comments included edits to this sentence that appear in substance the same. Staff kept Maine's edits.

Commented [RAW19]: Hazardous operation isn't "required"

Commented [Staff20R19]: Okay with edits

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The most appropriate action(s) to take in a resolution of the insurer will depend on the cause and magnitude of the financial issues that are prompting the need for regulatory action. *[Where applicable, note that a temporary moratorium may be imposed on policyholder withdrawals or surrenders.]*

RESOLUTION DIFFERENCES

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

General Account vs. Separate Account

[This state] differentiates between the resolution of [the insurer's] general account business and its separate account business. A separate account refers to an ~~investment~~ account established by an insurer under [insert jurisdiction's legal/statutory provisions governing the creation of separate accounts] to segregate from the insurer's general assets funds backing certain of the insurer's liabilities. A separate account must be used ~~to manage policyholder funds placed in~~for variable insurance products to provide the investment options permitted by those products. Insurers have also used separate accounts to support certain fixed products, including fixed payout annuity obligations under pension risk transfer annuities. The~~se~~is accounts ~~is~~are maintained separately from the general account, and the purpose of each separate account is ~~distinctions are~~ important in this context.

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

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

Reinsurance Assumed Business

[Where a US insurance entity is a professional reinsurer, the exclusion of assumed reinsurance from guaranty association coverage ceding insurers' status as general creditors, and the potential complexity and multitude of the reinsurance agreements may result in different considerations of

Commented [Staff21]: NOLHGA/NCIGF Comment: Note that this section seems to conflate separate accounts with variable products. While all variable products must utilize a separate account, separate accounts are also used for non-variable products where the funds in the separate account support certain liabilities but do not provide investment returns for the benefit of policyholders and are not registered with the SEC. We suggest revisions to acknowledge these other uses of separate accounts and distinguish where the text is referring only to variable product separate accounts.

Commented [Staff22R21]: Okay with edits

Commented [Staff23]: NOLHGA/NCIGF Comment: There are no provisions in the guaranty association statutes that discuss separate accounts and general accounts. Moreover, such accounts are not relevant to how guaranty associations determine coverage.

Commented [Staff24R23]: Okay with edit.

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how to handle a receivership, including the choice between rehabilitation vs. and liquidation, which that should be described here.]

Pursuant to [Insurance Code], policies or contracts of reinsurance are not covered by the guaranty association unless the assuming insurer has assumed the ceding insurer's entire obligation assumption certificates have been issued to the directly to the insured parties on the underlying policies. Pursuant to [Insurance Code], policies or contracts of reinsurance are not covered by the guaranty association unless, in the case of life and health insolvencies, the assumption certificates have been issued by the reinsurer to the direct insureds. Property and casualty guaranty funds do not cover reinsurance in any situation.

Commented [RAW25]: The language that included the "assumption certificate" exception is an accurate quote from 520, but I don't think it's easily accessible to the reader who doesn't already know this. 540 doesn't even expressly exclude reinsurance, but the effect of both the existing language and the proposed amendments is similar; however, neither version mentions anything called an "assumption certificate."

Commented [Staff26R25]: NOLHGA/NCIGF also had edits to this sentence. Staff kept NOLHGA/NCIGF edits.

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

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

RESOLUTION ACTIONS

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

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

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

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

Another possible regulatory action is an order of Seizure [or Conservation]. This order is used to ensure assets remain in place and under control of the receiver and the general supervision of the court. This

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

Rehabilitation

An order of Rehabilitation is sought when the ~~receiver~~ Commissioner wants a period of time to evaluate whether actions can be taken to restore or transform the insurer and restore financial stability. The receiver ~~receives~~ is then granted authority to marshal and take title to all assets of the insurer's estate and runs the day-to-day operations. An Order of Rehabilitation and Plan of Rehabilitation will be tailored to the specific circumstances around the rehabilitation and the goals of the receiver. In most U.S. jurisdictions, the Commissioner serves as receiver. (The appointment of deputy receivers and other consultants is discussed below.)

Liquidation

An order of Liquidation is sought when the ~~receiver~~Commissioner determines ~~there is no possibility~~that (further) efforts to rehabilitate the insurer would be futile or increase the risk of harm to policyholders, creditors or the public, and the best option to protect policyholders, ~~and~~ creditors, and the public is to liquidate the insurer. In a Liquidation, all new and renewal business ceases. However, for life insurance, health insurance (including long-term care) and annuities, policies and contracts will be continued by the guaranty associations in accordance with the terms of the policies and contracts and applicable guaranty association statutes. Again, the receiver is granted~~receives~~ authority to marshal and take title to all assets of the insurer's estate. The liquidation order would also place a temporary stay on any litigation. The Board of Director's powers would be suspended, and the receiver placed in charge of running the day-to-day operations. Some or all of the insurer's upper management could be terminated as determined by the receiver.

In all the above actions, dividends would cease, and it is likely [this state] would have stopped any dividends prior to the deterioration in financial condition to the point where regulatory action was necessary. Even in the ordinary course of business, an insurer may not pay ~~The Commissioner has broad authority to object to ordinary dividends and must prior approve any~~ extraordinary dividends without the prior approval of the Commissioner, .and the Commissioner has broad authority to object to ordinary dividends for cause.

Commented [Staff27]: NOLHGA/NCIGF had similar edit to this sentence. Staff kept Maine's edits.

ANALYSIS OF RESOLUTION ACTIONS

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

1. ORDER OF SUPERVISION

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

Commented [RAW28]: e.g.???

Commented [Staff29R28]: Okay with edit

The Order

- [Insurance Code] allows the Commissioner to issue an order of Supervision, which allows the Commissioner to order the insurer to take actions to abate the hazardous conditions identified by the Commissioner. Under Supervision there is no judicial oversight. *[If judicial action is required in this state, replace applicable language.]*
- The Superv-ision order provides an [*Insert timeframe*] for the company to abate the hazardous conditions. The Commissioner may determine to extend the Supervision timeframe dependent on the company's progress in abating the hazardous conditions or, if satisfactory progress has not been met, place the company in a more ~~severe~~ stringent delinquency proceeding (i.e., seizure, conservation, rehabilitation, liquidation). The Commissioner may also decide to suspend, revoke or limit the company's certificate of authority to do business.
- Supervision does not vest control or title of the company's assets under the Commissioner.
- Supervision typically is a confidential proceeding, allowing the Commissioner to work with the company to correct the hazardous financial conditions without raising concerns of policyholders, creditors, or others.
- *[Consider other risk scenario specific comments.]* ~~*such as for life and annuity insurers: "If confidentiality is breached it may cause a run on the bank scenario i.e., policy surrenders."]*~~

Operations of a Supervision (subject to specific content of an order)

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

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Confidentiality and Notification/Communication

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

Commented [RAW30]: The insurer itself might have the right to waive confidentiality in whole or part.

Commented [Staff31R30]: This is sample text for the template and would be modified depending on the state's requirements

Oversight of Supervision

- In a Supervision, the Commissioner generally designates an internal or external party as supervisor ~~(referred to as "Supervisor" in this section)~~ to oversee and monitor the company's progress in developing and implementing corrective actions necessary to abate the hazardous financial conditions. The Supervisor interacts with company management and provides the Commissioner and interested parties with progress reports.
- The Commissioner may hire an external Supervisor to monitor and oversee the Supervision. [*Insert the state's rule on compensation, such as "The amount of compensation would be dependent on the expertise and experience of the external Supervisor. The Commissioner may appoint an internal supervisor and those costs would be covered within the Department's budget."]*

Commented [RAW32]: We started using this term earlier – consider reordering?

Commented [Staff33R32]: See edit to Operation of Supervision section.

2. ORDER OF SEIZURE OR CONSERVATION

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

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The Commissioner immediately takes possession and control over the property, books, accounts and other records and physical premises.

The Order

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

Operations of a Seizure

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

Confidentiality and Notification/Communication

- *[If applicable in the state, insert confidentiality statement.]* Seizure orders are confidential. ~~*[If confidentiality is breached it may cause a run on the bank scenario i.e., policy surrenders or withdrawals.]*~~, ~~and~~ However, the order may be shared with limited parties as designated by statute. Those parties may include but are not limited to guaranty associations, reinsurers, insurance regulatory officials and debtors and creditors of the company and its affiliates. These parties are required to keep the Seizure confidential.~~"~~ The confidentiality of the seizure order is intended to allow the receiver to discharge the conservation, if appropriate, and return the insurer to normal business operations without public knowledge and the resultant harm to the insurer's business.
- The Commissioner would inform those parties *[or insert a list]* covered by the statute's confidentiality provisions of the Seizure order.

Commented [RAW34]: Might there be readers who don't know what "ex parte" means?

Commented [Staff35R34]: Staff Response: It would be up to the lead state drafting the resolution plan to answer any questions from international jurisdictions on US legal terminology.

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- Under a Seizure order, guaranty associations are not triggered for coverage. However, the appointed party may discuss the Seizure and any potential formal delinquency proceedings with the guaranty associations, where the guaranty associations are covered by [*the statute's confidentiality or confidentiality agreements*]. *[Note that depending on the state law, if a court finds that a life and/or health insurer is financially impaired, such finding may be sufficient to trigger the involvement of life and health guaranty associations].*

Commented [Staff36]: NOLHGA/NCIGF Comment: Please see note above about life and health guaranty association triggering for an impaired insurer. Even if the above language is retained (as revised), we do not see the need to make repeated references to an option that has rarely been exercised.

Commented [Staff37R36]: Okay with edit.

Oversight of Seizure

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

3. ORDER OF REHABILITATION

After Supervision and Seizure [*or Conservation*], Rehabilitation is the next most severe stringent resolution delinquency proceeding short of Liquidation. Rehabilitation is designed to generate a Rehabilitation plan that will either correct the difficulties that led to the insurer being placed in receivership and restore the company's financial condition to sound basis or transition the company's policyholder liabilities to financially sound insurers. The Deputy Rehabilitator(s) may determine the company cannot be rehabilitated. If that is the determination, then a petition for Liquidation will be filed with the court.

Commented [RAW38]: We don't mention the Deputy(ies) until the end of the next page, and I don't think we need to do it here.

Commented [Staff39R38]: Okay with edit

The Order

- [Insurance Code] allows the Commissioner to petition the Court for an order of Rehabilitation based on one or more of the criteria listed above including, but not limited to, the concern that

allowing the company to transact business would be hazardous to policyholders, creditors and the public.

- Rehabilitation orders are public documents and are subject to judicial oversight by [Name of Court].
- The Rehabilitation order vests authority to marshal and take title of all assets of the insurer's estate with the Commissioner as Rehabilitator.
- During Rehabilitation, the receiver may look for possible buyers for the insurer or even books of business or may consider other options to restore profitability or minimize losses.
- There are a number of issues ~~that may occur~~ that can complicate a successful Rehabilitation, such as loss of essential personnel, inability to restructure non-policyholder contractual obligations, loss of asset values due to market conditions, litigation, reinsurer disputes, inability to find insurers to reinsure company policies on an satisfactory basis, unexpected liabilities under derivative or policy contracts, inadequate policy or claim reserves, rating downgrade due to the Rehabilitation order and inability of investment income to meet policy minimum guarantees as well as other matters.
- The length of time of a Rehabilitation is dependent on the complexity, financial condition, size of the company, and the development of a plan of rehabilitation. Rehabilitation can take multiple years to complete.

Operations of a Rehabilitation

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

Commented [Staff40]: NOLHGA/NCIGF Comment: We do not recall this ever happening. Moratoriums are more thoroughly covered on the next page, and we suggest keeping that discussion rather than this sentence.

Commented [Staff41R40]: Okay with deletion, as this is just an example list.

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Rehabilitator sells or reinsurers reinsures a block of business with another insurer, an additional moratorium may be implemented before the policyholder can change insurers.

- Treatment of derivative counterparties will be subject to [insert state law if applicable].
- Because Rehabilitation is a formal delinquency action, counterparties to the company's derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with [insurer], risks thathedging strategies previously undertaken by [insurer] had hedged may disappear and expose [insurer] to adverse financial risks. [Insurer's] credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.
- If the company has any secured lloans outstanding, for example, withadvances of credit from the a Federal Home Loan Bank (FHLB), the FHLB lender would be able to take possession of any collateral pledged as security for the loan amounts.
- *[Describe the handling of significant assumed reinsurance business in receivershiprehabilitation, e.g., if the US entity is a reinsurer or a direct writer with significant assumed book of business.]*

- *[This bullet applies to resolution plans involving life, annuity and health insurers.]* A Rehabilitation order against a life, annuity or health insurer such as [name(s) of insurer(s)] would trigger guaranty association involvement and coverage under the definition of "impaired" insurer contained in their statutes. The guaranty association may guarantee, assume or reinsure any or all of the impaired insurer policies, provide additional funds to assume or reinsure the impaired insurer policies, provide substitute benefits in some cases for the impaired insurer and other actions.
- Proof of claim forms would need to be sent out for unpaid pre-rehabilitation liabilities. It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in thattheir respective states.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable]*. Other state insurance departments often will seek to either revoke or suspend the company's authority to transact business in that state. The Commissioner may coordinate with those other states to ensure revocation or suspension is handled in the best interests of policyholders.
- Various matters will need to be filed with the Court for approval including legal settlements, payments to pre-rehabilitation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Rehabilitation

- The Commissioner may generally would appoint one or morea Deputy Rehabilitators. The [*Specify the title of any department director of receivership, or other position, or standing receivership support organization*] is usually appointed as Deputy Rehabilitator or manages the Rehabilitators rehabilitation staff if they are outside consultants. Given the insurer's size and complexity, the Deputy Rehabilitators would likely hire a rehabilitation team to assist in the Rehabilitation. The rehabilitation team would likely have specialists such as actuaries, investment specialists and others. *[Insert any needed specialists based on the insurer's unique risk profile.]* An investment

Commented [Staff42]: NOLHGA/NCIGF Comment: Given complexities around the topic, consider a less specific statement such as: "Treatment of derivative counterparties will be subject to [insert state law if applicable]."

Commented [Staff43R42]: Edited as suggested.

Commented [RAW44]: If the risks disappeared, that would be a good thing. It's the disappearance of the hedges we need to worry about.

Commented [Staff45R44]: Staff Response: Replaced with NOLHGA/NCIGF recommended bullet.

Commented [RAW46]: Does an FHLB have special rights that other secured lenders lack??? Revert to original language if it's unique to FLHBs.

Commented [Staff47R46]: Okay with edits as this is an example.

Commented [RAW48]: There are multiple regional FHLBs.

Commented [Staff49R48]: NOLHGA/NCIGF recommend deleting

Commented [RAW50]: Groups subject to resolution planning could often have members of both guaranty associations within the group. In some cases a single legal entity writes some cross-category business.

Commented [Staff51R50]: NOLHGA/NCIGF recommended deleting this paragraph.

Commented [Staff52]: NOLHGA/NCIGF Comment: Please see note above about life and health guaranty association triggering for an impaired insurer. Even if the above language is retained (as revised), we do not see the need to make repeated references to an option that has rarely been exercised.

Commented [Staff53R52]: Deleted

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bank may be hired to assist in identifying potential purchasers of blocks of business, merger partners or sources of capital infusion.

- The [*name of the department's Receivership or other Division*] has procedures in place for hiring outside specialists/outside Deputy Rehabilitators as well as a list of qualified vendors. The hiring of any outside consultants/specialists is subject to *[Specify state's rules on hiring and compensation such as "the Receivership procurement procedures"]* and their compensation is subject to Court approval. [*Specify the state's legal structure for handling receivership matters, such as "The Attorney General usually handles receivership matters for the Commissioner"*].
- Because of [insurer's] size and complexity, it may be necessary to hire outside legal counsel. There are a number of qualified law firms that have prior significant national rehabilitation legal experience. Any outside legal counsel and their compensation would be subject to Court approval.
- [*Specify the state's rules on funding of compensation, such as "Payment of any outside specialists, Deputy Rehabilitators and/or legal funds would be paid out of the Rehabilitation estate funds. The (Name of the department's receivership director, if applicable) costs are funded by the Department subject to potential reimbursement by the Rehabilitation estate."]*
- The Rehabilitator or Deputy Rehabilitators and the Rehabilitation team are responsible for the day-to-day operations of the company.
- The Deputy Rehabilitator(s) and the rehabilitation team would be responsible for drafting a plan of Rehabilitation subject to the Commissioner Rehabilitator and the Court's approval. The Rehabilitation Pplan may include reorganization, reinsurance of various blocks of company business, merger or purchase or other options in order for the company to meet its obligations to policyholders and creditors. The Rehabilitator generally is required to follow the principle that no creditor should be worse off in a Rehabilitation than the creditor would be treated in a liquidation. The Rehabilitation Plan will follow the creditor priorities as stated in [Insurance Code]. The Deputy Rehabilitators would seek the guaranty association input on any sale or reinsurance of company blocks of business. The Deputy Rehabilitators and the rRehabilitation team would be responsible for communicating the plan of Rehabilitation to all interested parties.

4. ORDER OF LIQUIDATION

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

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

The Order

- Liquidation orders are public documents and are subject to judicial oversight by [Name of the Court].
- The Liquidation order does vests title of the assets with the Commissioner as Liquidator.
- Liquidations are complicated by unexpected or prolonged litigation, federal tax issues, unexpected or inaccurate reserves for liabilities, assets valuation issues and collection of receivables especially reinsurance related receivables.

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- The length of time of a Liquidation is dependent on the complexity, financial condition, and size of the company. ~~Like Rehabilitation, a~~A Liquidation can take multiple years to complete, often even longer than a Rehabilitation, in order to achieve the best possible outcome for policyholders and other creditors.

Operations of a Liquidation

- After the Court has issued the Liquidation order all new business writings would cease.
- *[Insert applicable insurance code that describes the effect of the order of liquidation upon contracts of the insolvent insurer, i.e., continuance in force, termination or cancelation of policies:]*
  - [Insurance code] provides that upon issuance of the order, all of the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of liquidation. The Liquidation order provides notice to policyholders and~~,~~ terminates policies and contracts where a guarantee of insurance is provided upon [*insert termination period*].
  - *[For life, annuity and health insurers.]* Life and health insurance policies and annuities shall continue in force for such a period and under such terms provided for by the guaranty associations. Those life, health and annuity products not covered by a guaranty association would terminate [Insert termination period from state statute]. The Liquidation order ~~w~~could ~~most likely~~ include a temporary moratorium on cash surrenders or policy loans except in defined hardship matters. If the Liquidator sells or ~~reinsurers~~ reinsures a block of business with another insurer an additional moratorium may be implemented before the policyholder can change insurers.
- *[Insert the state's handling in liquidation of any material issues or risks or unique policy types that are specific to the insurer that may require special consideration, such as the following:]*
  - Treatment of derivative counterparties will be subject to [insert state law if applicable].
  - ~~Because Liquidation is a formal delinquency action, counterparties to the company's derivative contracts may decide to exercise any contractual rights to terminate, liquidate or net out their positions with the company. If the counterparties decide to terminate, liquidate or net out their positions with [insurer], risks that [insurer] had hedged may disappear and expose [insurer] to adverse financial risks. [Insurer's] credit rating may be lowered and finding replacement derivative contracts may not be possible or the cost of such contracts may rise.~~
  - If the company has any secured ~~l~~loans outstanding, for example, ~~with~~advances of credit from ~~the~~ a Federal Home Loan Bank (FHLB), the ~~FHLB~~ lender would be able to take possession of any collateral pledged as security for the loan amounts.
  - [Insurance code] excludes [*material policy types or business not covered*] from guaranty fund coverage.
  - *[Describe the handling of significant assumed reinsurance business in receivership, if the US entity is a reinsurer or a direct writer with a significant assumed book of business. e.g., exclusion from guaranty fund coverage; claims fall within general creditor class of priorities; limitations on setoffs.]*
- The Liquidation order would terminate the authority of the board of directors and officers.
- A Liquidation order with a finding of insolvency entered against a member insurer would trigger guaranty association involvement and coverage under ~~the definition of "insolvent" insurer contained in~~ their statutes.

Commented [Staff54]: NOLHGA/NCIGF Comment: See note above regarding derivative counterparties.

Commented [Staff55R54]: Staff made a similar replacement of the bullet.

Commented [RAW56]: Does an FHLB have special rights that other secured lenders lack??? Revert to original language if it's unique to FLHBs.

Commented [Staff57R56]: This is an example, Okay with edits.

Commented [RAW58]: There are multiple regional FHLBs.

Commented [Staff59R58]: Okay.

Commented [RAW60]: Strictly speaking, the definition isn't the trigger, it's the substantive provisions that use the defined term.

Commented [Staff61R60]: See NOLHGA/NCIGF edits

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- The Liquidation order would contain an injunction against filing new legal actions or pursuing current actions.
- Proof of claim forms would need to be sent out for unpaid pre-liquidation liabilities.
- It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in ~~that~~ their respective states.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*
- The ~~Deputy~~ Liquidator~~s~~ would need to discuss the transition of policyholder administration and claims adjudication processes with the ~~e~~affected guaranty associations (with such conversations happening in advance of a liquidation order being issued).
- Various matters will need to be filed with the Court for approval including legal settlements, any distribution to liquidation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Liquidation

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

Commented [Staff62]: NOLHGA/NCIGF comment: Apply any changes made to Rehabilitation section

Commented [Staff63R62]: See similar edits made.

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Guaranty Associations

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

- ~~Under a Liquidation order, g~~Guaranty associations are triggered ~~under certain~~when the member insurer meets the conditions ~~for insurers meeting~~in the statutory definition of "insolvent insurer~~s~~." (i.e., is placed under an order of liquidation with a finding of insolvency).
- Each guaranty association has limits on the amount of coverage ~~they~~ it provides for each type of ~~policy benefit~~insurance as well as aggregate limits per policyholder. These amounts vary somewhat by state.
- The Deputy Liquidator~~s would work with~~ and the affected guaranty associations (through NOLHGA or NCIGF) would work together to consider the possibility of ~~to potentially~~ reinsur~~e~~ing or ~~transfer~~transferring the existing blocks of business to new insurers ~~when possible~~, or on the run-off of remaining blocks of business. Whether in the case of a sale or run-off, guaranty association coverage is determined by the affected guaranty associations in compliance with state law.
- The life and health guaranty association may guarantee, assume or reinsure any or all of the insolvent insurer's covered policies or provide additional funds to another carrier in an assumption of the business. Also, ~~with the Commissioner's approval,~~ the guaranty association generally have the authority~~may~~ to issue an alternative policy, modify a current policy, implement temporary policy moratoriums, or pay policy claims subject to coverage limits, among other actions. Some of these options rarely are exercised (e.g., issuing alternative policies).
    - *[Specific to life/annuity]* The guaranty associations may be required by statute to modify guaranteed or credited interest rates on certain policies.

POLICYHOLDER PROTECTION SCHEMES (AKA., GUARANTY ~~FUNDS~~ASSOCIATIONS)

Guaranty associations provide a mechanism for the payment of covered claims under certain insurance policies, ~~or~~and to continue ~~coverages~~life, health and annuity policies and contracts. Their purpose is to~~, aimed to~~ avoid excessive delays in the payment of claims and ~~to the extent allowed by state statute,~~ to minimize the financial loss to covered claimants or policyholders resulting from the insolvency of an insurer and allow life, health and annuity policyholders to continue (subject to statutory limits) long duration policies that they might otherwise be unable to replace in the market.

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

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

Commented [RAW64]: It would have been simpler just to say "when the insurer becomes insolvent," but there are several steps between the insurer going broke and meeting the statutory definition of "insolvent insurer" (which also contains some other conditions that aren't part of the English definition of the term).

Commented [Staff65R64]: NOLHGA/NCIGF had similar edits to this sentence. They are combined here with Maine.

Commented [Staff66]: NOLHGA/NCIGF Comment: Please see note above about life and health guaranty association triggering for an impaired insurer. Even if the above language is retained (as revised), we do not see the need to make repeated references to an option that has rarely been exercised.

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Further details on the coverage and eligibility requirements for coverage by the [this state's guaranty association(s)] can be found at [*Insert name of attachment or website*]. A list of coverage and limitations of [this state's guaranty association(s)] can be found at [*Insert name of attachment or website*]. *[Customize to address the types of business conducted in this state by insurers within scope of this resolution plan.]* Please consult the NOLHGA website [GA Laws] and NCIGF website [Laws and Law Summaries; Comparison of Laws by Provision] for information about eligibility, coverage and limitations for all guaranty associations.

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

IMPLEMENTATION

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

The receiver in cooperation with the [this state's guaranty association] will consider whether outside expertise is necessary depending on the complexity of the insurer's operations. *[Specify the state's process for beginning the hiring process, such as requesting bids to determine the best qualified contractors.]*

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

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

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

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

The NAIC's *Receiver's Handbook for Insurance Company Insolvencies* provides guidance for the resolution of an insurer.

Commented [Staff67]: NOLHGA/NCIGF comment: Consider referencing the Receivers Handbook generally.

Commented [Staff68R67]: See below.

Commented [Staff69]: NOLHGA/NCIGF comment: We were unclear as to the referenced "program" here.

Commented [Staff70R69]: This was generally in reference to the need for outside expertise depending on the complexity of the insurer (hedging programs, reinsurance programs, etc.). See staff edits.

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COMMUNICATION STRATEGY

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

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

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

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

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

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

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

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

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

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

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

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

TRIGGERS FOR RESOLUTION

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

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

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

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

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

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

IMPACT ON POLICYHOLDER PROTECTION SCHEME

Policyholder protection mechanisms are in place in all U.S. states and several of its territories. These mechanisms, commonly known as "guaranty associations" or "guaranty funds", pay certain policy claims

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and/or continue certain policy coverages, generally upon the issuance of a liquidation order with a finding of insolvency by a court in the appropriate U.S. jurisdiction. The operation and obligations of guaranty associations are governed by statute. Funding to support the guaranty associations' statutory obligations comes from the remaining assets of the insolvent insurer, assessments on certain licensed insurance companies that are "members" of the guaranty associations, future premiums (if applicable), and statutory deposits collected by the states (if available).

While the laws governing state insurance guaranty associations vary somewhat, most states have laws patterned after the *Life and Health Insurance Guaranty Association Model Act (#520)* and the *Property and Casualty Insurance Guaranty Association Model Act (#540)* adopted by the National Association of Insurance Commissioners (NAIC). Under the Model Act, a state's guaranty association generally must cover resident claims against an insolvent member insurer (placed into liquidation with a finding of insolvency). This means that usually, the guaranty association of the policyholder/claimant's state of residence is responsible for paying policyholder protection claims, subject to that state's laws, regardless of where the insurer is domiciled. For life and health insurers, the guaranty associations also continue in-force policies and annuities of an insolvent insurer. Life and health guaranty associations have discretionary authority to provide coverage or continue policies/annuities for policies of an impaired insurer (placed into rehabilitation and not an insolvent insurer). Due to concerns and challenges associated with this authority, it has not been used in multi-state insolvencies and has only rarely been used in single state cases. If a policyholder/claimant is not fully covered by the applicable guaranty association, the policyholder/claimant's rights against the estate of the insurer would be governed by the receivership laws of the insurer's domiciliary jurisdiction, as discussed more fully below.

Additional information about the guaranty system is available on the websites of the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF).

Benefit limits are generally consistent but can vary somewhat by state.

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

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

Aggregate limits and other rules may apply.

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

(1) Full amount of workers' compensation insurance coverage,

(2) $10,000 per policy, for return of unearned premium for a covered claim, and,
(3) $500,000 per claimant for all other covered claims.

High net worth limitations and other rules apply in many jurisdictions for property and casualty claims. These limitations generally exclude or call for recovery of claims by or against policyholders that have a net worth exceeding the threshold. The thresholds vary by jurisdiction but typically range from $10 million to $50 million.

The coverage limits for each guaranty association and information about certain limitations on coverage can be found on NOLHGA's website and NCIGF's website.

[The above reference the NAIC Model Act. For a resolution plan, modify the above to the affected state's guaranty Association acts or describe any material differences between the affected state guaranty association act(s) and the two NAIC Model Acts.]

OVERVIEW OF A RESOLUTION REGIME

Receivership actions would be independent for each individual insurance legal entity and would be conducted by their respective domiciliary jurisdictions. Factors would be considered independently such as minimum capital requirements or RBC levels in determining whether it should be placed into any receivership proceeding. An insolvency at the holding company level would be outside the scope of state insurance receivership laws and would be within the jurisdiction of the federal Bankruptcy Courts. Insurance regulators would coordinate to avoid contagion in the event of the insolvency or threatened insolvency of [Insurance Holding Company Name] [or its parent(s) or affiliate(s)].

[Modify or eliminate the above paragraph if there is no holding company subject to federal bankruptcy jurisdiction, or if the holding company is within scope of the Dodd-Frank Act.]

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

A multi-state resolution will be undertaken with a high degree of national coordination under the state-based system. The NAIC's Financial Analysis Working Group is a group of senior financial regulators that coordinates and provides peer review for the oversight of financially troubled insurers. Likewise, through the NAIC's Receivership Financial Analysis Working Group, senior resolution professionals can coordinate planning and execution of multi-state receiverships. NOLHGA and NCIGF coordinate policyholder protection for multi-state insolvencies.

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

affiliated or third-party agreements, stays and injunctions, timeline for asset recovery (including through litigation), and coordination with other states and jurisdictions where the insurer has business. Therefore, the length of any receivership action is difficult to predict and may take years to complete to effectuate the best possible outcome for policyholders and other creditors.

The [other state insurance department(s)] would handle any resolution of [affiliated insurance entity(ies) domiciled in another state(s)]. [Other state]'s receivership scheme is similar to [this state]'s scheme in that any receivership would be overseen by the local court. (For simplicity, the District of Columbia is referred to here as a state.) *[Omit last sentence if group does not do business in DC. Add additional explanatory material if group has operations in territories and possessions, or has subsidiaries domiciled outside the US or foreign branches that might be subject to foreign resolution laws.]*

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

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

Should there be an insolvency of the insurer, [this state] must coordinate its activities on the receivership with [this state's] guaranty association and the national state-based guaranty system. Attached is [Insurance Code] that provides the statutory authority of [this state's] guaranty association, and coverage limits provided by the association. The guaranty funds in all the states where the insurer was licensed would be triggered to cover policyholder liabilities in accordance with the guaranty association laws of those states. The Commissioner as receiver and [this state's guaranty association] would work with NOLHGA or NCIGF to coordinate the efforts of all the affected guaranty associations. Once triggered, the guaranty association will begin to pay claims and, for life/health insurance liquidations, continue coverage, typically without delay.

[Insurance Code] provides the Commissioner with several regulatory tools that can be used when insurance companies experience financial difficulties. Regulatory action is taken when insurance companies trigger any of the hazardous financial condition standards delineated in [Insurance Code], including RBC standards as developed by the NAIC and adopted by [this state], which give the Commissioner authority to take action before a company is insolvent. Failure to meet RBC requirements

requires specific prescribed actions that must be taken based upon the RBC level of the reporting entity; the required actions escalate with each RBC threshold that is breached. The hazardous condition criteria are much broader in nature and include qualitative as well as quantitative standards. [*Specify the regulatory actions*] within [Insurance Code] require a court order and oversight.

- Supervision is an order from the Commissioner that the insurance company take certain actions to abate hazardous conditions. Supervision is frequently used as the first step in a process to resolve financial issues within the insurer.
- If the issue is significant and needs immediate action to protect policyholders the Commissioner may decide Conservation, Seizure, Rehabilitation or Liquidation are appropriate, and petition the court.

The most appropriate action(s) to take in a resolution of the insurer will depend on the cause and magnitude of the financial issues that are prompting the need for regulatory action. [*Where applicable, note that a temporary moratorium may be imposed on policyholder withdrawals or surrenders.]*

RESOLUTION DIFFERENCES

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

General Account vs. Separate Account

[This state] differentiates between the resolution of [the insurer's] general account business and its separate account business. A separate account is an account, established by an insurer under [insert jurisdiction's legal/statutory provisions governing the creation of separate accounts] to segregate funds backing certain of the insurer's liabilities from the insurer's general assets. The term "separate account" must be used for variable insurance products to provide the investment options permitted by those products. Insurers have also used separate accounts to support certain fixed products, including fixed payout annuity obligations under pension risk transfer annuities. These accounts are maintained separately from the general account, and the purpose of each separate account is important in this context.

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

Pursuant to [Insurance Code], separate accounts are insulated from general account creditors and liquidation claims. *[Consider inserting sections of the insurance code that define insulated vs. non-*

insulated; that further define separate account and differentiate general account vs. separate account assets.]

Reinsurance Assumed Business

[Where a US insurance entity is a professional reinsurer, the exclusion of assumed reinsurance from guaranty association coverage ceding insurers' status as general creditors, and the potential complexity and multitude of the reinsurance agreements may result in different considerations of how to handle a receivership, including the choice between rehabilitation and liquidation, which should be described here.]

Pursuant to [Insurance Code], policies or contracts of reinsurance are not covered by the guaranty association unless, in the case of life and health insolvencies, the assumption certificates have been issued by the reinsurer to the direct insureds. Property and casualty guaranty funds do not cover reinsurance in any situation.

Unique Lines of Business or Insurance Entities in the Group

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

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

DELINQUENCY AND RESOLUTION ACTIONS

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

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

Administrative Supervision

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

Seizure or Conservation

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

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

Rehabilitation

An order of Rehabilitation is sought when the Commissioner wants a period of time to evaluate whether actions can be taken to restore or transform the insurer and restore financial stability. The receiver is then granted authority to marshal and take title to all assets of the insurer's estate and runs the day-to-day operations. An Order of Rehabilitation and Plan of Rehabilitation will be tailored to the specific circumstances around the rehabilitation and the goals of the receiver. In most U.S. jurisdictions, the Commissioner serves as receiver. (The appointment of deputy receivers and other consultants is discussed below.)

Liquidation

An order of Liquidation is sought when the Commissioner determines that (further) efforts to rehabilitate the insurer would be futile or increase the risk of harm to policyholders, creditors or the public, and the best option to protect policyholders, creditors, and the public is to liquidate the insurer. In a Liquidation, all new and renewal business ceases. However, for life insurance, health insurance (including long-term care) and annuities, policies and contracts will be continued by the guaranty associations in accordance with the terms of the policies and contracts and applicable guaranty association statutes. Again, the receiver is granted authority to marshal and take title to all assets of the insurer's estate. The liquidation order would also place a temporary stay on any litigation. The Board of Director's powers would be suspended, and the receiver placed in charge of running the day-to-day operations. Some or all the insurer's upper management could be terminated as determined by the receiver.

In all the above actions, dividends would cease, and it is likely [this state] would have stopped any dividends prior to the deterioration in financial condition to the point where regulatory action was necessary. Even in the ordinary course of business, an insurer may not pay extraordinary dividends without the prior approval of the Commissioner, .and the Commissioner has broad authority to object to ordinary dividends for cause.

ANALYSIS OF DELINQUENCY AND RESOLUTION ACTIONS

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

1. ORDER OF SUPERVISION

Supervision is the least severe delinquency action. It is dependent on correctly identifying the causes of the hazardous financial condition and taking efficient and timely actions to correct them. The correct

identification of problem areas and developing an effective correction action plan is dependent on the skill and cooperation of the company employees, management, and board of directors, as well as having an adequate company infrastructure (e.g., IT systems) in place. Another factor to consider is the unexpected severity of the hazardous conditions. Administrative supervision orders are sometimes useful in temporarily stabilizing a deteriorating situation prior to the entry of an order of conservation, rehabilitation, or liquidation.

The Order

- [Insurance Code] allows the Commissioner to issue an order of Supervision, which allows the Commissioner to order the insurer to take actions to abate the hazardous conditions identified by the Commissioner. Under Supervision there is no judicial oversight. *[If judicial action is required in this state, replace applicable language.]*
- The Supervision order provides an [*Insert timeframe*] for the company to abate the hazardous conditions. The Commissioner may determine to extend the Supervision timeframe dependent on the company's progress in abating the hazardous conditions or, if satisfactory progress has not been met, place the company in a more stringent delinquency proceeding (i.e., seizure, conservation, rehabilitation, liquidation). The Commissioner may also decide to suspend, revoke, or limit the company's certificate of authority to do business.
- Supervision does not vest control or title of the company's assets under the Commissioner.
- Supervision typically is a confidential proceeding, allowing the Commissioner to work with the company to correct the hazardous financial conditions without raising concerns of policyholders, creditors, or others.
- *[Consider other risk scenario specific comments.]*

Operations of a Supervision (subject to specific content of an order)

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

Confidentiality and Notification/Communication

- The Supervisor would be responsible for providing updates to the Commissioner and impacted parties covered by the confidentiality provisions. [*Insert a comment on the confidentiality of*

supervision orders in this state, such as "Supervision orders are confidential, and the order may be shared with limited parties as designated by statute. Those parties include but are not limited to guaranty associations, reinsurers, insurance regulatory officials and debtors and creditors of the company and its affiliates. These parties are required to keep the Supervision confidential."]

- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*
- The Commissioner would inform those parties *[or insert a list]* covered by the statute's confidentiality, as to the provisions of the Supervision order.
- Under Supervision, guaranty associations are not triggered. However, the Supervisor may discuss the Supervision with the guaranty associations, where the guaranty associations are covered by [*the state's confidentiality statute or confidentiality agreements].* In Supervision, the notification to [*NOLHGA or NCIGF*] and the guaranty associations of the existence of a Supervision order acts as a notice of a potential liquidation that may trigger coverage should the insurer's financial condition worsen, or the insurer does not successfully abate the conditions of the Supervision order and a more severe resolution action becomes necessary.

Oversight of Supervision

- In a Supervision, the Commissioner generally designates an internal or external party as supervisor to oversee and monitor the company's progress in developing and implementing corrective actions necessary to abate the hazardous financial conditions. The Supervisor interacts with company management and provides the Commissioner and interested parties with progress reports.
- The Commissioner may hire an external Supervisor to monitor and oversee the Supervision. [*Insert the state's rule on compensation, such as "The amount of compensation would be dependent on the expertise and experience of the external Supervisor. The Commissioner may appoint an internal supervisor and those costs would be covered within the Department's budget."]*

2. ORDER OF SEIZURE OR CONSERVATION

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

The Order

- The Commissioner would request an ex-parte confidential order from [Name of Court]. The conditions for issuing a Seizure order require either one or more statutory grounds that would justify a formal delinquency (i.e., Rehabilitation or Liquidation), or a demonstration that the

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interests of policyholders, creditors or the public are endangered by a delay in entering such an action and therefore requires immediate action, or any other reason determined to be necessary by the Commissioner.

- The duration of the Seizure order is [*a specific time period or*] such time as the Court determines the Commissioner needs to determine the financial condition of the company. The Court may hold hearings from time to time to decide the status of the Seizure order. If the Commissioner does not commence a formal delinquency hearing after a reasonable period of time, the Court may vacate the Seizure order. The company may petition the Court at any time during the Seizure order for a hearing. Such hearings may be held privately in chambers. Generally, seizure orders are for less than six months.

Operations of a Seizure

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

Confidentiality and Notification/Communication

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

Oversight of Seizure

- In a Seizure, the Commissioner generally designates an internal or external party to oversee and monitor the company's operations (the party is referred to as the "conservator" in some jurisdictions) and investigates the company's financial condition. Because the company is enjoined from disposition of its property, the appointed party will have to approve any disposition of company assets including cash disbursements. The appointed party interacts with company management and provides the Commissioner and interested parties with progress reports.

- The appointed party would work with company management to make a determination of the financial condition of the company. The appointed party would identify those areas that may negatively impact the company's financial condition. The appointed party would then have ongoing meetings with company management to discuss the financial condition of the company and also verify the results of the financial review. The appointed party would be responsible for providing updates to the Commissioner and impacted parties covered by the confidentiality provisions.
- The Commissioner may hire an external party to monitor and implement the Seizure order. The amount of compensation would be dependent on the expertise and experience of the external party. The Commissioner may appoint the [*Specify the title of department director of receivership or other position*] to implement the Seizure order and those costs would be covered [Specify how costs are covered, such as "within the Department's budget"].
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*

3. ORDER OF REHABILITATION

Rehabilitation is the most stringent resolution proceeding short of Liquidation. Rehabilitation is designed to generate a Rehabilitation plan that will either correct the difficulties that led to the insurer being placed in receivership and restore the company's financial condition to sound basis or transition the company's policyholder liabilities to financially sound insurers. The Rehabilitator may determine the company cannot be rehabilitated. If that is the determination, then a petition for Liquidation will be filed with the court.

<u>The Order</u>

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

Operations of a Rehabilitation

- After the Court has issued the Rehabilitation order, the receiver (or a deputy receiver) would be placed in charge of running the day-to-day operations of the insurer.
- The Rehabilitation order would suspend the authority of the board of directors, managers and officers unless reappointed by the Commissioner. Some or all of the insurer's upper management could be terminated as determined by the receiver.
- All current legal proceedings and litigation against the company would be stayed for [number of days based on state's insurance code] and the Rehabilitation order would contain an injunction against filing new legal actions.
- The Rehabilitation order may include *[For this bullet suggest only including those items that may be included in the order which are material to the insurer, rather than an exhaustive list.]:*
    - Prohibit or severely limit all new business writings.
    - Require the insurer to modify or even cancel certain managing general agent ("MGA"), third-party administrator ("TPA") and general agency agreements.
    - Provide that reinsurance agreements may not be canceled, and that the insurer may not obtain any new reinsurance without the approval of the receiver.
    - Require recapitalization.
    - Restrict new investments or liquidate investments.
- *[Insert the state's handling in rehabilitation of any material issues or risks that are specific to the insurer, such as the following]:*
    - The Rehabilitation order may include a moratorium on cash withdrawals, surrenders or policy loans except in defined hardship matters. If the Rehabilitator sells or reinsures a block of business with another insurer, an additional moratorium may be implemented before the policyholder can change insurers.
    - Treatment of derivative counterparties will be subject to [insert state law if applicable].
    - If the company has any secured loans outstanding, for example, advances of credit from a Federal Home Loan Bank (FHLB), the lender would be able to take possession of any collateral pledged as security for the loan amounts.
    - *[Describe the handling of significant assumed reinsurance business in rehabilitation, e.g., if the US entity is a reinsurer or a direct writer with significant assumed book of business.]*
- Proof of claim forms would need to be sent out for unpaid pre-rehabilitation liabilities.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].* Other state insurance departments often will seek to either revoke or suspend the company's authority to transact business in that state. The Commissioner may coordinate with those other states to ensure revocation or suspension is handled in the best interests of policyholders.
- Various matters will need to be filed with the Court for approval including legal settlements, payments to pre-rehabilitation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Rehabilitation

- The Commissioner generally would appoint a Deputy Rehabilitators. The [*Specify the title of any department director of receivership, other position, or standing receivership support organization*] is usually appointed as Deputy Rehabilitator or manages the rehabilitation staff if they are outside consultants. Given the insurer's size and complexity, the Deputy Rehabilitator would likely hire a

rehabilitation team to assist in the Rehabilitation. The rehabilitation team would likely have specialists such as actuaries, investment specialists and others. *[Insert any needed specialists based on the insurer's unique risk profile.]* An investment bank may be hired to assist in identifying potential purchasers of blocks of business, merger partners or sources of capital infusion.

- The [*name of the department's Receivership or other Division*] has procedures in place for hiring outside specialists/outside Deputy Rehabilitators as well as a list of qualified vendors. The hiring of any outside consultants/specialists is subject to *[Specify state's rules on hiring and compensation such as "the Receivership procurement procedures"]* and their compensation is subject to Court approval. [*Specify the state's legal structure for handling receivership matters, such as "The Attorney General usually handles receivership matters for the Commissioner"*].
- Because of [insurer's] size and complexity, it may be necessary to hire outside legal counsel. There are a number of qualified law firms that have significant national rehabilitation legal experience. Any outside legal counsel and their compensation would be subject to Court approval.
- [*Specify the state's rules on funding of compensation, such as "Payment of any outside specialists, Deputy Rehabilitators and/or legal funds would be paid out of the Rehabilitation estate funds. The (Name of the department's receivership director, if applicable) costs are funded by the Department subject to potential reimbursement by the Rehabilitation estate."]*
- The Deputy Rehabilitator and the Rehabilitation team are responsible for the day-to-day operations of the company.
- The Deputy Rehabilitator and the rehabilitation team would be responsible for drafting a plan of Rehabilitation subject to the Rehabilitator and the Court's approval. The Rehabilitation plan may include reorganization, reinsurance of various blocks of company business, merger or purchase or other options in order for the company to meet its obligations to policyholders and creditors. The Rehabilitator generally is required to follow the principle that no creditor should be worse off in a Rehabilitation than the creditor would be treated in a liquidation. The Rehabilitation Plan will follow the creditor priorities as stated in [Insurance Code]. The Deputy Rehabilitator would seek guaranty association input on any sale or reinsurance of company blocks of business. The Deputy Rehabilitator and the Rehabilitation team would be responsible for communicating the plan of Rehabilitation to all interested parties.

4. ORDER OF LIQUIDATION

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

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

The Order

- Liquidation orders are public documents and are subject to judicial oversight by [Name of the Court].
- The Liquidation order vests title of the assets with the Commissioner as Liquidator.
- Liquidations are complicated by unexpected or prolonged litigation, federal tax issues, unexpected or inaccurate reserves for liabilities, asset valuation issues and collection of receivables especially reinsurance related receivables.

- The length of time of a Liquidation is dependent on the complexity, financial condition, and size of the company. A Liquidation can take multiple years to complete, often even longer than a Rehabilitation, to achieve the best possible outcome for policyholders and other creditors.

<u>Operations of a Liquidation</u>

- After the Court has issued the Liquidation order all new business writings would cease.
- *[Insert applicable insurance code that describes the effect of the order of liquidation upon contracts of the insolvent insurer, i.e., continuance in force, termination, or cancelation of policies:]*
  - [Insurance code] provides that upon issuance of the order, all the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of liquidation. The Liquidation order provides notice to policyholders and terminates policies and contracts where a guarantee of insurance is provided upon [*insert termination period*].
  - *[For life, annuity, and health insurers.]* Life and health insurance policies and annuities shall continue in force for such a period and under such terms provided for by the guaranty associations. Those life, health and annuity products not covered by a guaranty association would terminate [Insert termination period from state statute]. The Liquidation order could include a temporary moratorium on cash surrenders or policy loans except in defined hardship matters. If the Liquidator sells or reinsures a block of business with another insurer an additional moratorium may be implemented before the policyholder can change insurers.
- *[Insert the state's handling in liquidation of any material issues or risks or unique policy types that are specific to the insurer that may require special consideration, such as the following:]*
  - Treatment of derivative counterparties will be subject to [insert state law if applicable].
  - If the company has any secured loans outstanding, for example, advances of credit from a Federal Home Loan Bank (FHLB), the lender would be able to take possession of any collateral pledged as security for the loan amounts.
  - [Insurance code] excludes [*material policy types or business not covered*] from guaranty fund coverage.
  - *[Describe the handling of significant assumed reinsurance business in receivership, if the US entity is a reinsurer or a direct writer with a significant assumed book of business. e.g., exclusion from guaranty fund coverage; claims fall within general creditor class of priorities; limitations on setoffs.]*
- The Liquidation order would terminate the authority of the board of directors and officers.
- A Liquidation order with a finding of insolvency entered against a member insurer would trigger guaranty association involvement and coverage under their statutes.
- The Liquidation order would contain an injunction against filing new legal actions or pursuing current actions.
- Proof of claim forms would need to be sent out for unpaid pre-liquidation liabilities.
- It is likely that other state insurance departments would seek to either revoke or suspend the company's authority to transact business in their respective states.
- The Commissioner would coordinate actions with *[Insert name(s) of other state insurance departments where multiple insurers are domiciled in multiple states, and federal and international supervisors, as applicable].*
- The Liquidator would need to discuss the transition of policyholder administration and claims adjudication processes with the affected guaranty associations (with such conversations happening in advance of a liquidation order being issued).

- Various matters will need to be filed with the Court for approval including legal settlements, any distribution to liquidation creditors, modifications of contractual obligations, sales of assets and/or transfers of existing business to other insurance carriers.

Oversight of a Liquidation

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

Guaranty Associations

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

- Guaranty associations are triggered when the member insurer meets the conditions in the statutory definition of "insolvent insurer." (i.e., is placed under an order of liquidation with a finding of insolvency).
- Each guaranty association has limits on the amount of coverage it provides for each type of insurance as well as aggregate limits per policyholder. These amounts vary somewhat by state.
- The Deputy Liquidator and the affected guaranty associations (through NOLHGA or NCIGF) would work together to consider the possibility of reinsuring or transferring the existing blocks of business to new insurers, or on the run-off of remaining blocks of business. Whether in the case

of a sale or run-off, guaranty association coverage is determined by the affected guaranty associations in compliance with state law.

- The life and health guaranty association may guarantee, assume, or reinsure any or all the insolvent insurer's covered policies or provide additional funds to another carrier in an assumption of the business. Also, the guaranty association generally have the authority to issue an alternative policy, modify a current policy, implement temporary policy moratoriums, or pay policy claims subject to coverage limits, among other actions. Some of these options rarely are exercised (e.g., issuing alternative policies).
    - *[Specific to life/annuity]* The guaranty associations may be required by statute to modify guaranteed or credited interest rates on certain policies.

POLICYHOLDER PROTECTION SCHEMES (AKA., GUARANTY ASSOCIATIONS)

Guaranty associations provide a mechanism for the payment of covered claims under certain insurance policies, and to continue life, health and annuity policies and contracts. Their purpose is to avoid excessive delays in the payment of claims and to minimize the financial loss to covered claimants or policyholders resulting from the insolvency of an insurer and allow life, health and annuity policyholders to continue (subject to statutory limits) long duration policies that they might otherwise be unable to replace in the market.

A state's guaranty association generally must cover resident claims of an insolvent insurer (placed in a liquidation proceeding). Benefit limits vary by state. [This state's] benefit limits are:

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

Further details on the coverage and eligibility requirements for coverage by the [this state's guaranty association(s)] can be found at [*Insert name of attachment or website*]. A list of coverage and limitations of [this state's guaranty association(s)] can be found at [*Insert name of attachment or website*]. *[Customize to address the types of business conducted in this state by insurers within scope of this resolution plan.]* Please consult the NOLHGA website [GA Laws] and NCIGF website [Laws and Law Summaries; Comparison of Laws by Provision] for information about eligibility, coverage, and limitations for all guaranty associations.

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

IMPLEMENTATION

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

The receiver in cooperation with the [this state's guaranty association] will consider whether outside expertise is necessary depending on the complexity of the insurer's operations. *[Specify the state's process for beginning the hiring process, such as requesting bids to determine the best qualified contractors.]*

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

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

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

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

The NAIC's *Receiver's Handbook for Insurance Company Insolvencies* provides guidance for the resolution of an insurer.

COMMUNICATION STRATEGY

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

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

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

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

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

Consistent with the NAICs' *Troubled Insurance Company Handbook*, [this state] must be proactive in communicating with regulators including regulators in other states. [This state] will also immediately

update [*the international group-wide supervisor (GWS), if not this state; or other Crisis Management Group (CMG) members, if the GWS is this state]* so that CMG members are informed of the proposed action.

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

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

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To: Judy Weaver, Chair of Financial Analysis (E) Working Group

From: James J. Donelon, Commissioner, Chair of Receivership and Insolvency (E) Task Force

Date: October 2, 2023

Re: Referral of U.S. Resolution Template

The Receivership and Insolvency (E) Task Force has adopted a template with sample text that may be used by a U.S. lead state to describe the U.S. receivership regime within resolution plans or to facilitate dialogue with international supervisors during Supervisory Colleges and Crisis Management Group (CMG) discussions (Attachment A).

The template was exposed to all state insurance department regulators and interested parties for a 30-day comment period ending September 14, 2023. Comments were reviewed and edits were incorporated into the draft.

Although resolution planning as outlined in the International Association of Insurance Supervisors (IAIS) Insurance Core Principles and Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), and U.S. state insurance departments' participation in Supervisory Colleges and CMGs is not intended to be limited to financially troubled insurance companies, the Task Force requests the Working Group consider including the template in the *Troubled Insurance Company Handbook* (regulator only publication) for consistency with the *Receiver's Handbook for Insurance Company Insolvencies* for pre-receivership guidance.

If you have any questions, please contact NAIC staff, Jane Koenigsman (jkoenigsman@naic.org).

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August 10, 2023

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

BY ELECTRONIC MAIL

RE: MODEL 540 COMMENTS

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

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

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

BACKGROUND

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

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

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

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

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

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

1. Proposes to delete language (Subsection D) that already goes a long way in assuring continuity of guaranty fund coverage in the case of IBTs and CDs. In fact, it is likely that policyholders would retain guaranty fund coverage in most IBT and CD transactions without making ANY change to Model 540. But if language is desired to avoid any uncertainty, the four lines of Version 2 would accomplish this goal.

2. Gives rise to illogical outcomes. For example, consider this scenario:

    a. Insurer A assumes a workers compensation block, (including open workers compensation claims), from a self insured trust in year 1;
    b. In years 2 through 15, Insurer A pays premium taxes and guaranty association assessments on the workers compensation policies assumed with the block, including those under which open claims had arisen that were also assumed;
    c. In year 16, Insurer A becomes insolvent.
    d. Under Version 1, those assumed workers compensation claims would not be covered by the guaranty funds because the policy had not been issued originally by a member insurer. See Version 1, section G(1). It would make no difference that Insurer A will have been paying premium taxes and assessments on these policies for fifteen years.
    e. Moreover, at that point, the assumed claim and policy are likely to be all but indistinguishable from Insurer A's other policies and claims. Yet, Version 1 will create two classes of business, one covered the other not, though they be otherwise largely indistinguishable.

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Receivership and Insolvency (E) Task Force
August 10, 2023, page 4

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

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

PROPOSED VERSION 2

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

H. "Covered claim" means the following:

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

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

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

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

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

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

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

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

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

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

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

THE ASSUMED CLAIMS COVERAGE

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

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

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

THE RENEWED ATTACK

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

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

> **"[a]t most, if one wanted to adopt a "belt and suspenders" approach, the language in Section D(2) (or subsection (3) of Alternative 2) could be amended as follows:**
>
> ***An assumption reinsurance or other transaction in which all of the following occurred:"***

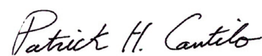
Among the responses to this argument, was that few states had adopted the 2009 amendments. That led me to propose the simple 4-line Version 2 that could be used in states that had not adopted the assumed claims language to assure that IBT and CD transactions would not result in loss of guaranty association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

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

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

I thank you for your kindness in considering my comments.

Very truly yours,



Patrick H. Cantilo

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 24, 2005

APPLICATION OF

RECIPROCAL OF AMERICA and
THE RECIPROCAL GROUP

CASE NO. INS-2003-00239

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

2005 AUG 24 DOCUMENT CONTROL

FINAL ORDER

On July 11, 2003, the Deputy Receiver of Reciprocal of America[1] filed an Application for Order Authorizing the Continuation of Workers' Compensation Disability Payments by Reciprocal of America and The Reciprocal Group for Workers' Compensation Claims Denied Coverage by State Guaranty Associations ("Application") in Case No. INS-2003-00024. Therein, the Deputy Receiver of ROA sought an order from the State Corporation Commission ("Commission") authorizing him to continue payment of medical and recurring partial or total disability payments for workers' compensation claims that were assumed by ROA through assumption reinsurance, or similar transactions, and denied or likely to be denied coverage by the applicable state guaranty associations.[2]

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

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

[2] Application at 1.

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

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

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

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

[4] Id.

[5] Id. at 6-7.

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

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

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

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

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

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

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

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

On November 12, 2003, the Commission entered an Order, in which it directed the Deputy Receiver of ROA to pay the Assumed Claims insofar as they constitute indemnity and wage-replacement payments but did not authorize the payment of physician or hospital bills. In the same Order, the Commission assigned the determination of whether the SITs and GSIAs or employers thereof constitute "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 ii of the Code of Virginia[11] ("Code") to a hearing examiner and docketed the proceeding as Case No. INS-2003-00239.[12]

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

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

[11] Statutory references are to the Code of Virginia.

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

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We reinstated our Order dated November 12, 2003, effective as of January 8, 2004.[13] Hence, the Deputy Receiver of ROA was authorized to pay the Assumed Claims insofar as they constitute indemnity and wage-replacement payments as of January 8, 2004.[14]

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

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

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

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

[16] Amendment at 6.

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

The Guaranty Associations and the VPCIGA pursued an appeal of the November 12, 2003, and January 8, 2004, Orders to the Supreme Court of Virginia, which dismissed their appeal on July 9, 2004.[17] The litigation before the hearing examiner continued while such appeal was pending. An evidentiary hearing was convened on September 22, 2004, and continued for six days thereafter. The Deputy Receiver of ROA, the Guaranty Associations, the VPCIGA, the Kentucky Hospitals, Coastal, the SDRs of the Tennessee Companies, the UEF, the Children's Hospital of Alabama, the Bureau of Insurance, and Richard W.E. Bland all participated in the hearing in one form or another. Post-hearing briefs were filed by the Deputy Receiver of ROA, the Kentucky Hospitals, Coastal, the UEF, the VPCIGA, and the Guaranty Associations.

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

(1) Virginia substantive law should control in this case to avoid exposing the ROA receivership estate to a myriad of possible conflicting state laws, to provide for the equitable payment of claims and distribution of the assets of the ROA estate among creditors of the same class no matter where the creditors may reside, and to provide for the orderly administration and wind down of the ROA estate;

(2) Virginia law recognizes that entities such as the SITs and GSIAs transact the business of insurance, but are exempt from regulation as insurance companies under Title 38.2 of the

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

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Code of Virginia, except as specifically provided for in statutes adopted by the General Assembly;

(3) The Commission is not bound by the erroneous legal conclusions of a member of the staff in the Bureau of Insurance;

(4) There is no basis for judicially estopping ROA and the SITs and GSIAs from arguing that they were self-insured trusts or group self-insurance associations that issued contracts of insurance providing coverage for their employer-members' liability or workers' compensation risks;

(5) The employer-members of SITs and GSIAs pooled their risk of loss for the purpose of transferring an individual employer-member's risk of loss to the group;

(6) The SITs and GSIAs were a type of reciprocal insurer in which the employer-members were both the insurer and the insured;

(7) The arrangement in which HWCF provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

(8) The arrangement in which A-HAT provided its employer-members medical professional liability, general liability, and personal injury liability coverage was an insurance contract under Virginia law;

(9) The arrangement in which C-HAT provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

10) The arrangement in which K-HAT provided its employer-members hospital professional and general liability coverage was an insurance contract under Virginia law;

11) The arrangement in which MHA Public provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

12) The arrangement in which MHA Private provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

13) The arrangement in which THA provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

14) The arrangement in which HPG provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

15) The arrangements in which AWCT and MHA/MSC provided their employer-members workers' compensation liability coverage were insurance contracts under Virginia law;

16) The fortuity and known loss doctrines are inapplicable in this case;

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

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

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

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[18] See Report at 116.

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

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

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

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

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

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Discussion

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

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

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

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

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

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

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

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

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

[23] See Report at 114-117.

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

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

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

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

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

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

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

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

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

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

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

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

[26] 871 A.2d at 592.

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

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

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

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

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

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

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

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

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

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

Apportioned without preference

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

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

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

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

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

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

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

[31] Report at 127.

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

Conclusion

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

Accordingly, IT IS ORDERED THAT:

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

---

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

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

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

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

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

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

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

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December 22, 2005

Via Hand Delivery

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

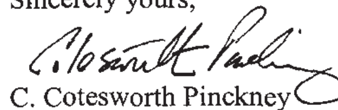
Re: *Application of Reciprocal of America and the Reciprocal Group; For a Determination Whether Certain Worker's Compensation Insurance Policy Payments May be Made to Claimants Formerly Covered by SITs and GSIAs,* Case No. INS-2003-00239; Notice of Withdrawal of Appeal

Dear Mr. Peck:

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

Thank you for your assistance in this matter.

Sincerely yours,



C. Cotesworth Pinckney

Enclosures

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

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COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

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

NOTICE OF WITHDRAWAL OF APPEAL

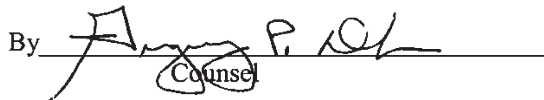
The Indiana Insurance Guaranty Association, Kansas Insurance Guaranty Association, Mississippi Insurance Guaranty Association and Tennessee Insurance Guaranty Association (the "Guaranty Associations"), the Virginia Property and Casualty Insurance Guaranty Association (the "Virginia Association"), the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

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

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

Dated December 21, 2005.

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

By 
Counsel

VIRGINIA PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION

By
Counsel

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COASTAL REGION BOARD OF DIRECTORS
AND THE ALABAMA SUBSCRIBERS

By
Counsel

THE KENTUCKY HOSPITALS

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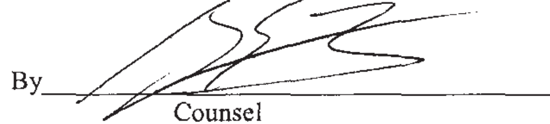
COASTAL REGION BOARD OF DIRECTORS
AND THE ALABAMA SUBSCRIBERS

By______________________________
Counsel

THE KENTUCKY HOSPITALS



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CERTIFICATE OF SERVICE

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

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

and photocopies thereof were mailed by first class mail to:

Duke de Haas, Esq.
Counsel to the Commission
State Corporation Commission
P. O. Box 1197
Richmond, Virginia 23218

Judith W. Jagdmann
Attorney General of Virginia
900 East Main Street
Richmond, Virginia 23219

Alfred W. Gross, Deputy Receiver of
Reciprocal of America and
The Reciprocal Group
Bureau of Insurance
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Mississippi Insurance Guaranty Association and
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National Conference of Insurance Guaranty Funds NCIGF[SM]

September 14, 2023

Honorable James Donelon
Honorable Glen Mulready, Vice Chairman
Receivership and Insolvency (E) Task Force

Subject: August 16 Exposure Draft on Guaranty Fund Coverage for Restructured Business

Dear Commissioner Donelon and Commissioner Mulready:

We are submitting a short letter to reiterate our position on the proposed guaranty fund model law amendment to address restructuring transactions as exposed by the RITF on August 16.

First and foremost, we urge the NAIC to act as expeditiously as possible to adopt this draft and make it available in the states. Most state guaranty fund laws currently do not explicitly address restructured business, and we are concerned that most current state guaranty fund laws would not cover the resulting claims should the transferee entity become insolvent and be ordered into liquidation. Since the most recent laws on this matter permit restructuring of various personal lines and workers compensation business, a modification of guaranty fund law is critical to protect claimants.

As you know, NCIGF's policy is coverage neutrality – that is, if there was guaranty fund coverage before the transaction the coverage should remain in place after the transaction. Conversely, coverage that did not exist prior to the transaction should not be created by the transaction. We believe this position aligns with the charge to the Receivership Law Working Group and the most recent drafts circulated by the Restructuring Mechanisms Working Group. We attach our previous comments which expand on this point.

We feel that the proposed amendment to the covered claim definition at Section 5G(2), as a standalone revision, is consistent with the NCIGF policy. We would be comfortable recommending it to our members and others who may be involved in addressing restructured business guaranty fund coverage in the various states.

Further, we believe that the strike through of the 2009 amendments (including the adjustment to 5G(1)) intended to address assumption transactions is appropriate given that 1) as adopted by the NAIC in 2009 the language does not address IBTs and CDs, 2) the amendments have only been adopted in three states and 3) the proposed revisions provide a more streamlined approach for coverage of various types of restructured business including certain assumption reinsurance transactions.

The optional paragraph 5G(3) in the exposure draft goes beyond the coverage neutrality position in that it would cover business that did not originate from a guaranty fund member company. That is, such claims would not have been guaranty fund covered claims if they had not been transferred. NCIGF does not support 5G(3). The additional modifications to the model intended to address "look-back" assessments on previously uncovered business may unduly complicate state efforts to amend their guaranty fund acts. However, we understand that some regulators believe the optional G(3) language should be made available and we respect this position.

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www.ncigf.org

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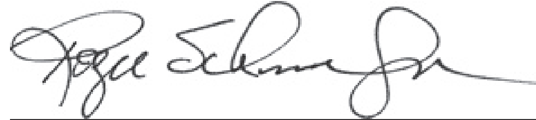
Finally, we wish to extend our appreciation to Robert Wake, General Counsel for the Maine Bureau of Insurance, for his extensive technical work in the drafting process that resulted in the August 16 exposure draft and his continued support of efforts to protect policyholders.

Note that NCIGF is not commenting on the cyber security amendments included in the exposure draft at this time although we do support their inclusion in the exposure draft.

Many thanks for considering our comments. Please feel free to contact me or Barbara Cox for additional information.

Very truly yours,



President & CEO
National Conference of Insurance Guaranty Funds

Attachment – NCIGF Letter of June 23, 2023

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National Conference of Insurance Guaranty Funds NCIGF[SM]

June 20, 2023

Kevin Baldwin and Laura Slaymaker
Co-Chairmen of the Receivership Law (E) Working Group

Subject: May 23 Exposure Draft on Guaranty Fund Coverage for Restructured Business

Dear Kevin and Laura:

We appreciate the Receivership Law Working Group's consideration of our proposed guaranty fund model law amendment to address restructuring transactions. As you know, NCIGF's policy is coverage neutrality – that is, if there was guaranty fund coverage before the transaction the coverage should remain in place after the transaction. Conversely, coverage that did not exist prior to the transaction should not be created by the transaction. We believe this position aligns with the charge to the Model Law Working Group and the most recent drafts circulated by the Restructuring Working Group. [1]

We feel that the proposed amendment to the covered claim definition at 5G(2), as a standalone revision, is consistent with the NCIGF policy. We would be comfortable recommending it to our members and others who may be involved in addressing restructured business guaranty fund coverage in the various states.

Further, we believe that the strike through of the 2009 amendments (including the adjustment to 5G(1)) intended to address assumption transactions is appropriate given that 1) as adopted in 2009 the language does not address IBTs and CDs and 2) the amendments have only been adopted in three states.

The optional paragraph 5G(3) in the exposure draft goes beyond the NCIGF coverage neutrality position and is not supported by the NCIGF. Likewise, the additional language which we understand is intended to offer options to support G(3) (such as additional definitions and options to provide for a look back to recover guaranty fund assessments that may have been collected had the business originally been covered business) is not necessary without G(3). It also may unduly complicate state efforts to amend their guaranty fund acts because of its complexity.

Note that NCIGF is not commenting on the cyber security amendments included in the exposure draft at this time. However, we do look forward to continued discussion of these amendments.

[1] See the Request for NAIC Model Law Development adopted by the E Committee 7/21/22 – "The scope of the request is limited to addressing the issue of continuity of guaranty fund coverage when a policy is transferred from one insurer to another." See also Best Practices Procedures for IBT/Corporate Divisions discussion draft dated 4-4-23 – "For corporate divisions involving property and casualty insurance, the applicant's representation that that the laws of each U.S. jurisdiction where any such policies issued by the dividing insurer are allocated address restructuring transactions such that rights to guaranty fund coverage are not reduced, eliminated, or ***otherwise*** ***changed*** as a result of the transaction. Emphasis added. We are not aware of any objections expressed on this portion of the discussion draft.

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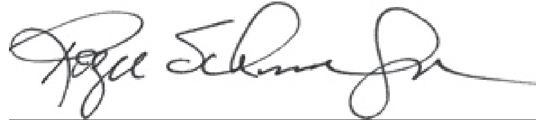
Many thanks for considering our comments. Please feel free to contact me or Barbara Cox for additional information.

Very truly yours,



President & CEO
National Conference of Insurance Guaranty Funds

[1] See the Request for NAIC Model Law Development adopted by the E Committee 7/21/22 – "The scope of the request is limited to addressing the issue of continuity of guaranty fund coverage when a policy is transferred from one insurer to another." See also Best Practices Procedures for IBT/Corporate Divisions discussion draft dated 4-4-23 – "For corporate divisions involving property and casualty insurance, the applicant's representation that that the laws of each U.S. jurisdiction where any such policies issued by the dividing insurer are allocated address restructuring transactions such that rights to guaranty fund coverage are not reduced, eliminated, or ***otherwise*** ***changed*** as a result of the transaction. Emphasis added. We are not aware of any objections expressed on this portion of the discussion draft.

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STATE CORPORATION COMMISSION

September 13, 2023

The Honorable James J. Donelon, Chair
The Honorable Glen Mulready, Vice Chair
Receivership and Insolvency (E) Task Force
c/o Jane Koenigsman
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Re: Comments on the Exposure Draft of the Amendments to the Property and Casualty Insurance Guaranty Association Model Act (#540)

Dear Commissioners Donelon and Mulready,

The Virginia Bureau of Insurance ("Bureau") appreciates the ability to offer its comments on the exposure draft of the amendments to the Property and Casualty Insurance Guaranty Association Model Act (#540) ("Model 540") released by the Receivership and Insolvency (E) Task Force following its meeting at the NAIC Summer National Meeting in Seattle.

Virginia is one of a number of states that consider "assumed claims" to be "covered claims" under the statutory provisions of the Virginia Property and Casualty Insurance Guaranty Association.[1] The Bureau offers these comments in support of preserving guaranty association protection for policyholders with "assumed claims" under the 2009 amendments to Model 540. The current amendments under consideration go beyond the charge given to the Receivership Law (E) Working Group ("RLWG") by unnecessarily making coverage optional for "assumed claims." RLWG was tasked with amending Model 540 to ensure no loss of guaranty association coverage in Insurance Business Transfer or Corporate Division transactions. The Bureau encourages the Receivership and Insolvency Task Force to not adopt the current amendments to Model 540 with respect to "assumed claims."

Thank you for considering these comments. Please do not hesitate to reach out with any questions.

Sincerely,
Dan Bumpus
Senior Counsel
State Corporation Commission
Counsel to the Virginia Bureau of Insurance

[1] *See* § 38.2-1603 of the Code of Virginia.

TYLER BUILDING, 1300 EAST MAIN STREET, RICHMOND, VA 23219-3630 scc.virginia.gov

Comments by Robert Alan Wake (Maine)

on Proposed Amendments to Model 540

September 11, 2023

As one of the principal drafters of the "transferred claims" provisions of the Proposed Amendments, I am submitting these comments to explain what these amendments do, what they do not do, and why we chose the approach we chose. I am also responding to some specific objections raised by critics of the proposal, and at the end, noting a few typos in the exposure draft of the cybersecurity amendments.

When the drafting team looked for ways to address the problem of ensuring that guaranty fund coverage is not lost after business transfers and corporate divisions, we considered several different approaches:

- Revise the "assumed claims" provisions that were added to the Model Act in 2009, because they were the first attempt to maintain continuity of guaranty fund coverage when the insurer against which the claim is filed is different from the insurer that wrote the policy;
- Revise the definition of "insolvent insurer" to ensure that business transferees and resulting insurers from corporate divisions would always satisfy the complex substantive criteria that have been embedded within that definition;
- Provide a limited "guaranty association membership" to business transferees and resulting insurers from corporate divisions to make it easier to satisfy the existing definition of insolvent insurer;
- Modify the definition of "covered claim" in a manner that bypasses the potential pitfalls created by the existing language that requires a "policy" that was "issued or assumed by" an "insurer that becomes an insolvent insurer."

Unfortunately, the drafting team was unable to reach a unanimous consensus. However, after reviewing language that has already been adopted by New Hampshire, all the drafting team members except Patrick Cantilo, who has submitted his own separate comments, agreed that adding a new paragraph to the definition of "covered claim" was by far the simplest approach, with the least risk of unintended consequences.

The New "Preservation of Coverage" Paragraph

What proposed Section 5G(2) does is to create a general rule that if a policy is purchased from Insurer A, and has guaranty fund protection because Insurer A is a member insurer, it does not lose that protection if the policy obligations are transferred to Insurer B. The claim against insurer B will be covered if insurer B is liquidated to the same extent as a claim against Insurer A would have been covered if Insurer A were still on the risk and Insurer A had been liquidated.

This approach means that it is unnecessary to determine whether there had been an "insurance business transfer," "corporate division," or (for states that adopted the 2009 amendments) an "assumption reinsurance transaction." All of these are included, and so are other transactions such as common-law novations that are not addressed by the existing Model Act language. All we need

to know is that the policy was protected when Insurer A issued it and that Insurer A is no longer on the risk.

This is a strength of the proposed approach, not a weakness as Mr. Cantilo argues in his comments. It simplifies the language, avoids ambiguities, and minimizes judgment calls. If we can close other gaps in protection besides the ones that originally motivated the amendments, there is no reason to go out of our way to add limiting language that would protect one class of claimants while keeping other equally deserving classes of claimants unprotected.

The only situation where anyone has questioned the desirability of keeping guaranty fund protection in place is where Insurer B, the new insurer, was not a member insurer at the time of the transfer. But this is essential in order to fulfill our charge, because the most dangerous situation for the claimant arises when a regulator in another jurisdiction involuntarily transfers a policy to an insurer that does not hold a license in This State: it might not qualify, it might not even decide to seek licensure, or there might be a delay between the transfer of the policy and the license approval. Considerations are different if the policy is **voluntarily** transferred to a non-member insurer (the worst case might be where the insured commutes the tail of a policy and transfers it to its own captive), and this is why, in response to Mr. Cantilo's Working Group comments, we added Section 5G(2)(d) to protect against that scenario.

Complexity

The other objection that has been raised to this approach is its alleged complexity. As Mr. Cantilo noted in his August 10 comment letter, the proposed amendments affect 278 lines of the Model Act. What he neglects to mention is that the "base version" of the proposed amendments (for states that do not adopt the optional language) adds a single, self-contained 13-line paragraph. The only other change the base version makes to the text of the Model Act is to delete language that was added by the 2009 amendments, language that only a handful of states have adopted. Furthermore, if as state does already have similar language and wish to keep it, Section 5G(2) is designed so that it can simply be added to their existing guaranty fund laws without requiring any further changes.

Is There a Coverage Gap?

The August 10 letter also asserts that the base version of the proposed amendments is not an adequate replacement for the "assumed claims" language, because it would fail to close a serious gap in coverage that supposedly exists in the 47 states that have chosen not to adopt the 2009 amendments to the Model Act. The letter presents a scenario where a member insurer takes over a block of workers' compensation coverage from a self-insurance trust, covers that business for 15 years in a manner that makes it "all but indistinguishable from Insurer A's other policies and claims," paying premium taxes and guaranty fund assessments all the while, and then the insurer goes belly-up.

Everyone agrees that in this scenario, the guaranty fund ought to cover the claims. But that does not present a problem, because that is precisely what will happen under both the proposed amendments and those 47 existing state laws. The reason the company has been paying premium taxes and guaranty fund assessments on this block of business is because it issued policies to the employers at the time the self-insurance trust was dissolved, and then continued renewing those

policies for 15 years. Those policies look indistinguishable from the insurer's other policies because they are indistinguishable.

Optional Protection for Non-Member-to-Member Transfers

Furthermore, in response to concerns that guaranty fund protection should continue to be available in every scenario where it is available under existing laws, we added a new optional Section 5G(3), along with two short optional additions Section 5K and a new optional Section 8A(4). These are proposed as optional because the vast majority of existing state laws do not provide coverage in any scenario that would not be covered by the base version of the proposed amendments.

They have been criticized as "complex," but as with the base version, what is complex is not the language that has been added but the language that has been deleted. For example, they have been streamlined so as to do away with two alternative definitions of "assumed claims transaction," an idiosyncratic definition of "novation" that precludes the novation of a policy to a solvent insurer, and two of the four alternative versions of Section 8A(3). (We still need two versions of Section 8A(3) for reasons totally unrelated to the proposed amendments – some states have separate guaranty fund accounts based on types of business while others have a single account.)

Typos in Cybersecurity Amendments

Finally, there are three typos in the exposed version of the cybersecurity amendments. First, as written, the word "insurance" is doubled at the beginning of Section 3E. The original word "insurance" should remain capitalized and either be deleted in its entirety or shown in its entirety in strikeout text. Also, the word "third-party" in Section 8A(1)(a)(iv) and optional Section 13B(5) should be hyphenated. This was probably the result of copying and pasting from a PDF.

Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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

Section 1. Title

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

Section 2. Purpose

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

Section 3. Scope

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

A. Life, annuity, health or disability insurance;

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

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

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

E. Other than coverages that may be set forth in a cybersecurity insurance policy, ~~I~~insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or

property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

F. Title insurance;

G. Ocean marine insurance;

H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

I. Any insurance provided by or guaranteed by government.

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

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

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;

2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;

3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;

4. Changes in the value of specific assets or commodities, or price levels in general.

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

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

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

Section 4. Construction

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

Section 5. Definitions

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

As used in this Act:

[Optional:

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

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

A. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.

B. "Association" means the [State] Insurance Guaranty Association created under Section 6.

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

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

~~D. **[Alternative 1]** "Assumed claims transaction" means the following:~~

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

~~(2) An assumption reinsurance transaction in which all of the following has occurred:~~

~~(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies: and~~

~~(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and~~

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

~~**[Alternative 2]** "Assumed claims transaction" means the following:~~

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

~~associations, if the merged entity is a non-member insurer; or~~

~~(2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:~~

~~(a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and~~

~~(b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.~~

~~(c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or~~

~~(3) An assumption reinsurance transaction in which all of the following has occurred:~~

~~(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;~~

~~(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; andAs a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.~~

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

D~~E~~. "Claimant" means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

E~~F~~. "Commissioner" means the Commissioner of Insurance of this State.

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

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

G~~H~~. "Covered claim" means the following:

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

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

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

the insured event; or

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

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

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

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

(c) The claim would have been a covered claim, as defined in Section 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and

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

[Optional:

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

(a) A merger in which the surviving company was a member insurer immediately after the merger;

(b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or

(c) A transaction entered into pursuant to a plan approved by the member insurer's domiciliary regulator.]

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

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

(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation,

through a merger between the insolvent insurer and another entity obligated under the policies; or

(2) An assumption reinsurance transaction in which all of the following has occurred:

(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies: and

(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

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

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

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

(2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:

(a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and

(b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.

(c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or

(3) An assumption reinsurance transaction in which all of the following has occurred:

(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;

(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

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

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

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against

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a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

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

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

[Optional:

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

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

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

I~~J~~. "Insured" means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

J~~K~~. (1) "Member insurer" means any person who:

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

(b) Is licensed to transact insurance in this State (except at the option of the State).

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

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

[Optional:

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

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

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

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

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

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

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

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

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

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

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

Section 6. Creation of the Association

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

[Alternate Section 6. Creation of the Association

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

A. *The workers' compensation insurance account;*

B. *The automobile insurance account; and*

C. *The account for all other insurance to which this Act applies.]*

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

Section 7. Board of Directors

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

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

B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.

D. Any board member who is an insurer in receivership shall be terminated as a boar*d member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.

E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

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

Section 8. Powers and Duties of the Association

A. The association shall:

(1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

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

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

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

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

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Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

against the liquidator or receiver of an insolvent insurer.

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

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

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

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

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

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

(3) **[Alternative 1~~a~~]** Assess insurers amounts necessary to pay the obligations of the association under S~~ubs~~ection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as

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soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

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

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

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Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

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

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

[Optional:

(4) Assess member insurers that have entered into transactions described in Section 5G(3), in addition to the assessment levied under Section 8A(3), an amount reflecting liabilities that may have arisen before the date of the transaction. The assessment under this Section 8A(4) is not subject to the annual percentage limitation under Section 8A(3) and shall be the amount that would have been paid by the assuming insurer under Section 8A(3) during the three calendar years preceding the

effective date of the transaction if the business had been written directly by the assuming insurer. If the amount of the applicable premiums for the three year period cannot be determined, the assessment shall be 130% of the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the assumed claims transaction, multiplied by the applicable guaranty association assessment percentage for the calendar year of the transaction.]

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

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

(5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

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

(6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:

(i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:

(I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or

(II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.

(ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.

(iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

(b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.

(7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.

(8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.

(9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

(1) Employ or retain persons as are necessary to handle claims, provide covered policy benefits and services, and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;

(5) Perform other acts necessary or proper to effectuate the purpose of this Act;

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

[Alternate Section 8B(6)

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

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

C. Suits involving the association:

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

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

[Optional:

D. (1) The legislature finds:

(a) The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;

(b) The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;

(c) The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;

(d) The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and

(e) In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.

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

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

(3) In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.

(4) Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.

(5) In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].

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

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

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

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

Section 9. Plan of Operation

A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.

(2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules

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necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

(1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;

(2) Establish procedures for handling assets of the association;

(3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;

(4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;

(5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;

(6) Establish regular places and times for meetings of the board of directors;

(7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;

(8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;

(9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;

(10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

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

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

jurisdiction;

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

B. The commissioner may:

(1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than $100 per month;

(2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Examine, audit, or otherwise regulate the association.

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

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

Section 11. Coordination Among Guaranty Associations

A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.

B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

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

B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense

or otherwise.

C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to Statepriority of distribution in liquidation act].

D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

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

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

[Alternate Section 13A

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

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

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

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

[Alternative 1 for Section 13B

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

(2) The association shall have the right to recover from a high net worth insured all amounts paid by

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

the association to or on behalf of such insured, whether for indemnity, defense or otherwise.*]*

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

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

[Alternative 2 for Section 13B

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

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

(a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;

(b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or

(c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

(3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.

(4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.*]*

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

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

[Alternative 3 for Section 13B

B. The association shall not be obligated to pay any first party claims by a high net worth insured.*]*

C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an

obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.

D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.

E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.

(2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

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

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

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

The credit shall be deducted from the lesser of:

(i) The amount of the judgment or settlement of the claim; or

(ii) The policy limits of the policy of the insolvent insurer.*]*

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

(3) Except to the extent that the claimant has a contractual right to claim defense under an insurance

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Draft: 10/2/23
Model #540

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group, July 24, 2023

policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.

(4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.

(5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:

(a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and

(b) Any amount payable by or on behalf of a self-insurer.

(6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.

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

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

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.

B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.

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

Section 16. Tax Exemption

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

Section 17. Recoupment of Assessments

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

[*Alternative 1 for Section 17*

A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.

B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.

D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:

(1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and

(2) The last sentence in Subsection C above shall not apply.

E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.*]*

[*Alternative 2 for Section 17*

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

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

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

C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.

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D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.*]*

[*Alternative 3 for Section 17*
The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.*]*

Section 18. Immunity

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

Section 19. Stay of Proceedings

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

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

____

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

1970 Proc. I 218, 252, 253-262, 298 (adopted).
1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. I 44, 46, 126, 217 (amended).
1981 Proc. I 47, 50, 175, 225 (amended).
1984 Proc. I 6, 31, 196, 326, 352 (amended).
1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
1986 Proc. II 410-411 (amendments adopted later printed here).
1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

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Draft: 11/9/23

Receiver’s Handbook (E) Subgroup
Virtual Meeting
November 9, 2023

The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Nov. 9, 2023. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Miriam Victorian, Vice Chair (FL); Joe Holloway (CA); Jared Kosky (CT); Tom Mitchell (MI); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brain Riewe (TX).

1. Adopted its Oct. 5 and Aug. 18 Minutes

The Subgroup met Oct. 5 and Aug. 18. During its Oct. 5 meeting, the Subgroup exposed Chapters 9, 10, and 11, as well as the appendix, of the *Receiver’s Handbook for Insurance Company Insolvencies* (Receiver’s Handbook) for a 30-day public comment period that ended Nov. 6. During its Aug. 18 meeting, the Subgroup took the following action: 1) adopted Chapter 7 of the Receiver’s Handbook; 2) re-exposed Chapter 6 and Chapter 8 of the Receiver’s Handbook; and 3) discussed the drafting group for Chapters 9, 10, and 11 of the Receiver’s Handbook.

McDonald made a motion, second by Victorian, to adopt the Subgroup’s Oct. 5 (Attachment Two-A) and Aug. 18 (Attachment Two-B) minutes. The motion passed unanimously.

2. Adopted Chapter 6 and Chapter 8 of the Receiver’s Handbook

Victorian made a motion, seconded by McDonald, to adopt Chapter 6 and Chapter 8 of the Receiver's Handbook (Attachment Two-C). The motion passed unanimously.

3. Adopted Chapters 9, 10, and 11 and Appendices of the Receiver’s Handbook

Baldwin noted that no formal comment letters were received by the end of comment period on Nov. 5. However, NAIC legal had updated citations and reinsurance sections. The drafting group submitted minor edits. Model laws references were updated. All these edits were red lined.

McDonald made a motion, seconded by Mitchell, to adopt Chapters 9, 10, and 11, and appendices of the Receiver’s Handbook (Attachment Two-D). The motion passed unanimously.

Having no further business, the Receiver’s Handbook (E) Subgroup adjourned.

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Draft: 11/6/23

Receiver's Handbook (E) Subgroup
Virtual Meeting
October 5, 2023

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Oct. 5, 2023. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Miriam Victorian, Vice Chair (FL); Jared Kosky (CT); and Laura Lyon Slaymaker and Crystal McDonald (PA).

There was not a quorum present. Therefore, the Subgroup was only able to do the following:

1. Exposed Chapters 9, 10, 11 and appendix of the Receiver's Handbook

The Subgroup exposed Chapters 9, 10, 11 and appendix for a 30-day period ending Nov. 6, 2023.

Having no further business, the Receiver's Handbook (E) Subgroup adjourned.

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Draft: 8/23/23

Receiver's Handbook (E) Subgroup
Virtual Meeting
August 18, 2022

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Aug. 18, 2023. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Miriam Victorian, Vice Chair (FL); Jared Kosky (CT); Tom Mitchell (MI); Leatrice Geckler (NM); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brian Riewe (TX).

1. Adopted Chapter 7 of the Receiver's Handbook

Kosky made a motion, seconded by Mitchell, to adopt Chapter 7 of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook) (Attachment Two-B1). The motion passed unanimously.

2. Re-Exposed Chapter 6 and Exposed Chapter 8 of the Receiver's Handbook

The Subgroup considered exposing Chapter 6 and Chapter 8 of the Receiver's Handbook. All comments should be sent to Sherry Flippo (NAIC) at sflippo@naic.org.

Victorian made a motion, seconded by Slaymaker and McDonald, to expose Chapters 6 and Chapter 8 of the Receiver's Handbook for a 30-day public comment period ending Sept. 18. The motion passed unanimously.

3. Discussed the Drafting Group for Chapters 9, 10, and 11 and Released Current Edits to Chapter 9

In August, the drafting group will have a kickoff meeting. The Subgroup released the current edits to Chapter 9 . Additionally, it was noted that the current Receiver's Handbook version is posted on the Subgroup's website under the documents tab.

Having no further business, the Receiver's Handbook (E) Subgroup adjourned.

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I. INTRODUCTION

Reinsurance is often referred to as "insurance for insurance companies," but it is separate and distinct from the insurance relationship existing between a policyholder and its insurer. The direct (primary, umbrella, or excess) insurer (reinsured or ceding company) cedes to a reinsurer (assuming company) a portion of its risk under policies issued to its policyholder (the original insured) pursuant to a reinsurance agreement. Reinsurance is an agreement of indemnity, whereby the assuming insurer in consideration of premium paid agrees to indemnify the ceding company against all or part of the loss that the ceding company may sustain under the policy or policies it has issued. Generally, absent a cut-through (discussed below at _), the reinsurer has no privity with or obligation to the original insured.

Just as reinsurance is important to the operations of an insurer, it is equally important to a receiver. Reinsurance receivables often represent a significant portion of an insurer's assets. Understanding reinsurance is critical to the efficient collection of this important asset. Generally, ceded reinsurance agreements should be continued. In the context of a life/health company insolvency, IRMA §612 provides for ceded reinsurance to be continued or terminated pursuant to the terms of each contract if the ceding insurer is in conservation or rehabilitation proceedings, but further provides that such contracts *shall be continued in liquidation* unless they were terminated in accordance with their terms prior to liquidation or were terminated pursuant to the liquidation order. In addition, both IRMA §612 and §8(N) of the NAIC's Life GA Model Act, as adopted in state laws, provide the life and health insurance guaranty associations the right to elect to continue and assume the rights and obligations of the ceding insurer with respect to reinsurance contracts that relate to guaranty association covered obligations, subject to the requirements set forth therein. To the extent those guaranty association covered obligations are subsequently transferred to an assuming insurer, the reinsurance continued on those contracts may also be transferred to the assuming insurer.

Reinsurance is a sophisticated international industry involving various types of unique contractual relationships. Reinsurance is utilized by insurers to achieve a variety of purposes and effects. It can increase an insurer's capacity to accept larger risks, provide financial support for an insurer, add stability to an insurer's results, protect against accumulations of losses, and provide the expertise of reinsurers who specialize in a particular area of insurance. Reinsurers may in turn be reinsured by other reinsurers referred to as "retrocessionnaires," who may also be reinsured, and so on. In this fashion, a broad spreading of risk is achieved.

It is important to note the terms used in reinsurance do not necessarily have the same meaning when used in the insurance context. A classic example is date of loss. In insurance it often means the date of the damage, while in reinsurance it can be the date the contract was accepted, terminates or any other meaning agreed by the parties. Some common definitions are:

Acceptance	Agreement by which a reinsurer consents to underwrite risk from a ceding company under specified circumstances.
Bordereau	A list compiled by a ceding insurer that provides the loss and premium histories of risks ceded or proposed to be ceded to a reinsurer.
Cede	To transfer part or all of a risk to a reinsurer.
Cedent	Company that is transferring the risk to a reinsurer. Generally the term is used when referring to the direct insurance company that is ceding business to the reinsurer.
Ceding Commission	The amount the reinsurer pays (or ceding company retains) when the cedent buys reinsurance. Generally, the amount of the commission is attributable to the cedent's acquisition costs.

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Cession	The portion of the risk that has been ceded to the reinsurer.
Commutation	The manner in which the cedent and the reinsurer will agree to a termination of past and future liabilities under a reinsurance contract.
Cover Note	A document issued by the reinsurance intermediary or the broker, indicating the reinsurance coverage that has been bound.
Cut-through Clause or Endorsement	A guarantee by the reinsurer to a party that is otherwise not in privity with the reinsurance contract (often the insured) that payment will be made by the reinsurer under certain specified conditions, e.g., insolvency of the cedent.
Excess of Loss Reinsurance	Reinsurance that attaches once a loss has exceeded a specific amount.
Facultative Reinsurance	Reinsurance in which the reinsurer retains the "faculty" to underwrite each risk individually.
Inuring Reinsurance	When for the benefit of the reinsurer, it will refer to other reinsurance contracts that will reduce the amount otherwise recoverable under a particular reinsurance cover. When for the benefit of the cedent, it refers to other reinsurance contracts that will not reduce the amount recoverable under a particular reinsurance cover. Sometimes referred to as "common account."
Quota Share Reinsurance	Generally, a reinsurance agreement by a reinsurer to reimburse a cedent in the same percentage in which the reinsurer receives premium from the cedent.
Reinsurer	A person or entity that assumes risk from the cedent.
Retention	The amount of risk retained by the ceding company.
Retrocedent	A reinsurer that transfers risk it has assumed to another reinsurer; e.g., cedent cedes to a reinsurer that in turn retrocedes to a retrocessionnaire.
Retrocession	A transaction whereby a reinsurer transfers risk that it has assumed from the cedent to another reinsurer.
Retrocessionnaire	A reinsurer that assumed risk from the retrocedent.
Surplus Share Reinsurance	A type of reinsurance treaty, similar to quota share reinsurance, which spells out specific amounts to be retained by the cedent.
Treaty [New row] Unauthorized	A type of reinsurance contract that differs from a facultative contract because it does not retain the faculty of underwriting the individual risk. A reinsurer that is unlicensed to conduct the business of insurance. The reinsurer is said to be "unauthorized" and not to provide security to the cedent which the cedent may reflect in its statutory financial statements either as an asset or a reduction in liabilities.

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Additional definitions may be found in the NAIC's *Credit for Reinsurance Model Law* (#785), *Credit for Reinsurance Model Regulation* (#786), *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787) *Special Purpose Reinsurance Vehicle Model Act* (#789), *Life and Health Reinsurance Agreement Model Regulation* (#797), and *Assumption Reinsurance Model Act* (#803). Glossaries can be found at various Web sites.

Guaranty Association Coverage

When an insolvent insurer is a reinsurer, guaranty associations do not provide coverage for reinsured policies unless there has been an assumption and novation and the insolvent insurer has become directly obligated to the original policyholders. See NAIC Life GA Model Act § 3(B)(2)(b) and NAIC P&C GF Model Act § 5(D) (which has been adopted in a minority of states and sometimes with modification to supporting definitions).

II. REINSURANCE BASICS

There are several reinsurance arrangements that one might expect to find in an insurer's reinsurance program. Whether undertaken in property and casualty, or life, accident and health insurance lines, there are numerous provisions that are required to be included in reinsurance agreements pursuant to state law (e.g., an insolvency clause – see _ below). In addition, all of the terms and conditions of a reinsurance relationship are required to be written as part of the principal agreement; "side" agreements and letters are not permitted.A. Property and Casualty Reinsurance Arrangements

A reinsurance program can be extremely complex and may consist of multiple interacting arrangements, all responsive to the same loss. Furthermore, an insurer's net retention, after applyingtreaty reinsurance and facultative reinsurance, may be further protected by catastrophe or stop loss reinsurance. Also, overlap between different treaties may cover aspects of the same loss.

Two particular types of reinsurance arrangements bear specific mention – fronting and cut-through arrangements. Both fronting and cut-through arrangements affect the parties to the transaction, but do not change the ultimate economics involved.

Fronting is an arrangement by which an authorized insurer issues policies to cover risks underwritten by unauthorized or inexperienced insurers (or for the benefit of insureds who cannot transact the business of insurance) and then transfers its own liability to such unauthorized insurer by means of reinsurance. Fronting involves two actions: (1) a substantial cession of business; and (2) a delegation of claims and underwriting authority from a licensed to an unlicensed insurer. The fronting insurer remains financially liable to the policyholder for the entire insured amount even though, in reality, the fronting insurer may only bear a small financial liability, if any. While fronting can serve useful purposes, abuses can occur if the fronting company fails to exercise control with respect to underwriting, claims, or the risk to which it exposes its assets. A certain amount of disclosure, however, is required on Schedule F of the Annual Statement. Ceding companies are required to disclose whether they have contracts ceding 75 percent of direct written premiums in Schedule F.

A cut-through is either a clause in or an endorsement to an insurance policy or reinsurance contract which provides that, in the event of the insolvency of the insurance company, the amount of any loss that would have been recovered from the reinsurer by the insurance company (or its statutory receiver) will, instead, be paid by the reinsurer directly to the policyholder, claimant or other payee, as specified by the clause or endorsement. Cut-throughs may provide a competitive advantage among commercial insurers. Some clients require insurers to obtain a cut-through or face the possibility of losing business to another insurance company. Reinsurers usually provide cut-throughs only when requested by the insured and reinsured. If a reinsurer issues a cut-through, it has a contractual obligation to pay the beneficiary of the cut-through rather than the receiver. The cut-through does not change the amount of the reinsurance recoverable, only to whom

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it is paid. Cut-throughs are common in captive arrangements, particularly where the insured owns, rents, or otherwise participates in the captive.

In general, reinsurance agreements are written as proportional or non-proportional and on either a treaty or facultative basis. Proportional reinsurance is reinsurance that involves the cession by the cedent of a specified share of risk, so that premiums and losses are shared proportionately between the ceding insurer and the reinsurer. Non-proportional reinsurance is a form of reinsurance that, subject to a specified limit, indemnifies the ceding company against the amount of loss in excess of a specified retention. It includes various types of reinsurance, such as catastrophe reinsurance, per risk reinsurance, per occurrence reinsurance and aggregate excess of loss reinsurance. Treaty reinsurance (or obligatory reinsurance) refers to an arrangement under which a reinsurer automatically reinsures all the risks of a specific portfolio of the reinsured, without an option to decline specific risks within the portfolio. Facultative reinsurance, on the other hand, refers to the type of risk where the reinsurer has retained the "faculty" to underwrite the individual risk. A facultative contract is generally referred to as a facultative certificate.

1. Treaty Reinsurance

Under a treaty, the reinsurer is obligated to accept the cession of a class or certain classes of business written by the ceding insurer in accordance with the definitions, exclusions, terms and conditions of the reinsurance agreement. There are common treaty clauses, but each treaty must be read in its entirety to determine how subject premiums and losses are to be treated and how the treaty is affected by other treaties, i.e., inuring treaties. (See definitions in I. Introduction, above.)

A treaty can cover different types of risks. Some treaties cover one line of business, such as fire, casualty, marine, aviation, directors and officers, or boiler and machinery. Others cover an entire program or all business written by a managing general agent, program administrator or specific underwriting department. There are two principal categories of treaty reinsurance: (i) pro rata or proportional reinsurance, and (ii) non-proportional or excess of loss reinsurance.

Treaties tend to be long documents with many clauses and provisions. There are no "standard" contracts, and no two are alike.

2. Facultative Reinsurance

Facultative reinsurance is reinsurance of individual risks by offer and acceptance wherein the reinsurer either retains the "faculty" or ability to accept or reject each risk offered by the ceding company, or limits its acceptance to certain risks or lines of business of the cedent.

There are two principal categories of facultative reinsurance: facultative obligatory and semi-automatic facultative.

- Facultative obligatory reinsurance: These contracts are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

- Semi-automatic facultative reinsurance: Semi-automatic facultative reinsurance requires the reinsurer to accept certain defined risks of the reinsured, subject to the right of the reinsurer to reject liability for any of such risks within a stated period after submission. Like facultative obligatory reinsurance, semi-automatic facultative reinsurance is also a hybrid of both treaty and facultative reinsurance.

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Unlike treaties, many facultative contracts take the form of "certificates" comprising a Declarations page and a page of "standardized" General Terms and Conditions in order to ensure concurrency of terms within the reinsurance market.

3. Pro Rata and Excess of Loss Reinsurance

Pro rata and excess of loss reinsurance are forms of either treaty or facultative reinsurance.

a. Property/Casualty Pro Rata Reinsurance

Pro rata reinsurance, also known as proportional reinsurance, consists of quota share reinsurance and surplus reinsurance. Quota share reinsurance is a cession of a specified portion of the risk up to a certain limit of liability, such as 50 percent of the risk per occurrence up to $1 million.

Surplus treaties are pro rata reinsurance that are usually designated by such names as first surplus, second surplus, special surplus, etc., reflecting layers of surplus reinsurance over specified retentions. Several reinsurers may each have a percentage of liability on a surplus treaty in each of these layers. Each reinsurer's liability may be referred to as their "participation." It is called surplus reinsurance because it is reinsuring over a net retention by the cedent or over other layers of reinsurance. A reinsurer's respective participation is designated in a document known as an Interests and Liabilities Statement or agreement (I&L) and is designated as being on either a joint (each insurer is liable for the entire amount reinsured) or several (each reinsurer is liable only for a specified amount or percentage) basis.

b. Excess of Loss Reinsurance

Excess of loss reinsurance applies to losses that exceed an agreed dollar amount or percentage of premium. The reinsurance may apply to a single risk, to a number of losses arising out of one event, or to an aggregation of losses. Excess of loss reinsurance written on a per risk basis is most common, sometimes supplemented by aggregate loss limits applied on an annual basis. Because excess of loss reinsurance does not participate in the entire loss, premium and losses are not shared on a proportional basis with the cedent.

There are many types of excess of loss reinsurance, such as working excess, layered excess, per-risk reinsurance, aggregate excess of loss, and catastrophe or clash cover. The following are examples of excess of loss reinsurance:

- Working excess: This form of excess of loss reinsurance focuses on loss frequency, as opposed to loss severity, and is usually written with relatively low indemnity in excess of low retention, e.g., $400,000 indemnity in excess of $100,000 retention. (In reinsurance parlance, this is expressed as $400,000 xs. $100,000.)

- Layered cover: First excess is usually written over a retention where frequency diminishes and severity of loss is more of a factor. To protect against increased severity, second, third, fourth and higher excess layers may have also been purchased. A single loss may potentially expose any number of these excess covers.

- Per risk: Reinsurance in which the reinsurance limit and the reinsured's loss retention apply "per risk" rather than per accident, per event, or in the aggregate. With per risk reinsurance, the cedent's insurance policy limits are greater than the reinsurance retention. For example, an insurance company might insure commercial property risks with policy limits up to $10 million and then buy per risk reinsurance of $5 million in excess of $5 million. In this case, a loss of $6 million on that policy will result in the recovery of $1 million from the reinsurer.

- Catastrophe reinsurance: This cover requires more than one loss resulting from a catastrophe or series of events. For example, if only one insured building was damaged due to an earthquake, catastrophe reinsurance would not cover the claim. If multiple losses

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resulted, the catastrophe reinsurance might respond, but only after application of other available reinsurance. It is generally very high level, such as xs. $100 million. It is a form of excess of loss reinsurance that, subject to a specific limit, indemnifies the ceding company in excess of a specified retention with respect to an accumulation of losses resulting from an occurrence or series of occurrences arising from one or more disasters. It generally covers multiple books of business. Catastrophe contracts can also be written on an aggregate basis, under which protection is afforded for losses over a certain amount for each loss in excess of a second amount in the aggregate for all losses in all catastrophes occurring during a period of time, usually one year. There will be two limits that the receiver will have to track: the catastrophe limits and the individual loss limits.

- Clash cover: Clash cover is a form of casualty excess of loss reinsurance under which a cedent may combine and cede the losses of multiple direct insureds, subject to a single reinsurance retention, when the losses arise from the same event or occurrence.

- Aggregate or stop loss reinsurance: This coverage applies when total losses on a group of risks accumulate to a specified retention, which may be defined as a specific amount or a percentage of premium. Generally, once the retention is reached and the aggregate or stop loss reinsurance kicks in, the reinsurance covers all risks above the designated retention.

B. Life Reinsurance Arrangements

1. Types of Reinsurance

There are three distinct types of life reinsurance: yearly renewable term, coinsurance and modified coinsurance.

- Yearly renewable term (YRT): Under yearly renewable term reinsurance, the reinsurer indemnifies only the mortality risk. The mortality risk, but not the permanent plan reserves, is transferred to the reinsurer for a premium that varies each year with the amount at risk and ages of the insureds. While YRT reinsurance allows a ceding company to transfer mortality risk, it leaves the company responsible for establishing reserves. The reinsurer becomes liable for the reinsured portion of the net amount at risk but has no cash surrender value liability. While the precise formula for determining the reinsured portion of the net amount at risk varies from treaty to treaty, in general it equals the death benefit less cash surrender value on the portion reinsured. Thus, as the cash surrender value grows from year to year, the amount of reinsurance decreases.

- Coinsurance: Coinsurance is a broader form of reinsurance, under which the reinsurer indemnifies a proportionate share of all risks under the policy. In return, the reinsurer receives a proportionate share of the cedent's gross premium, less an expense allowance or ceding commission, and is responsible for establishing reserves. Under a coinsurance funds withheld treaty, the cedent retains all or some of the reinsurance premiums as security for the reinsurer's obligations. With a reinsurer that is not authorized for credit for reinsurance purposes ("unauthorized reinsurer"), additional security is often provided by trust accounts and letters of credit for any difference between the liability of the reinsurer and the funds withheld by the cedent.

- Modified coinsurance: Modified coinsurance differs from coinsurance in that the reserves on the reinsured portion of the policy are not held by the reinsurer; instead, the reserves are held by, and are the responsibility of, the cedent. The reinsurer receives its proportionate share of the cedent's gross premium, less expense allowances. Periodically, a reserve adjustment payment is made, which is equal to the reserves at the end of the reporting period less the sum of (i) the reserves at the beginning of the period and (ii) the earnings on the reserves at the

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beginning of the period. The interest element in this calculation is stated in the treaty. If the result of this calculation is positive, the payment is made to the ceding insurer, and if it is negative, the payment is made to the reinsurer. Generally, as long as new business flowing into the account exceeds lapses, the reserve adjustment will be positive.

Each of these forms of life reinsurance are documented in agreements having clauses and provisions unique to the business reinsured. Some contracts empower reinsurers to compel cedents to raise premium rates on the underlying business, which present many unique issues for receivers. Obtaining advice of competent legal counsel in such situations is important.

2. Types of Acceptance

- Automatic reinsurance: This is the most common form of life reinsurance. Automatic reinsurance enables the cedent to issue policies in excess of its retention promptly and economically. The maximum amount of reinsurance that may be ceded automatically on a particular life policy is usually a multiple of the ceding insurer's retention. In the past, the most common multiple was four, but in recent years, there has been a tendency toward higher multiples, such as six, eight or ten. Automatic treaty limits may also be expressed as a dollar amount. Reinsurers seek a reasonable relationship between a cedent's exposure and the exposure it can cede automatically to a reinsurer. It is assumed that the proper balance will provide more assurance that the ceding insurer will act prudently in underwriting a risk if it is retaining a meaningful or "material" portion of that risk.

- Facultative reinsurance: Virtually all automatic treaties also provide facultative facilities for risks that cannot be ceded automatically and for situations where the ceding insurer seeks the underwriting assistance of the reinsurer. A "facility" is an agreement setting out, among other things, the rules under which a reinsurer will reinsure risks ceded by the other party. Unlike automatic reinsurance where the underwriting assessment is made by the cedent, under facultative reinsurance, the reinsurer determines whether it will accept the risk and, if so, at what underwriting classification.

- Facultative obligatory reinsurance: These treaties are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

- Second excess reinsurance: These are automatic reinsurance treaties that are excess of an initial layer of automatic reinsurance provided by another reinsurer. For instance, a cedent might have first excess automatic cover of four times its $150,000 retention from one reinsurer plus a second excess automatic facility of two times retention from another reinsurer, permitting the cedent to issue up to $1,050,000 of insurance ($150,000 + 4 x $150,000 + 2 x $150,000) on its own underwriting authority. Second excess facilities are sometimes provided on a "criss-cross" basis by two reinsurers sharing an automatic account. One reinsurer might provide first excess cover on lives of persons whose surnames begin with any letter from A to K and second excess cover for surnames starting with L to Z. The other reinsurer would then provide first excess for L to Z and second for A to K. It is a convenient way of providing higher automatic cover when appropriate, without either reinsurer having too large a risk on any one life.

C. Financial Reinsurance

A reinsurance contract that fully participates in the insurance risk of the underlying policies and literally follows the fortunes of the ceding company, such as a simple quota share reinsurance treaty, is referred to

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as traditional reinsurance. A reinsurance transaction that does not transfer sufficient insurance risk, sometimes referred to as financial reinsurance or finite reinsurance, should be accounted for separately and not commingled with traditional reinsurance transactions. (See SSAP No. 62R, Property and Casualty Reinsurance and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, for further discussion on deposit accounting for reinsurance that does not transfer sufficient risk.) Thus, reinsurance transactions that do not transfer sufficient insurance risk are still a viable tool to achieve economic goals, but must be accounted for and reported separately from traditional insurance or reinsurance transactions. See Chapter 9—Legal Considerations.

Although the authoritative language on transfer of risk is in the Statement of Statutory Accounting Principles—SSAP No. 61R for Life, Deposit-type, Accident and Health and SSAP 62R for P&C—of the NAIC's *Accounting Practices and Procedure Manual*, some jurisdictions have enacted legislation, promulgated insurance regulations, or issued insurance bulletins that address transfer of risk issues. The receiver should consult applicable or governing state laws and regulations on this subject.

D. Loss Portfolio Transfer

Loss portfolio transfers are arrangements under which an existing block of loss reserves from events that have already occurred is transferred to a reinsurer acting as retrocessionnaire, and so without privity to the insured. The loss reserves may include known case reserves, reserves for incurred but not reported (IBNR) losses, and loss adjustment expense reserves. Since the losses on casualty business are not payable until future years, the consideration for the loss portfolio transaction is calculated based on present value concepts, i.e., the time value of money. Thus, the ceding company is transferring ultimate loss reserves at a discounted value, and the transaction will create immediate income and surplus relief to such company. The essential elements in this transaction are the payout stream of the loss reserves and the time value of money. The financial responsibility of the reinsurer may be capped.

E. Pooling Arrangements

Pooling arrangements are utilized among two or more insurers or reinsurers to underwrite a particular risk or type of business. An allocation of a share of premium, loss and expense is made to each member of the pool based on the pooling agreement. Pooling can be used among either affiliated or unaffiliated companies. Pooling is common within insurance holding company systems or groups of affiliated insurers, and must be reported as such.[1]

III. INTERMEDIARIES AND THEIR ROLES

A. Reinsurance Intermediaries and Brokers

If the ceding insurer chooses direct placement, it will handle all negotiations directly with the reinsurer. However, a ceding insurer may have received the assistance of a reinsurance intermediary (also known as a broker) to place reinsurance coverage. The terms "reinsurance intermediary" and "broker" are sometimes used interchangeably. In a number of jurisdictions, the reinsurance intermediary/broker is legally considered to be the agent of the cedent; this can be reversed by the reinsurance contract.

The reinsurance intermediary facilitates the relationship by acting as the liaison between the ceding insurer and the reinsurer. The reinsurance intermediary may be responsible for documenting the activity between the parties and passing through accounts and payments between the ceding insurer and reinsurer. Should the reinsurance intermediary agree that it is to have any of these obligations, the reinsurance contract should contain a reinsurance intermediary clause. The following is a sample:

> Intermediary is hereby recognized as the intermediary negotiating this Agreement for all business hereunder. All communications (including but not limited to notices, statements, premiums, return

[1] NAIC SSAP No. 63; *see also* Statutory Issue Paper No. 97 (Finalized March 16, 1998)

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premiums, commissions, taxes, losses, loss adjustment expense, salvages and loss settlements) relating thereto shall be transmitted to Insurer or Reinsurer through Intermediary. Payments by Insurer to Intermediary shall be deemed to constitute payment to Reinsurer. Payments by Reinsurer to Intermediary shall be deemed to constitute payment to Insurer only to the extent that such payments are actually received by Insurer.[2]

For the cedent, the reinsurance intermediary finds reinsurers willing to accept the risk and helps to negotiate reinsurance agreement terms and produce documentation. For the reinsurer, the reinsurance intermediary brings proposals from cedents and administers the transaction details. The reinsurance intermediary receives a fee (called brokerage or commission), which may be deducted from the premium amounts paid to the reinsurer.

Typically, the reinsurance intermediary will place a cedent's business with one or more reinsurers. When accounts are rendered by the cedent, the reinsurance intermediary will prepare an account for each reinsurer and distribute payments to them or seek reimbursement of amounts due the cedent, as appropriate.

The insolvent cedent, possibly subject to certain limitations, may elect to change the reinsurance intermediary at any time during the treaty and need only notify, in writing, the reinsurance intermediary of its decision and its intended handling of its reinsurance in the future. The receiver should be aware; however, that such change may result in the insolvent cedent incurring an obligation to pay an additional commission. Whether such commission is subject to set-off is an issue to consider with competent legal counsel.

The ceding insurer provides the reinsurance intermediary with a broker of record letter pursuant to which the reinsurance intermediary is granted the authority to solicit reinsurers to subscribe to a program. The reinsurance intermediary then presents a package of information to potential reinsurers, compiled in coordination with the insurer, which documents the program to be written and the insurer it represents. Traditionally the reinsurance contract was rarely signed by all parties prior to the inception date of the coverage. Instead, the reinsurers signed placement slips indicating their percentage participation and containing a summary of the reinsurance coverage—limits, retention, exclusions, standard clauses to be used in the contract, etc. The ceding insurer signed a similar document but referred to it as a cover note. When the reinsurance contract was ultimately circulated for execution, each reinsurer would execute a separate signature page or I&L , binding them to the formal contract. More recently, pursuant to US and international regulations, documentation of the transaction must be executed within nine months. many brokers and direct reinsurers have been moving toward contract at placement or contract certainty, the idea being that the full contract wording is agreed upon prior to the inception date of the coverage. In such a case, there would be no need for a placement slip; rather, the reinsurer would sign the I&L page to the contract.

The reinsurance intermediary then gathers all executed slips and I&Ls and provides them to the ceding insurer, indicating that the placement has been completed and summarizing its terms and conditions. Thereafter, the reinsurance intermediary often has the responsibility to draft a reinsurance treaty based on the agreed terms.

The ceding insurer reports premiums to the reinsurance intermediary, who then prepares the necessary accounts to the reinsurer or correspondent broker, together with appropriate remittances less the reinsurance intermediary fee, which may be netted against such premiums.

The ceding insurer reports losses through the reinsurance intermediary to the reinsurer. The reinsurer pays losses through the reinsurance intermediary to the ceding insurer. In some instances, a reinsurer will make its check payable to the cedent and forward it to the reinsurance intermediary, who will simply mark his records as paid and forward the check to the cedent. In other instances, the check will be drawn in favor of

[2] Note that the last sentence of the intermediary clause reverses the general accepted rule that payment to a disclosed agent is payment to the principal.

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the reinsurance intermediary, who will then be obligated to pay the cedent. Funds so paid are held in a fiduciary capacity. Most current reinsurance intermediary clauses deem payment as having been made only upon actual receipt by the cedent. For an example, see the NAIC *Reinsurance Intermediary Model Act* (#790) and New York Regulation 98.

State law following the NAIC Model requires reinsurance intermediaries to be licensed and to have written agreements with their cedents.

B. Role Upon Insolvency

The reinsurance intermediary should be immediately notified of the receivership of either the cedent or reinsurer. The reinsurance intermediary should be provided with a copy of any legal documents (insurance department letter or court orders). It is then the responsibility of the reinsurance intermediary to notify and advise all reinsurers or cedents of the status of the insolvent insurer. It may also be necessary to obtain underwriting and premium records of the reinsurance intermediary, since they are generally more complete than those of the company in receivership.

The responsibility of the reinsurance intermediary does not terminate when the insurer is placed in receivership. The reinsurance intermediary must continue to act in the best interest of the insolvent insurer, including rendering accounts and assisting in the collection of funds from reinsurers. In turn, the estate should continue to provide the reinsurance intermediary with timely claims and accounting reports that need to be rendered to reinsurers. Nonetheless, given the change in the relationship due to the receivership, the receiver may have to contemplate making a new arrangement if he/she has difficulty receiving service from the reinsurance intermediary. If not, there may be an issue whether the intermediary is entitled to assert set-off in respect of pre-receivership financial obligations that include commission(s). In that event, the receiver will want to seek advice from competent legal counsel.

IV. REINSURANCE ACCOUNTING AND COLLECTION PROCEDURES

The purpose of this section is to describe the accounting and collection responsibilities of the receiver for assumed and ceded reinsurance.

A. Introduction

For accounting purposes, reinsurance treaties are classified as either prospective or retroactive. A prospective treaty is one that covers future insurable events arising on or after the effective date of the contract. A retroactive reinsurance treaty (e.g., loss portfolio, as described above in _) is a treaty that covers past insurable events. A reinsurance treaty, whether prospective or retroactive, must transfer insurance risk. Unless insurance risk is transferred, the treaty must be accounted for as a deposit and not as reinsurance. Deposit accounting postpones recognition of revenues and income until the end of the treaty. Under the "nine-month rule," unless the full treaty wording is signed by the parties within nine months of its effective date, the accounting treatment for the reinsurance treaty must be converted from prospective to retroactive. For statutory accounting, a retroactive treaty must be excluded from the underwriting results of an insurance company and cannot be commingled with a prospective treaty.

SSAP No. 62R requires that, for a transaction to be classified as reinsurance, and to be included in the underwriting accounts of the company, the reinsurance treaty must be prospective, and the transaction must contain both underwriting and timing risk.

1. Underwriting risk is the ultimate amount of net cash flows from premiums, commissions, claims, and claims settlement expenses.
2. Timing risk is the timing of the receipt and payment of such cash flows.

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SSAP No. 62R further requires that indemnification of the ceding company against loss or liability relating to insurance risk in reinsurance requires both of the following:

1. The reinsurer assumes significant insurance risk under the reinsured portions of the underlying insurance contracts.
2. It is reasonably possible that the reinsurer may realize a significant loss from the transaction.

For complex or non-traditional reinsurance contracts, present value cash flow analysis of a transaction is often prudent to determine whether significant risk has been transferred or a loss may be realized. If a transaction does not meet these requirements, then the transaction must be reported in the financial statements as non-reinsurance or as a deposit. The authoritative statutory guidance for deposit accounting is contained in SSAP No. 61R.

The receiver's primary objective should be to examine the reinsurance agreements with a view to what is best for the estate. It is possible that reinsurance agreements may be amended, terminated, rescinded, commuted or continued to meet this objective.

B. Unearned Premium Reserves

There may be unearned premium reserves related to a reinsurance treaty for some time after the termination date of the treaty, as the underlying policies have not yet reached their expiration and premiums have not been fully earned. This situation may be altered by the termination method utilized. Typically, the parties may elect to terminate a treaty on either a "cut -off" or "run-off" basis. In run-off, a reinsurer will remain liable for losses for policies in force at termination, even if the occurrences take place after the termination date. Since cut-off terminates the reinsurer's liability as of a certain date, usually with a return to the cedent of any unearned premium reserves held by the reinsurer, the period for which the reinsurer may be liable for losses may be substantially reduced as compared to a run-off provision.

C. Contractual Adjustments

Reinsurance treaties may be subject to future premium or commission adjustments based upon experience. Common adjustments are retrospective premium rating, deposit premium adjustment and reinstatement premium adjustments. The most common commission adjustments are for contingent (profit) and sliding scale commissions.

A retrospective rated premium adjustment is a calculation of the final reinsurance premium for the treaty based upon the loss experience developed during the term of the treaty. An estimated reinsurance premium, sometimes referred to as a deposit premium, is paid by the cedent until the retrospective premium is determined. The final reinsurance premium is the deposit premium plus or minus the adjustment, often subject to a minimum and maximum dollar limit.

Ceding commission adjustments represent a sharing of profits between the reinsurer and cedent and are usually associated with pro rata reinsurance. A contingent commission, or profit commission, is a sharing of a predetermined amount of the profits, if any, realized by the reinsurer from the reinsurance treaty. A formula is specified in the treaty describing how premium, losses, IBNR, expenses and commissions are calculated for determining profitability. At specified dates, this calculation is made and settlement of accounts is undertaken. No additional premium results from a contingent commission agreement. These arrangements in life reinsurance may be referred to as experience refunds.

A sliding scale commission arrangement is one in which the final ceding commission is determined by calculating the loss ratio and relating this to a predetermined range of commission rates. As the loss ratio increases, the amount of commission decreases, or vice versa, usually subject to stated limitations.

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D. Ceded Reinsurance Recoverables

The initial step in establishing control over ceded reinsurance receivables is to gather and update all ceded reinsurance treaties and facultative certificates in order to create working abstracts of these arrangements. Once individual arrangements have been analyzed, a matrix of reinsurance coverages in place, by book of business, should be established so that the relationship of various ceded treaties is known. See Exhibits 7-1 and 7-2.

The most current account rendered for each treaty should be reviewed, and any open balances due to or payable from the estate should be reconciled. If the reinsurance was purchased through a reinsurance intermediary, there are likely to be multiple reinsurers. Each reinsurer and its percentage of participation should be identified and accounts verified.

Each treaty should be reviewed to determine:

- Lines of business covered
- Limits of coverage
- Dates of coverage
- Workflow and procedures needed to generate premium, losses, etc.
- Outstanding balances
- The appropriateness and method of cancellation of the coverage
- The method of termination (run-off or cut-off)
- The location and security of records underlying the placement of the treaty

Once all participants have been identified in the treaty review phase, an analysis of each reinsurer should be made to determine its financial strength. Procedures should be established to periodically monitor the solvency of reinsurers. If the financial stability of a reinsurer becomes a concern, possible commutation of the reinsurer's liability should be considered.

Treaties may contain security provisions requiring or permitting the insurer to obtain collateral for the reinsurers' obligations. If a treaty provides for letters of credit to secure the obligations of the reinsurers, the obligations of reinsurers should be reviewed and letters of credit either obtained or updated to reflect appropriate liability.

The initial step in the ceded reinsurance accounting process is to develop procedures that allow the assembly of data to produce reporting in conformity with requirements under the treaty.

Allowed claims in liquidation proceedings constitute the basis for submitting claims to reinsurers. Generally, rehabilitation follows the rules of the contract. Thus, it is important to maintain record-keeping systems that fully support the calculation of total claims reinsured.

1. Premium Processing

   In most property/casualty liquidations, the court order cancels coverage on the insurer's direct in force insurance business within 30 days of the date of the receivership. The cancellation of the underlying business terminates the need for ceded reinsurance for losses occurring after the termination date, but does not terminate the reinsurance under the treaty when the receivership is a liquidation based upon a finding of insolvency. In this event, the first consideration in premium accounting is to calculate any

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unearned premium reserves that the reinsurers may be holding at the termination date and request that they be returned to the estate. There may, however, be additional premiums or adjustments to be forwarded to the estate for direct business issued and in-force prior to receivership.

Appropriate calculation of this premium should take into consideration the earned portion due reinsurers. Proportional ceded reinsurance involves a calculation of the gross earned premium that is subject to the agreement and a credit to the reinsurer's account for the appropriate proportion. The gross earned premium is subject to ceding commissions due to the estate and, in most events, may be subject to an offset for paid losses.

2. Reinstatement Premiums

Premium adjustments may become due from the insurer to one or more reinsurers as subject premium is received or loss experience develops on business that was reinsured.

Certain types of excess of loss reinsurance agreements, primarily aggregate excess of loss agreements, may provide for an additional premium to be paid to the reinsurers if the total liability limit under the agreement is exhausted by loss payments. This additional premium is known as a reinstatement premium because its payment reinstates the limit of liability of the reinsurance agreement. Reinstatement may be optional, in which case the liquidator may wish to consider whether it should be paid, or if ultimate liabilities will be reduced due to the termination of the underlying policies.

Losses from direct business may be known sooner by the receiver, and reinstatement calculations, as defined by the treaty, may be prepared more rapidly. Losses from assumed reinsurance, however, usually develop over a period of years. For this reason, appropriate controls in accounting and claims are needed to identify any aggregate losses that may be subject to recovery from reinsurers.

The relative priority of such obligations should be considered in a liquidation, and the potential for preferential transfers should be considered in a rehabilitation. Notwithstanding this, it is important for the receiver to maintain current billing practices.

3. Losses Recoverable

Losses to be recovered from reinsurers may arise from both direct and assumed reinsurance operations. It is desirable for the receiver to coordinate reporting with guaranty funds to ensure complete, accurate and detailed information. Controls over this information are required to meet the data requirements of the reinsurance agreements.

In establishing its reinsurance processing procedures, the insurer should have provided for the capture of loss balances due or owing under each treaty or facultative certificate and for each participating reinsurer. If this information does not exist, it is important for the receiver to analyze each treaty by participation to identify each reinsurer. As a result of closer monitoring, a better control over slow-paying or non-paying reinsurers should be achieved.

In addition to paid losses for which the insurer seeks indemnification, outstanding reserves for losses and expenses (and possibly IBNR calculations) are to be reported to reinsurers. Controls should exist to identify certified and unauthorized reinsurers and to monitor the collateral they should provide, as well as the potential recovery against such collateral.

E. Assumed Reinsurance

Accounts for assumed business usually represent liabilities of the estate, as most premiums, except for premium adjustments, are typically received prior to receivership. Because assumed reinsurance is not covered by guaranty funds, and assumed reinsurance generally falls within the general creditor class of the estate's distribution priorities, its accounting is often not of primary importance in liquidations unless

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collateral is involved. The existence of collateral account heightens the importance for ongoing accounting and reporting in the underlying business. Whether collateral is supporting an assumed reinsurance transaction might not be clear on the insurer's financial statement, but that collateral could go back to the ceding company if the reinsurance agreement terminates. That transfer of assets could have an adverse effect on the assuming insurer. Typically, ceding companies have low priority claims in liquidation and GAs don't cover assumed (but not novated) reinsurance, therefore unwinding assumed reinsurance agreements could have an effect on the assuming insurer's financials. The insurer, however, may have purchased reinsurance protection on this business and is required to properly record and report these transactions to its reinsurers or retrocessionnaires in order to realize recoveries from them, which may be significant. Also, it is common for insurers both to assume and cede reinsurance to the same insurers/reinsurers, so that mutual accounts may need to be completed to collect balances.

The general accounting approach to assumed reinsurance is the same as that for ceded reinsurance. The receiver should obtain and safeguard all original documentation, abstract arrangements for working purposes, establish balances as of the receivership date, review each treaty and facultative certificate, develop experience histories by treaty, and assign maintenance responsibilities.

Controls similar to those used for ceded insurance should exist over assumed reinsurance reporting. If business has been solicited directly from cedents, those cedents should be informed of any reporting requirements. If, however, a reinsurance intermediary is involved, then the receiver should communicate the requirements to the intermediary, who has the continuing obligation to report to the ceding insurers.

Intermediaries often remit a net payment for the balance due, which may cause problems in the identification and allocation of payments to various cedents' balances. This becomes more of a problem in liquidations, due to possible statutory limitations on setoff. The receiver should consult with competent legal counsel and determine whether to notify intermediaries not to use net accounting or multiple treaty or reinsurer setoffs. Unless rigorous control is maintained by the receiver, the cash allocation process may become difficult.

The action plan for assumed reinsurance is:

1. Documentation
    - Obtain all treaties and update all documentation
    - Establish how treaties were assumed (direct/broker)
    - Abstract treaties into usable format
    - Update any electronic data processing systems used for assumed reinsurance
    - Prepare a matrix of the reinsurance program
2. Accounts
    - Establish latest account position by treaty and cedent
    - Verify balances with broker or cedent, if direct assumption
    - Review experience on each treaty
    - Develop plan to deal with problem accounts
    - Request any missing accounts

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- Establish diary for any adjustments due on accounts
- Review documentation to ensure proper reporting of catastrophic losses and aggregate accumulations
- Establish diary control for collection of balances
    - separate responsibility for pro rata reinsurance and excess of loss reinsurance
    - set up procedures for evaluating and recording excess of loss claims

F. Reinsurance Accounting Systems

Reinsurance accounting systems can vary however most systems are web-based. In a few cases, there may be a limited accounting systems.. The type of system used may depend upon the extent and the diversification of the cedent's reinsurance program.

1. Minimum Accounting System Requirements

The reinsurance accounting system must provide information to record the subject business for reinsurance in a manner readily identifiable for each reinsurance contract. The subject reinsurance premium is computed by application of the treaty rate to the subject premium and is adjusted for premiums paid on other reinsurance treaties that inure to the benefit of the treaty.

Losses that emanate from the subject business should be identified. Once the covered losses are identified, reinsurance recoverable under each treaty is computed. If the cedent reports to a reinsurance intermediary, who in turn reports to individual reinsurers, then one summary report should be prepared and mailed to the reinsurance intermediary. If the cedent insurer reports directly to the reinsurers, then individual reports should be prepared. The ceding insurer often retains a percentage of the risk for its account. This can be accounted for on a net basis or as if the ceding insurer is also a reinsurer.

2. Inventory of Reinsurance Accounting Records

The inventory of reinsurance accounting records should be coordinated with the inventory of records for the primary accounting function. The reinsurance accounting records should include:

- Chart and summary of the reinsurance program
- Correspondence files with intermediaries
- Correspondence files with reinsurers
- Formal reinsurance contract wording
- Reinsurance slips (if a formal treaty has not been finalized)
- Signed I&L forms from each reinsurer
- Letters of credit or other forms of security from reinsurers
- Reinsurance accounting folders

The insurer may have a reinsurance accounting procedure manual available that describes the reinsurance accounting cycle and how the data necessary for the reinsurance accounting is obtained and processed to comply with the reinsurance treaties.

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The chart and summary of the reinsurance program should describe the various reinsurance treaties, the business covered, and the relationship between the treaties. An individual chart and summary may be available for each reinsurance accounting year. The chart and summary change from year to year as the reinsurance program changes to meet the insurer's needs, objectives and business reinsured.

Correspondence files with intermediaries may include confirmations of reinsurers' participation, accounting reports sent to the intermediaries, or letters requesting payments or cash advances, disputing amounts recoverable, requesting collateral, etc. The reinsurance intermediary is required under the NAIC *Reinsurance Intermediary Model Act* (#790) to retain documents for 10 years. The receiver should instruct the reinsurance intermediary to retain all documents until notified that the documents are no longer needed by the receiver. If the relationship with the reinsurance intermediary is to be terminated, arrangements should be made for the intermediary to deliver all documents in its possession, or copies of the documents, to the receiver.

3. Review of Reinsurance Intermediary Records

The receiver may benefit by reviewing the systems and procedures currently being used by the reinsurance intermediary and evaluating its performance. Where applicable, various reports generated by the insurer should be compared to the reinsurance intermediary's records. When reviewing the records of the reinsurer or of the reinsurance intermediary, consider the following:

- What is the status of the treaty documentation?
- Do the balances developed by underwriting year and by reinsurer conform to the balances generated from the insurer's system?
- Has there been a delay between submission of a request for payment and receipt of the payment? This information may become part of the reinsurer evaluation process. If a reinsurer is habitually late in making payments, the receiver should determine what actions are required. The receiver may wish to have the reinsurance intermediary copy the receiver on all billing transmittals.
- While not customary, the receiver should consider a periodic review of the reinsurance intermediary (every quarter to six months). The purpose of the audit is to verify that the receiver has received complete documentation concerning its reinsurance contracts (e.g., wordings and I&Ls), the reinsurance intermediary has collected all money due from the reinsurer, and all payments received by the reinsurance intermediary have been paid to the appropriate parties.

G. Reinsurance Audits

By custom as well as by contract, reinsurers may have access to the cedents' books and records that pertain to the business reinsured. This section will briefly explain the various types of audits, the purpose of each and the information that one can expect to obtain.

Virtually every reinsurance treaty has an access-to-records clause or an inspection clause, such as, "The reinsurers or their authorized representative shall at all times have access to the books and records of the company, which pertain in any way to the business transacted under this agreement." Most facultative certificates have a similar provision. The same often holds true for agreements with pool managers, managing general agents and reinsurance managers.

Audits typically cover accounting, claims and underwriting. Many reinsurance counterparties conduct separate audits, although it may be more effective to examine all three areas simultaneously. This is especially true in those instances where the audit is being conducted as a result of a dispute or in anticipation of arbitration or litigation. (Note that a "dispute" has statutory accounting consequences, so the prudent receiver will beware declaring a dispute too soon.) The receiver needs to coordinate with the reinsurer and

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any affected guaranty funds as to how the audit should be conducted and who should be involved in the audit. The prudent receiver also will negotiate a memorandum of understanding or non-disclosure agreement that summarizes the intent, scope and logistics (onsite vs. remote access, hours and location(s)) for any audit, which may include, e.g., provisions governing confidentiality, admissibility in a dispute resolution foruam, etc.

Except in unusual circumstances, the auditors may be limited to review of records directly related to the business their clients assumed. They are generally allowed to review original records together with the cedent's and receiver's summaries of experience, to the extent those are prepared in the normal course of business. However, auditors should be denied material prepared in anticipation of litigation or preparation for trial, and in particular they should be denied access to communications to and from counsel retained in connection with reinsurance collections. These materials should be kept in files separate from the underlying claims and underwriting files. Auditors generally do, however, receive access, under appropriate safeguards to preserve confidentiality, to communications to and from claims counsel.

An important consideration is who needs to be present during an audit, from both the audting and audited sides.

1. Accounting Audit

The primary scope of this review focuses on verification of the periodic reporting (monthly, quarterly accountings) of the cedent. Although the bulk of the audit will be conducted at the cedent's offices, a significant amount of work, such as the following, may be conducted prior to that time.

- Review terms and conditions of reinsurance contracts, such as:
  - coverage (type of reinsurance contract, limits, underwriting restrictions, classes of risk and territory)
  - reinsurance period (including cancellation and termination provisions)
  - reporting and settlement
  - definitions
  - procurement of common account protection
- Review cedent's recent financial information, including:
  - financial statements
  - independent auditor's reports
  - financial reports filed with the Securities and Exchange Commission or similar authorities
  - financial statements filed with insurance regulatory authorities
  - other insurance department regulatory reports

A schedule of accounts and settlements between the assuming company and the cedent, according to the reinsurer's documentation, should be prepared to verify the balance outstanding on the account. This analysis should then be compared to a similar schedule from the cedent's records. The results can be used as a source of further investigation, if necessary.

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Copies of the cedent's procedural manuals for accounting, claims, reinsurance, and audit should be obtained, reviewed and stored.

Documentation on hand should include the most recent experience reports on the program. Investigation should be made into significant deviations from normal business custom and practice. If desired, a comparison to similar programs with other cedents may also be made.

Comparison of such data to actual historical information, especially in the areas of premium volume and loss experience, may be performed to help determine the scope of the audit required.

Prior to inception of the audit, which maybe in person or remote, a list of information and documentation required for the audit should be submitted to the cedent to facilitate its availability. The documentation that may be requested would include digital/electronic, read-only access to document sharing systems, and/or printed copies of:

- Premium and claim registers for originating business (primary or assumed)
- Individual policy and claim files to support registers for originating business
- Premium and claim registers for ceded business
- Individual policy and claim files to support ceded registers
- Accounts and bordereau from the cedent
- Cash receipt and disbursement records (including checks, cash journals, ledgers) applicable to settlement of premiums and losses for originating and ceded business
- All contracts relating to managing general agents, brokers, intermediaries and common account protection for originating and ceded business
- All documentation and support relating to letters of credit, trust accounts and funds withheld

Although generally not specified in the inspection clause, the auditors should have reasonable access to personnel involved in the preparation of any of the cedent's documentation pertinent to the audit procedures.

Having completed review of the pre-audit documentation and assuming the availability of all required information at the cedent's office, the audit may:

- Trace information on originating premium and claim registers through the reports to assuming reinsurers.
- Determine relationship of premium and claim registers for originating business (primary or assumed) to ceded premium and claim registers.
- Verify accuracy of reinsurance accounts and the existing control procedures for preparation of accounts to assuming reinsurers based on review of originating and ceded premium and claim registers.
- Analyze cash records in conjunction with accounts to assuming reinsurers to determine balance due from or to cedents;
- Verify timeliness of reporting and settlement of accounts.

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- Sample policy files (reinsurance contract files for assumed business) and claim files from premium and claim registers to verify that:

    - policies are in agreement with treaty terms relative to class of risk, period, limits and other provisions.

    - premium allocations for policies are proper, as are all commissions and other deductions.

    - claims are adequately documented and fall within the policy conditions.

Irregularities encountered in any of the above may be referred to the appropriate staff member of the cedent for resolution of the problem.

This is a simplified outline designed to establish a pattern for the audit. These general steps may not apply to the same degree in all instances. Individual audit programs should be geared to address the needs of the situation, contingent on the nature and volume of the business, as well as the auditor's evaluation of control systems in place.

2. Claim Audit

The ceding insurer should have adequate control procedures in place to allow the assuming insurer to make a determination on the accuracy and validity of the claim information it receives, as well as to assess the competence of the cedent's claims personnel.

- Claims procedure. Preliminary examinations of claim procedures, as outlined in the cedent's current and any prior claims manual(s), should be performed prior to the on-site review. Prior to the examination, a list of documentation required, including the following, should be requested:

    - Claim staffing, including description of positions

    - List of outside vendors, including adjusters, defense/claim attorneys and others

    - Claim control log

    - Claim registers, including aged listing of outstanding claims and salvage and subrogation registers

    - Claim files and related policy/assumed contract files

    - Cash records applicable to claim and expense payments

Assess the Claim Staff. An analysis of the claim control log, claim register and aged listing of outstanding claims, along with the claim handling and diary system procedures outlined in the cedent's claim manual, should be indicative of the adequacy of staffing levels. Discussion with the appropriate claim personnel and review of the claim manual should indicate procedures used to assign claims to outside adjusters and the follow-up procedures used to keep the status on claims current.

A random sampling of claims from the loss registers should be made to determine files to be examined for the remaining portions of the audit. If specific areas or claims are suspect, these files can be requested and examined in addition to the random sample.

- Claims review generally will include the following:

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- Determination of adequacy of file documentation, including notice of loss, adjusters' reports, attorneys' reports,[3] litigation releases and proofs of loss (including reinsurance notices)

- Verification of coverage of originating policy and reinsurance agreements as to term, risk, limits and other provisions

- Reconciliation of payments (loss and expense) to claim filed documentation

- Determination of third-party recoveries (salvage, subrogation, third-party deductibles and other reinsurance)

Claims accounting may require special attention. The auditor will want to verify the correctness of claim allocation by sampling allocation by claim registers and the cedent's retention. In some instances, a review of the claim registers for originating and ceded business may disclose problems in claim allocation.

3. Underwriting Audit

An underwriting audit conducted by the receiver of an insolvent company may differ from that performed by a reinsurer contemplating a continuing relationship with an insolvent cedent. Some vital areas that may be considered during such audit include verification that:

- Premium volume is within guidelines outlined in the reinsurance agreement, if any.

- Controls are in place to determine effective and complete reporting of premiums.

A sample of policy files may be selected (or the policy files that correspond to those used in the accounting or claims audit should be reviewed) to determine whether:

- Risks written conform to the specifications of the reinsurance agreement relating to class of business, types of coverage, exclusions and other warranties.

- Risks written conform to underwriting guidelines.

- Underwriter's approval has been properly executed in accordance with the reinsurance agreement and any related underlying agreement (e.g., managing general agents, brokers).

- Policy endorsements alter reinsurance obligations.

- Premiums have been properly developed to include reporting forms, business subject to audit and retrospectively rated business.

Auditing counterparties typically prepare summaries of their findings. The receiver will want to request and receive a copy of any such report.

4. Handling Audits of Receiver's Records

Because of the receiver's activity in collection of reinsurance balances claimed due, the receiver frequently receives requests for audit of his or her own records and those of the insolvent company. Allowing an audit is an important step in the ultimate collection of the insurer's reinsurance recoverables, but care should be taken that the audit process neither creates new defenses for reinsurers,

[3] Whether the reinsurer is entitled to these reports is the subject of frequent litigation, and the receiver should seek legal counsel before providing or not providing these reports.

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disrupts the receiver's own efforts to manage claims and assets, nor violates any applicable statutory confidentiality provisions.

a. Preconditions to audit

After taking possession of the insurer, the receiver is entitled to adequate time to gain control and understanding of the insurer's affairs and records before being subject to audit by reinsurers. Reinsurers may make preemptory demands for audit well before the receiver can respond. The receiver should assure the reinsurer that it will have an opportunity to audit as soon as the receiver has had sufficient time to become familiar with the records he or she has inherited.

The receiver should consider developing a standard audit procedure to be followed. Once the receiver in consultation with triggered guaranty funds is prepared to schedule an audit by the reinsurer(s), several dates should be requested from the auditor, so that the receiver and guaranty funds have the opportunity to ensure availability of requested claim files, crucial staff and space, and possibly counsel. The receiver needs a firm commitment from the auditors as to the time required for completion of the audit, especially where the claims requested include claims that are open and ongoing with guaranty funds.

To facilitate the audit and ensure document control, the receiver should request a list from the auditor of all files to be reviewed. The receiver should contact affected guaranty funds and arrange for file shipment. The receiver should send a letter to the auditor outlining the procedures to be used for the audit and identifying the liaison between the auditor and the company. The receiver should also have the auditor and the reinsurer sign a confidentiality agreement before the audit to protect the interests of the estate and the insured.

b. Preparations for audit

The auditor may be asked to designate in advance the records to be reviewed, so that they can be located and retrieved. Someone on the receiver's staff or counsel is usually designated to become familiar, if they are not already, with the history, terms, accounts and major issues arising from the business being audited, and to serve as principal liaison between the auditors and the receiver. Arrangements should be made to provide the auditors with a designated space, ideally a separate room, to which records can be brought as requested. Control over records produced for the auditors is essential. Arrangements should be made to have copies (and/or screen shots of electronic or digitally stored material) made, at the reinsurer's expense, of any records or documents they designate, and the receiver should keep track of what is copied. Pricing and availability of copying services should be discussed with the auditing company.

c. Conduct of the audit and follow up

Members of the receiver's staff not personally involved in the audit should be advised that an audit is being conducted, and reminded that requests for information from auditors should be in writing and referred to the designated liaison to ensure correctness and consistency of the information provided.

The receiver should request, and often will receive, a copy of the auditor's findings at the conclusion of the audit.

H. Managing Assumed Reinsurance

Even though assumed reinsurance claims have a lower payment priority in liquidation, maintaining and processing assumed reinsurance claim activity may be vital for setoff purposes, to develop satisfactory support for any retroceded reinsurance that the insolvent insurer may have purchased, and to ensure that existing funded security is not improperly drawn down. Preparation of a schedule of reporting due dates for each assumed reinsurance treaty is helpful.

Pro rata reinsurance loss activity will be reported in a summary of all losses on individual policies reinsured. This summary report, or bordereau, should be accompanied by individual policy identification and loss data.

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Initially, a reconciliation of the proofs of loss submitted by or on behalf of cedents may be undertaken with the physical inventory of pending or unprocessed assumed reinsurance claims. The receiver's staff should establish procedures so claims submitted by cedents conform with the terms of the reinsurance treaty, including dates of loss, coverage impacted such as lines or classes of business, and types of risks reinsured. Questions or problems may be referred to the reinsurance intermediary or cedent as appropriate.

Next, all assumed claims should be reviewed to ensure that they are being reported to the reinsurer in a manner consistent with the requirements of the reinsurance agreement, including issues of coverage, claim support, and timing of reporting. Each reported loss should also be reviewed to ensure there is an appropriate reserve. The receiver's staff should develop additional case reserves if required and, if appropriate, notify reinsurers and retrocessionnaires. The retrocedent should consider doing the following:

- Review (all) incoming loss advices.
- Match loss advices with treaty or facultative certificates.
- Confirm coverage.
- Create a file and enter data, calculating the appropriate share of paid and outstanding.
- Maintain a diary system, either manual or(preferably) electronic.
- Identify all applicable retrocessional treaties and transmit timely notice based on respective terms and conditions.
- Request updates, pertinent information, and documentation through the intermediaries as needed.
- Establish format for closing and eventual purging and storage, pursuant to applicable law and any litigation holds(s).
- Confirm that catastrophic losses are identified and reported (these should be accumulated with potential retrocessional recoveries in mind).
- Review each loss in detail and post any additional case reserves deemed necessary.
- Inquire as to any inuring reinsurance or common account.
- Monitor cedents' pursuit of subrogation, salvage, and other recoveries.
- A separate file is usually required for each facultative certificate or excess of loss treaty, and a separate claim file for each loss under a certificate or treaty may be desirable.
    - For pro rata reinsurance treaties, a single file encompassing one underwriting period should suffice, provided the bordereaux are informative enough for the technical staff to verify coverage.
- If annual aggregate coverage is involved, a system-produced report is helpful for tracking aggregate exhaustion.
- Develop forms for all the above.

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I. Managing Ceded Reinsurance Collections

1. Direct Claims and Guaranty Funds

A primary consideration for the receiver is to prepare for the collection of ceded reinsurance for claims that will eventually be allowed by the liquidation court. To that end, the receiver should:

- If necessary, in addition to Uniform Data Standards (UDS), develop a reporting system to be used by the guaranty funds that conforms to the requirements of the insurer's reinsurance agreement(s).
- Reconcile the insurer's records to periodic reports from the guaranty funds.
- Promptly and adequately document the handling of direct claims that are not covered by guaranty funds so as to be able to notify and bill reinsurers
- Ensure there is adequate control over any claims settled at an amount in excess of the guaranty funds' statutory limits.
- Ensure that the guaranty associations are handling claims properly. This is generally done by audits of the associations.

2. Reports

Accounts rendered should be on forms mutually agreed upon by the cedent and reinsurer, and payments from the reinsurers should be made within the payment terms required by the treaty, without diminution because of the insolvency of the cedent.

The different forms of reinsurance contracts may have different reporting requirements. Because the reinsurer is not required to pay a loss unless the information to support the cedent's payment has been received, it is prudent that the receiver deliver this information as soon as possible. Developing this information often requires coordination with guaranty funds.

3. Insolvency Clause

A reinsurer is obligated to reimburse its ceding insurer for a covered loss after the cedent pays or becomes liable or responsible for underlying loss. This arrangement functions well in ongoing business; however, historically it raised practical problems when the ceding insurer became insolvent. Given the indemnity nature of a reinsurance contract, the receiver often could not demand the reinsurer pay its portion of covered claims until the receiver had paid the underlying claims. Typically, the receiver of a ceding insurer was not able to pay such claims prior to receiving the reinsurance payments and, therefore, had difficulty recovering reinsurance receivables.

In 1939, the New York legislature passed a law requiring that all reinsurance contracts contain an "insolvency clause" if the cedent desired to receive credit for reinsurance. Following the 1939 law in New York, many states enacted a similar requirement, and all states now require some type of insolvency clause, which comes into effect if the ceding insurer is found by a court to be insolvent in an order of liquidation. The insolvency clause obligates the reinsurer to pay recoveries it owes under the reinsurance contract on the basis of the ceding company's allowed claims, not on the basis of whether the insolvent cedent has actually paid the money it owes its policyholders.

Most courts recognize that the main purpose of the insolvency clause is to ensure that a receiver has the requisite access to reinsurance funds.

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There may be unusual instances where the reinsurance contract does not contain an insolvency clause, but the contract provides that its interpretation or enforcement is subject to applicable state law (typically the ceding insurer's state of domicile). Many state insurance laws provide that a reinsurance contract must contain required terms before the ceding insurer may claim reinsurance credit for the reinsurance, and one of the required terms provides that the contract must contain insolvency clause language. Thus, a receiver should also determine if the applicable state law requires that reinsurance be paid without diminution because of the ceding insurer's insolvency, as this state law may allow for recovery in situations where an insolvency clause is not otherwise available for the recovery of reinsured claims.

4. Notice to Reinsurers

The insolvency clause usually provides that the reinsurer shall be given notice of the pendency of each claim against the company on the policies insured within a reasonable period of time after such claim is filed in the insolvency proceeding. The clause also provides that the reinsurer has the right to investigate each such claim and to interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defenses which it may deem available to the company or its liquidator.

V. TERMINATION OF REINSURANCE RELATIONSHIP

There are five principal methods for terminating a reinsurance relationship: commutation, cancellation, novation, rescission, and by operation of law. Before a receiver uses any of these methods, careful consideration should be given to whether the financial consequences will benefit the insolvent insurer and, consequently, the creditors. By assessing the potential benefits, a receiver will be able to prioritize efforts. If a receiver is considering terminating a reinsurance relationship in a life/health insurer liquidation, the receiver will need to coordinate with the affected guaranty associations. As noted above, both IRMA §612 and §8(N) of the NAIC's Life GA Model Act, as adopted in state laws, provide the life and health insurance guaranty associations the right to elect to continue and assume the rights and obligations of the ceding insurer with respect to reinsurance contracts that relate to guaranty association covered obligations, subject to the requirements set forth therein.

A. Commutation

A commutation is simply a mutual release from a contract in exchange for consideration. The mechanics of a loss commutation are that the reinsurer, by a cash payment to the cedent, discounted to present value, removes the outstanding reserves and IBNR from its books. The result on the cedent's books is that its surplus decreases by the amount of the difference between the cash received and the undiscounted reinsurance recoverable; the reinsurer's surplus is benefited in the same amount.

Commutation may be viewed as a special type of cancellation or as a means of ending the relationship after cancellation has occurred. Note that the New York Insurance Law requires commutation clauses to be included in life reinsurance agreements.

1. Commutation During Rehabilitation

It may be advantageous for the receiver to commute assumed business of an insurer or reinsurer in rehabilitations. Under certain circumstances, commutation could permit the receiver to expedite billing and collection from its reinsurers and retrocessionnaires. The alternative is to allow claims to remain open for an extended period, increasing the administrative burden and expense for both the receiver and the cedents. Note that the insolvency clause may apply, especially in property/casualty

Likewise, the receiver in rehabilitation may find a benefit in offering to commute outstanding losses with its reinsurers. There may be factors, such as knowledge of the weakened financial condition of a reinsurer, a desire to quantify IBNR relating to long-tail casualty business, or the ability to obtain immediate cash, which need to be considered when commuting with reinsurers and retrocessionnaires.

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Early commutation may benefit the estate by bringing in cash and avoiding controversy and delay in collection. The receiver is unlikely to be as concerned as an insurer outside of receivership would be, with the loss of surplus inherent in discounting loss reserves to present value.

2. Commutation During Liquidation

Commutation of assumed business by an insolvent reinsurer is the equivalent of determining creditors' claims but may raise questions of priorities or preferences to creditors in rehabilitation as well as liquidation, because commutation terms may require immediate payment to a creditor class which otherwise may not share in distributed assets until a later date, if at all. Commutation of an insolvent insurer's ceded business should involve consideration of the factors discussed above for the commutation of ceded business by an insolvent insurer in rehabilitation. The receiver should consider the advisability or necessity of obtaining receivership court approval of commutation agreements.

The NAIC *Insurer Receivership Model Act* (#550) (IRMA) contains provisions regarding commutation of a reinsurer's liabilities. Sections 614 and 615 of IRMA allow a receiver to commence mandatory arbitration of commutation proposals after a certain amount of claims development or in the case of a reinsurer in financial difficulty (as defined by the state's RBC provisions). Section 614 requires receivership court approval for commutations having a gross consideration in excess of $250,000.

The provisions of IRMA outline the procedures, rights and duties of both receivers and reinsurers in the arbitration process and allow the formation of a reinsurance recoverable trust for the satisfaction of any arbitration award. State law should be consulted to ensure compliance with the specific applicable details.

3. Technical Aspects

a. Data

A successful commutation requires complete, accurate and current data. Therefore, the receiver of a ceding insurer should update loss and premium figures in collaboration with respective state guaranty associations and reinsurance intermediaries before attempting a commutation.

The receiver of a reinsurer is largely dependent on information provided by the ceding insurers and reinsurance intermediaries. As a result, the receiver should consider conducting an on-site review or audit of the cedent's records relative to the program or treaty in question. The purpose of the examination is to ascertain that the reinsurer's accounts accurately reflect the business that was or should have been ceded.

b. Evaluate Future Loss Development

Future loss development is necessary to estimate the cost of the commutation. Actuarial staff should provide the calculation. Three basic steps are involved:

- Project reported outstanding and IBNR losses to ultimate incurred commensurate with the risk reinsured (e.g., auto v. general liability and/or asbestos).
- Project the timing of payment of losses to ultimate incurred.
- Calculate the net present value of ultimate incurred losses based on anticipated payment dates. If the parties can agree on a net present value, that becomes the commutation figure.

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B. Cancellation of Reinsurance Treaties

1. Term Treaties

The majority of facultative reinsurance agreements and some reinsurance treaties have a fixed termination date, often an anniversary of the date of inception. Nothing need be done to end coverage as of that date; it simply expires. These contracts often may be canceled as of an earlier date with 60 or 90 days' written notice to the other party, or as specified within the terms of the reinsurance agreement. Cancellation, however, does not usually end the reinsurance relationship, which continues until all claims are submitted and paid, particularly in respect of business written on an occurrence basis.

Non-life business in force at the date of receivership, including assumed reinsurance, is usually terminated within 31 days of the receivership order. Some categories of reinsurance agreements are difficult to terminate midterm (such as aggregate excess of loss and stop loss reinsurance agreements), due to loss accumulation period requirements under the contractual provisions. Under a rehabilitation proceeding, however, the receiver would have the option of continuing in-force reinsurance business during an appropriate run-off period instead of effecting a cut-off or early cancellation date.

2. Continuous Treaties

Most obligatory treaties and some facultative agreements have no fixed termination date and continue until terminated by one of the parties. Often, these agreements may be terminated by written notice 90 or 120 days prior to an anniversary of the inception date, or as defined by the reinsurance agreement.

3. Notice of Cancellation

While the form of the notice of cancellation is usually stated in the reinsurance agreement, there are certain aspects to the cancellation process that are not as obvious. The prudent receiver will consult competent legal counsel on the legality and/or effectiveness of a receivership triggered termination. Reinsurance treaties, both term and continuous, are reviewed annually in what is known as a renewal process. Either party may issue a provisional notice of cancellation while renewal negotiations continue. The provisional notice can be withdrawn once a new agreement is reached. Another means of accomplishing the same purpose is for the parties to agree to a reduced period for notice of cancellation.

4. Cut-off vs. Run-off Cancellation

Facultative reinsurance is generally coterminous with the underlying policy. Treaty reinsurance generally applies to policies incepting during its term, and therefore continues to apply as long as the underlying policies have losses reported the underlying policies are often canceled by a liquidation order, but claims will continue to be reported). This is referred to as "run-off." The receiver may also elect to cancel treaties on a "cut-off" basis, pursuant to which the reinsurer returns any unearned premiums and has no responsibility for losses that occur after the treaty terminates.

C. Novation

1. Definition

In novation, a new insurer is substituted for the existing insurer, and the insured must look to the substituted insurer for performance and must pay premiums to the substituted insurer. In a reinsurance context, the principles remain the same, although it should be a three-party agreement between the cedent, the reinsurer and the original policyholder.

Insurance terminology tends to call a novation "assumption and reinsurance." This term is more descriptive of implementation techniques but is inaccurate even in this limited role. The novation

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usually takes the form of a reinsurance treaty but one with an unusual feature. Not only does the reinsurer assume 100 percent of the risk, the reinsurer also is substituted for the original insurer. It is the latter feature that distinguishes a novation from a reinsurance transaction.

2. Use of Novation

The principal purpose of a novation is to move an existing book of business from one insurer to another. Novation may be more efficient than having the original carrier not renew the business while the new insurer is soliciting the same insureds. Regulatory limitations on nonrenewal of certain lines of business and consumer protection may be primary reasons for novation.

3. Practical Difficulties

Traditionally, a novation requires the consent of all parties to the contract, the insured, the original insurer and the reinsurer. Some states exempt assumption/novation transactions in the context of a rehabilitation or liquidation from the policyholder consent requirement. It may be difficult to obtain the actual consent of thousands of policyholders who may not understand the process and who may not be sufficiently interested. There is considerable debate as to the level of notification and consent necessary for a novation. Some insurance departments have required mass mailings to insureds explaining the transaction and offering the opportunity to object or decline novation. However, in a receivership, a transfer of business can often be arranged under the receivership authority statute and/or the order of the receivership court.

4. Bulk Transfer Distinguished

In general, a bulk transfer is the reinsurance of all or substantially all of a book of business. Often, a bulk transfer requires notice to the cedent's state of domicile. A bulk transfer may or may not involve a novation, and a novation may or may not involve all or substantially all of an insurer's book of business. The difference is whether the prior reinsurer continues to retain any liability or ongoing obligation.

D. Rescission

1. Definition

It is important to distinguish "rescission" from "cancellation." Cancellation means to terminate the unperformed portion of a treaty. Rescission restores the parties to their original position prior to entering into the treaty. Rescission is a remedy available only under limited circumstances.

2. Technical Aspects

Typically, general contract principles apply to reinsurance contracts. Under general contract principles, rescission may be obtained by mutual consent of the parties, by a party that has been injured by acts of the other, or through litigation or arbitration proceedings Generally, reinsurance agreement rescissions occur because a party contends it has been defrauded or damaged. Most disputes arise because the reinsurer believes the cedent has made material misrepresentations respecting the nature, quality or volume of the business ceded. In these cases, a complete accounting or a reconstruction of accounts for the contract period may be required.

E. By Operation of Law

In some states with enabling legislation, insurance business may be transferred by operation of law. Since 2000, reinsurance counterparties in the EU have been able to transfer direct and assumed insurance

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portfolios with continued coverage for re/insureds and a full release for the transferor without completion of either a novation process or concomitant opt-in/out rights for re/insureds. In the US insurance market, a small number of states offer one or both of the following two alternatives: insurance business division and insurance business transfer. Coordination regarding policyholder rights in other jurisdictions and other state laws is an important aspect that is receiving ongoing study in US Insurance regulators. See meeting materials, exposure drafts, and other documents of the NAIC Restructuring Mechanisms Subgroup[4] for updates in this area.

Business *division* (e.g., in Arizona, Connecticut, Delaware, Georgia, Illinois, Iowa, Michigan, Pennsylvania[5]) offers companies the ability to divide business operations into two or more entities upon the approval of the regulator; business *transfer* is effected via novation following judicial approval (e.g., in Rhode Island, Vermont and Oklahoma[6]); both mechanisms have regulatory and judicial components.

Oklahoma approved the first transfer in an intra-group transaction and Illinois approved the first US division, also in an intra-group transaction. Each of these is highly specialized, and review of the requirements to effect in, and/or the impact upon, a receivership should be undertaken with the advice of competent legal counsel.

VI. SETOFF

A. Overview

Setoff is a device that permits two contracting parties to net reciprocal debt obligations and pay only the remaining balance. It is an important element of any receivership. Setoff is an area of considerable controversy, and it is important to develop an effective approach for handling the various issues that will arise because of its application. It is important to begin this approach early in the receivership with a careful analysis of the applicable provisions of the governing receivership state law. Note that there are/may be unique issues arising from the organizational structure of counterparties; e.g., policyholder-owned reinsurers, fronting insurers, captives (including "pure," hybrid, and series captives), and special purpose vehicles. For example, "triangular" set-offs are not permitted. Thus, where A owes B, C owes A, and B and C are affiliates, A may not lawfully set off what it owes B against what C owes A.[7]

B. Recoupment and Counterclaims

The concepts of setoff, recoupment and counterclaim are often confused. Although each provides a means by which a debtor may attempt to limit the net amount of a creditor's recovery, it is important that the receiver have a basic understanding of the distinguishing features of each procedure, as well as the central concept of "mutuality" (and potential differences imposed by varying priorities of asset distribution) which are discussed in Chapter 9—Legal Considerations.

C. Procedural Steps in Administering Setoffs

The receiver should review the governing receivership state's current statute relating to setoff, and determine the past practices and procedures that have been utilized within the jurisdiction. It would also be prudent to review any court rulings and decisions relating to setoff to determine their applicability to various

[4] https://content.naic.org/cmte_e_res_mech_sg.htm
[5] *See, e.g.,* 215 ILL. COMP. STAT. 5-35B.
[6] *See, e.g.,* OKLA. STAT. tit. 36, § 1681-8
[7] *In re Orexigen Therapeutics, Inc.*, 990 F.3d 748 (3d Cir. 2021).

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issues that may arise. The reinsurance agreement may also have provisions relating to setoff, although they may not override applicable statutes.

Once the receiver has elected a course of action for handling setoff issues, written policy and guidelines should be prepared, and coordinated with and reviewed by counsel. The receiver may file the setoff policy and its guidelines with the receivership court and communicate as soon as practicable to cedents, reinsurers, intermediaries and other interested parties.

It may also be necessary for the receiver to audit or review reinsurance account statements, including payments received and processed earlier by the receiver's internal staff, to ensure that there is a consistent application of the mandated setoff procedures. If it is determined that improper setoffs are being applied, communications to appropriate parties should be initiated, and if the matter cannot thereafter be mutually resolved, the receiver should consider mediation, partial or total rejection of a proof of claim, or appropriate legal action, including arbitration and litigation.

Some receivers require details about claimed set-offs to be included in proofs of claim.,

D. Setoff Against Insolvent Insurers and Reinsurers

To determine if the receiver has a right of setoff against an insolvent insurer or reinsurer, the insurance law of the state of domicile of the insolvent insurer or reinsurer may be applicable and therefore will need to be reviewed. It will be necessary to determine whether the receiver will be able to assert setoff under the other insolvent's domiciliary state laws. See Chapter 9—Legal Considerations.

VII. ARBITRATION CONTROVERSIES

An insolvent insurer will likely be involved in dispute resolution. There will be looming questions, however, of how the resolutions will occur, how the disputes will be resolved, how long they will take and how much they will cost. These are questions a receiver will face on a regular basis.[8]

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.

Many reinsurance agreements contain clauses that require parties to a reinsurance agreement to resolve their disputes through arbitration. When one of the parties is in receivership, the issue of whether reinsurers may compel arbitration or are required to resolve their disputes in the receivership court is governed by local law.

A majority of reinsurance agreements provide for arbitration as the sole means of resolving conflict. Most courts, including the U.S. Supreme Court, favor enforcing agreements to arbitrate, but a small number of jurisdictions have held otherwise.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 being a confidential process, having expert triers of fact, offering broad ranges of relief, and other procedural and substantive benefits. However, there is no right of appeal *per se,* and successful challenges to arbitral awards are difficult to moiunt.

Arbitration rights within reinsurance agreements are enforceable under Section 105E of the NAIC *Insurer Receivership Model Act* (#550). If there is a balance payable to the receiver after offsets are considered by the arbitrator, that balance must be paid in cash. If, alternatively, the balance is in favor of the reinsurer, that balance becomes a claim against the insolvent insurer to be paid pursuant to the priority scheme, pro rata, when the insolvent insurer's assets are distributed.

[8] This is a very cursory discussion—please refer to the Legal Chapter for a detailed analysis of this subject.

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VIII. LETTERS OF CREDIT

A. Nature of the Letter of Credit in Reinsurance Transactions

In general terms, the letter of credit (LOC) is an undertaking by a bank as issuer to honor a draft drawn upon it by a beneficiary (the cedent) in accordance with the terms of the LOC. The LOC is issued by the bank at the request of a the reinsurer, in furtherance of a separate agreement between the reinsurer and the ceding insurer. Reinsurers may also be beneficiaries of LOCs provided by cedents to collateralize future premium payment obligations and ensure financial statement credit.

The bank is obligated to pay on the LOC when the beneficiary presents a sight draft that complies on its face with the terms of the LOC. In many jurisdictions, compliance with the LOC terms must be exact to trigger the bank's payment obligation. In some jurisdictions, substantial compliance is sufficient to trigger the bank's payment obligation. The bank should not look at whether the underlying reinsurance agreement was properly performed before it pays on the complying sight draft. Any contractual disputes between the account party and the beneficiary involving the reinsurance agreement remain separate from the issuing bank's obligation to pay under the LOC.

In the insurance industry, LOCs are frequently used to enable the reinsurer to secure their obligations to the cedent under reinsurance agreements so that the cedent may take credit for the reinsurance on its financial statement, either as an asset or as a deduction from liability. This is permitted under the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786).

In the event of a failure of the reinsurer to fulfill its obligations under the reinsurance agreement, the cedent may draw down the LOC. The issuing bank must honor such a demand, unless the demand documents are forged or are otherwise tainted by fraud, or there was fraud in the underlying transaction. These exceptions must be distinguished from mere commercial disputes between the parties, which, as noted above, do not impact the bank's obligation to pay on a complying sight draft.

B. Basic Features of the Letter of Credit

The Credit for Reinsurance Model Law and Regulation are an accreditation standard, and as such the provisions for LOCs in each state's laws must be substantially similar. LOCs supporting reinsurance with certified or unauthorized must be "clean" (that is non-"documentary" under which certain evidence may be required), meaning the LOC must be payable on a sight draft without any supporting documents, and the LOC must be irrevocable, meaning it cannot be terminated prior to expiration by the account party without the beneficiary's consent.

Acceptable LOCs are required to contain an evergreen clause, which requires the bank to give specified advance notice (usually 30 days) of non-renewal to the beneficiary/cedent. Failure of the bank to serve notice of non-renewal prevents expiration, resulting in an automatic renewal of the LOC. On the other hand, non-renewal of the LOC while balances remain due to the cedent is grounds for the cedent to draw down the LOC.

In addition to these basic features, the bank issuing the LOC must meet certain standards in accordance with Model #785, Section 4. Other states require that the LOC be issued or confirmed by either a domestic bank, a foreign bank licensed in the United States, which is either on the NAIC Securities Valuation Office (SVO) list.

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C. What Should a Receiver Know About LOCs?

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the LOCs and list them in accordance with the treaties collateralized and expiration dates. Any evergreen clauses should be noted on treaties under notice of cancellation.

Counsel should be consulted to confirm that the receiver has the power to draw down the LOCs, or if the receiver does not, this power should be immediately obtained from the supervisory court.

It is recommended that a receiver notify each issuing bank that the cedent is in receivership. The receiver should take whatever steps are necessary to ensure that only the receiver is empowered to draw down the LOCs and that the receiver will receive notices of non-renewal. The receiver should seek to have the LOC amended to change the name of the beneficiary to the estate.

Each reinsurer should be advised by the receiver that it must maintain the outstanding LOCs in accordance with the terms of the specific reinsurance agreement.

Once the above steps have been taken, the receiver should verify the liabilities secured by the LOCs. If an LOC is about to expire and leave outstanding obligations unsecured, the receiver should notify the reinsurer to renew the expiring LOC. If the reinsurer does not agree to renew, counsel should be consulted on the appropriateness of drawing down the LOC to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify all of the LOCs issued on behalf of the reinsurer and list them in accordance with the contract collateralized and expiration date. If any notices of termination have been issued pursuant to evergreen clauses, these should also be listed. Finally, if any collateral has been posted with an issuing bank to secure the LOC, the receiver should properly identify such collateral.

It is also recommended that a receiver notify each issuing bank that the reinsurer is in receivership, and identify the receiver to confirm that only the receiver is authorized to give the bank instructions with respect to the LOCs, which would normally be given by the account party.

The receiver should also communicate with all cedents in whose favor banks issued LOCs on behalf of reinsurers so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the LOCs will be maintained in accordance with the reinsurance agreement. The receiver should also take whatever steps are necessary to ensure that the LOCs will not be improperly drawn down.

Once the receiver properly identifies all of the outstanding LOCs and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the LOCs in order to protect the reinsurer's position by preserving its collateral. The receiver should ascertain the liabilities secured by the LOCs and guard against wrongful draws by cedents against the outstanding LOCs. A danger also exists that the collateral posted will be wrongfully used by the bank to gain a preference on other, unsecured debts allegedly owed to the bank by the reinsurer. The receiver can also protect the reinsurer's position by depositing any interest earned on collateral into the reinsurer's estate, assuming this power is consistent with the account agreement.

There also may be unique set-off issues.

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IX. TRUST FUNDS

A. Nature of the Trust Fund in Reinsurance Transactions

A reinsurance trust fund is an arrangement between the reinsurer (the grantor) and the cedent (the beneficiary), under which assets are deposited with a trustee, pending the performance of certain contractual obligations between the parties. In some instances the cedent may be the grantor and the reinsurer may be the beneficiary. If the beneficiary makes a demand upon the trustee stating that the contractual obligations are unfulfilled, the trustee is obligated to pay in accordance with the terms of the trust. The Credit for Reinsurance Model Regulation (#786) contains minimum standards for how a trust should be established and operated.

In reinsurance, trust funds serve as an alternative to LOCs. Certified and unauthorized reinsurers establish and fund them to secure their obligations to the cedent. Trust funds serve as security for the risk undertaken by the cedent and ceded to the reinsurer, allowing the cedent to take reinsurance credit for the ceded risk. Only certain specified assets are generally permitted to be used to fund the trust, including: cash, certain readily marketable securities such as United States government obligations and nationally traded stocks, and clean, irrevocable letters of credit.

B. Basic Features of the Trust Fund

The administration of the trust fund is governed by the trust instrument that provides for the term, or duration, of the trust fund. It may also include a provision concerning control of the trust assets. The grantor is often given the power to substitute qualified assets, so long as the value of the corpus remains at the agreed level. The trust instrument may also include a provision concerning the ability to control investment of trust assets.

During the term of the trust fund, the principal will yield interest, and the trust instrument may contain a provision allocating the interest either to the grantor or the trust corpus. The trust instrument may also specify under what circumstances a demand can be made on the trustee, allowing the grantee to obtain trust funds. In the event that the grantor wishes to terminate the trust, the trust instrument will include a provision requiring the grantor to give advance notice to the trustee that the trust will be terminated. Finally, in the event that a trustee should resign or die, a provision may be included that allows for the substitution of trustees.

C. What Should a Receiver Do About Trust Funds

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the trust funds established in the cedent's favor and list them in accordance with the treaty collateralized and expiration dates. If any notices of termination have been issued on the identified trust funds pursuant to their termination provisions, these should also be listed.

The receiver should also ensure that he or she is empowered to remove assets from the trust funds if such removal is necessary to fulfill the reinsurer's obligations under the reinsurance agreements. Counsel should be consulted to confirm that the receiver has the power to remove assets and under what conditions assets can be removed, or if the receiver does not, such power should be immediately obtained from the supervisory court.

It is also recommended that a receiver notify each trustee that the cedent is in receivership, clearly identify the receiver, and take whatever steps are necessary in each case to ensure that only the receiver is empowered to remove assets from the trust funds that might otherwise be removed by the cedent.

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The receiver should also communicate with each reinsurer on whose behalf a trustee holds a trust fund with the cedent as grantee so that each is aware that the cedent is in receivership. The receiver should assure each reinsurer that no improper removal of assets will occur. It should also be emphasized to the reinsurer that it must maintain the trust funds in accordance with the terms of the specific reinsurance agreement.

Once the receiver properly identifies all of the established trust funds and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the trust funds in order to protect the cedent's position by preserving its security. The receiver should ascertain the liabilities secured by the trust funds. If a trust fund is about to expire, and may leave outstanding obligations unsecured, the receiver should call upon the reinsurer to continue the expiring trust fund. If the reinsurer refuses to maintain the fund, counsel should be consulted on the appropriateness of removing assets from the trust fund to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify the trust funds established on behalf of the reinsurer as grantor and list them in accordance with the agreements collateralized and expiration dates. If any notices of termination have been issued pursuant to the termination provisions of certain trust instruments, these should also be listed.

It is also recommended that a receiver notify each trustee that the reinsurer is in receivership, clearly identify the receiver, and confirm that only the receiver is authorized to give the bank instructions with respect to the trust funds, which would ordinarily be given by the reinsurer.

The receiver should also communicate with all cedents in whose favor a trustee holds a trust fund with the reinsurer as grantor so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the trust funds will be maintained in accordance with the reinsurance agreement, although the receiver will probably be unable to comply with the demands for increases in trust funds or LOC balances due to the probability of creating an illegal preference. Occasionally, trust accounts and LOCs are in excess of amounts necessary to secure liabilities, and in cooperation with cedents, the receiver may be able to retrieve those excess amounts. The receiver should also take whatever steps are necessary to ensure that trust fund assets will not be improperly removed.

Once the receiver properly identifies all of the outstanding trust funds and takes the necessary steps to solidify his powers with regard to them, the receiver must then manage the trust funds in order to protect the reinsurer's position by preserving its assets. The receiver should ascertain the liabilities secured by the trust funds and guard against wrongful removal of assets by cedents. The danger that the assets will be wrongfully used to gain a preference on other, unsecured debts, should be addressed. The receiver can also protect the reinsurer's position by depositing any interest earned on the assets into the reinsurer's estate, assuming this power is consistent with the terms of the trust.

X. FUNDS WITHHELD

"Funds withheld" refers to an arrangement wherebythe fact that the cedent does not pay the premiums to the reinsurer; instead, the cedent "withholds" the premiums. Generally, this provision is only used with unauthorized reinsurers. The purpose of these provisions is to allow the cedent to reduce the provisions for unauthorized reinsurance in its statutory statement. The reinsurer's asset, in lieu of cash, is "Funds held by or deposited with reinsured companies." So in other words, the receiver will already have the funds under his exclusive control.

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XI. INSOLVENT NON-UNITED STATES LICENSED REINSURERS

The estate may have ceded reinsurance with a non-United States licensed reinsurer[9] that is subject to a rehabilitation or liquidation proceeding in its domiciliary jurisdiction. In addition, that non-United States licensed reinsurer may also be subject to an ancillary proceeding under Chapter 15 of the United States Bankruptcy Code.

A. The Non-U.S. Proceeding

As in the United States, the non-U.S. proceeding may be either a rehabilitation, liquidation or equivalent (e.g., in the UK, there are voluntary arrangements, schemes of arrangement, and winding ups, among other mechanisms). In either event, particularly if ceded reinsurance is involved, the receiver should communicate with the non-U.S. receiver to ensure that the estate receives notice of the proceedings and is identified as a creditor. It will then be necessary to keep current with the proceedings to protect the interests of the estate. The procedures described in this chapter for dealing with ceded reinsurance will generally be applicable to these non-U.S. proceedings.

B. Chapter 15 Proceedings

Insurance receiverships are specifically excluded from the ambit of the U.S. Bankruptcy Code; however, the Code does have an influence on insurance issues in at least one important case: if an insurer purchased reinsurance from a non-U.S. reinsurance company, and that reinsurer has become insolvent.

Chapter 15 permits a representative of a non-U.S. proceeding to petition the United States bankruptcy court for relief and permits the court to: (a) enjoin proceedings against the non-U.S. licensed reinsurer, enforcement of judgments or the commencement or continuation of any action against the debtor; (b) order the delivery of the debtor's property to the representative; and (c) order other appropriate relief. Chapter 15 proceedings are limited in scope, do not commence a full bankruptcy proceeding, and confer broad discretion to the courts. Generally, following the adoption of a plan of rehabilitation or liquidation in the non-U.S. proceeding, the debtor requests the bankruptcy court to give full force and effect to that plan and make it binding and enforceable against all creditors in the United States.

Receivers should consider various approaches when faced with a Chapter 15 proceeding. A receiver should file a notice of appearance and request for service of notice to ensure that it receives copies of the filings made in the proceeding, including periodic status reports. Consideration should be given to participation on the creditors' committee if the amount due to the estate is material, and the expense and time to the estate justify participation. Evaluation of proposed schemes of arrangement may also need to be made to protect the interests of the estate. The estate should also continue to report claims as it did prior to the proceeding and should review and recognize any of its obligations under the existing agreements.

Chapter 15 of the Bankruptcy Code now states that a court may not grant relief under the chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable state insurance law or regulation for the benefit of claim holders in the United States. The purpose of the language is to make certain a bankruptcy court has no power over U.S.-based reinsurance collateral posted for the benefit of U.S. claimants.

[9] Also known as alien reinsurers.

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I. INTRODUCTION

This chapter provides an overview of the operation of state Property and Casualty Insurance Guaranty Funds and the Life and Health Insurance Guaranty Associations and their relationship to a receivership. All 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands[1] have a guaranty mechanism[2] in place for the payment of covered claims arising from the insolvency of insurers licensed in their state. In the case of life/health insurance, the guaranty mechanism also provides for the continuation of eligible contracts that would otherwise terminate because of the insolvency. Before the creation of guaranty association systems, a typical claimant might wait years for payment of a claim and then receive only a small percentage of what was due under the policy or contract. Guaranty associations, subject to statutory limitations, alleviate these problems. Section II of this chapter will discuss in greater detail the operation of property/casualty guaranty funds. Section III is devoted entirely to life/health guaranty associations.

Insurance guaranty mechanisms obtain the funds necessary to pay claims from remaining estate assets, in some cases from statutory deposits collected by states and by assessing member insurers. Assessments are limited by state law to a certain percentage of the members' written premium. In the case of property casualty guaranty funds, the members may be permitted by statute to recoup the assessments through premium increases, premium tax offsets or policy surcharges. As for the life/health guaranty associations, recoupment of assessments through premium increases or policy surcharges is typically not feasible because many life/health contracts are issued on a level premium basis.[3] The burden of the assessments on solvent insurers is mitigated in the majority of states, by statutes that allow insurers to offset a portion of the insurer's assessments, over a period of years, against the insurer's premium tax liability. Section 13 of the NAIC's *Life and Health Insurance Guaranty Association Model Act* (#520) (Life Model Act), some version of which has been adopted in most states, permits offsets against premium, franchise or income taxes over a five-year period for amounts paid by life/health insurers to meet their assessment obligations. In addition, Section 9G of the Life Model Act allows life/health insurers to consider the amount reasonably necessary to meet their assessment obligations in the determination of the premiums they charge.

Guaranty associations, both life/health and property/casualty, in most states are overseen by a board of directors, largely composed of representatives of member insurers. Some guaranty association boards also include public members. A minority of guaranty associations also have representatives of state departments of insurance or legislative representatives sitting on the guaranty association's board. The guaranty associations typically employ a Manager, Administrator or Executive Director to oversee daily operations.

Before a claim against an insolvent insurer can be considered a "covered claim" and eligible for guaranty association coverage, the guaranty association must be "triggered" with respect to the particular insolvency. Guaranty associations generally are triggered by the issuance of a court order of liquidation with a finding of insolvency. Some guaranty associations may be triggered under other circumstances. In the event of a multi-state insolvency, it is important that the receiver communicate and coordinate with National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), or National Conference of Insurance Guaranty Funds (NCIGF) as appropriate. Before preparing an order of rehabilitation or liquidation. This will ensure that guaranty associations are triggered as intended and are not triggered prematurely or inadvertently. NOLHGA and NCIGF have the ability to help with coordination and communication to affected GAs.

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[1] U.S. Virgin Islands has one guaranty fund that covers life/health and property/casualty. Oct. 6, 2019, Act No. 8211 was signed into law, and amended 22 V.I.C. § 232 (Scope) to provide that this "chapter shall apply to all kinds of direct insurance, except title, surety, credit, mortgage guaranty and ocean marine insurance."

[2] The term "guaranty fund" typically refers to a property and casualty insurance guaranty fund. The term "guaranty association" typically refers to a life and health insurance guaranty association. However, in various places throughout this handbook, the terms "guaranty fund" and "guaranty association" are often used synonymously, particularly when referring to both types of guaranty mechanisms. Efforts have been made in this chapter to specify property and casualty or life and health when referring specifically to one or the other type of guaranty mechanism or insurer insolvency proceeding.

[3] A few states do permit policy surcharges to recoup assessments for health insurance insolvencies.

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The guaranty associations and the receiver both have statutory duties to protect policyholders of the insolvent insurer. The duties of the guaranty associations to protect policyholders are limited to covered policies or claims, as set forth in state guaranty association statutes. The guaranty associations can be very helpful, if not critical, to the receivership process. In a life/health insolvency, for example, the guaranty associations may, in some cases, be able to arrange for and facilitate transfer of covered obligations to a solvent insurer upon entry of an order for liquidation with a finding of insolvency, provided there has been sufficient pre-liquidation planning and coordination.[4] Maintaining open communication and cooperation between the guaranty associations and the receiver, subject to appropriate confidentiality agreements, during pre-receivership planning and throughout the course of the proceedings will enable both the guaranty associations and the receiver to function more efficiently for the benefit of those whose interests they are obligated to serve.

II. PROPERTY AND CASUALTY GUARANTY FUNDS

A. Introduction

Most property/casualty guaranty fund enabling acts are based on the NAIC *Property and Liability Insurance Guaranty Association Model Act* (540) (P/C Model Act). Although the P/C Model Act is useful for a better understanding of how guaranty funds operate, the law in each state should be consulted, as most states have modified provisions of the P/C Model Act.

The property and casualty guaranty funds have formed an organization known as the National Conference of Insurance Guaranty Funds (NCIGF). Its address is:

National Conference of Insurance Guaranty Funds
300 North Meridian Street
Suite 1020
Indianapolis, IN 46204
Phone: (317) 464-8199
Facsimile: (317) 464-8180
Web site: http://www.ncigf.org

NCIGF can be a useful source of information to receivers when a new property/casualty insolvency occurs. It can help disseminate information to triggered guaranty funds, schedule initial meetings between the receiver and guaranty funds, and establish a coordinating committee to work with the receiver to resolve issues that may arise during the receivership. This organization can also provide names and addresses of guaranty fund contacts and assistance in establishing data reporting to and from the guaranty funds. The Secure Uniform Data Standards (SUDS) is managed by the NCIGF and has become the standard mechanism to transfer data in a secure manner. (See Chapter 2 for more information on UDS and SUDS.)

The NCIGF Web site (See at http://www.ncigf.org) has tables that summarize the key provisions contained in each state's property/casualty guaranty fund enabling act, including lines of insurance covered, whether coverage is provided for unearned premium, whether the guaranty fund has net worth limitations or a claims bar date and the per claim limit and deductible that applies to each claim. The tables are intended to provide a general summary of the guaranty fund laws. The applicable state statute should be reviewed to determine coverage for a specific claim.

[4] In some instances, it is possible to arrange for the transfer to close as of the effective date of the liquidation order.

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B. Triggering Fund Liability

See Chapter 1 Section II.G.4

1. General Statutory Activation Requirements

Previously, the P/C Model Act defined insolvent insurer as "(a) an insurer authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and (b) determined to be insolvent by a court of competent jurisdiction." Due to a variety of triggering related issues that could not be readily resolved by such a general, simplistic definition, amendments to the P/C Model Act expanded the definition of "insolvent insurer" to read as follows:

> "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued 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 amended language makes it clear that guaranty fund resources are only to be used in situations where any doubt pertaining to the insurer's insolvent status has been fully considered and resolved by a judicial proceeding. It must be noted, however, that there are a number of variations found within enacted guaranty fund statutes around the country. While many jurisdictions have either adopted or moved toward the current P/C Model Act triggering test, there are numerous others that fall at various points along the spectrum between the current version and the original 1969 version. It is imperative that the statutes be carefully reviewed in each jurisdiction where activation is anticipated.

2. Regulatory Status of Company

In addition to being declared insolvent, an insurer must have been "licensed," either at the time the policy was issued or when the loss occurred, to be eligible for guaranty fund coverage.[5]

New Jersey has a separate statutory mechanism for the payment of covered claims arising in connection with coverages issued by eligible surplus lines insurers. This mechanism exists in addition to the guaranty fund for insolvent licensed property and casualty insurers. Even in New Jersey, however, there is no statutory protection for ineligible surplus lines insurers.

The initial triggering inquiry must not be limited to whether the insurer in question was licensed at the time of the finding of insolvency.[6] Many, probably most, guaranty fund acts contain language that is sufficiently broad to include claims against an insurer whose license has been surrendered or revoked prior to the declaration of insolvency, so long as the insurer was licensed at the time the policy was issued or when the insured event occurred. When this situation arises, the receiver should contact the relevant guaranty fund as it will be most familiar with its enabling statute and local court decisions interpreting the statute.

3. Court of Competent Jurisdiction

The requirement of a finding of insolvency can only be satisfied by a judicial declaration. The rationale for this requirement is that activation triggers numerous consequences, many of which are irreversible

[5] In this context, "Licensed" means holding a Certificate of Authority, which authorizes an insurer to do business in a state. Such insurers are also referred to as "admitted insurers." Insurers doing business on a surplus lines or other non-admitted basis are not authorized.

[6] At the time of publication of this Handbook, the NAIC is considering "restructuring mechanisms" permitted under the laws of some states (i.e., insurance business transfers and corporate divisions). Whether claims of an assuming or resulting insurer in one of these transactions would be considered "covered claims" eligible for guaranty fund coverage in the event of its liquidation is a question of state law. NCIGF is working with the NAIC to address this issue and provide clarity going forward.

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once put in motion. Judicial review is perceived to be an effective safeguard against arbitrariness and ambiguity.

The current version of the P/C Model Act gives exclusive competent status to the court that is within the insurer's state of domicile. Although it is theoretically possible for a court in another jurisdiction to be viewed as competent for the purpose of triggering guaranty fund obligations, the P/C Model Act's current version does not confer jurisdiction on these courts.

4. Liquidation Order

Were a court of competent jurisdiction to issue a declaration of insolvency that is later modified or reversed on appeal, after guaranty funds have been triggered and claim payments have been initiated, problems can arise. To remedy such consequent dilemmas, both the P/C Model Act and many state legislatures have modified the triggering test, requiring that the judicial declaration of insolvency be final. In other words, activation of guaranty funds in such jurisdictions can be deferred, and perhaps avoided, depending upon the pursuit or exhaustion of stays or appellate remedies.

Nonetheless, although the P/C Model Act drafters clearly contemplated that activation of the guaranty funds would occur only where liquidation had been ordered, the wording of the initial triggering clause left open the possibility that companies placed in rehabilitation could trigger guaranty fund benefits. The more current view, which has also been incorporated in the P/C Model Act, is to require not only a final determination of insolvency, but rather an actual order of liquidation with a finding of insolvency. This limiting language precludes the use of guaranty fund resources as bail-out funds to be used in an attempt to rehabilitate—rather than liquidate—the company. There are a few guaranty funds, however, which still trigger with a finding of insolvency without an order of liquidation. Because of the complexity and variation from state to state of the trigger, it is important to seek legal assistance and to work with the NCIGF when drafting the orders of liquidation or rehabilitation to ensure the appropriate activation of the guaranty funds. (See the Laws and Laws Summaries under Resources on the NCIGF Web site at http://www.ncigf.org).

C. Scope of Coverage

Guaranty funds that have been properly triggered by a liquidation order are obligated to pay "covered claims," that is, claims that are defined as covered under the applicable guaranty fund act(s). Generally speaking, unpaid loss and unearned premium claims under specified property/casualty lines of business written by an insolvent insurer are covered claims, but only to the extent of the lesser of either (1) the applicable policy limits; or (2) the statutory guaranty fund limits on covered claim payments. Residency is usually determined at the time of the insured event. In addition, in order for claims to be covered, the various acts typically require that: the claim be incurred either prior to the entry of the liquidation order or within 30 days of the entry of the order, or before the policy expires or the insured replaces the policy if either of the latter occurs within 30 days of the entry of the liquidation order. Claims of an affiliate of the insolvent insurer typically are not covered, even if such claims otherwise meet the definition of covered claims.

Property/casualty lines of business usually not covered by a guaranty fund include: mortgage guaranty; financial guaranty; fidelity and surety; credit insurance; insurance of warranties or service contracts; title insurance; ocean marine insurance; and any insurance provided by or guaranteed by government. Only direct insurance (not reinsurance) is covered. The receiver should consult with the affected guaranty fund(s) to determine which lines are covered and which lines are excluded.

Usually, the guaranty fund of the state of the insured's residence has primary responsibility for a claim, and the guaranty fund of the state of the claimant's residence has secondary responsibility. One exception to this rule involves workers' compensation claims. The guaranty fund of the state of residence of the claimant has primary responsibility for these claims. With respect to claims involving property with a permanent location, the guaranty fund of the state where the property is located has primary responsibility. Guaranty funds are usually entitled to take credit for amounts paid by other guaranty funds on the same claim.

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Some guaranty fund statutes provide for a per claim deductible. A majority of guaranty association statutes provide that coverage is limited to $300,000 per covered claim, except for workers' compensation claims, which are covered to the extent of benefits provided by state law.

Most guaranty fund statutes require a claimant to first exhaust all other sources of recovery, including other insurance. The guaranty association's obligation is reduced by any amounts recovered from other sources.

The majority of the property casualty guaranty funds' enabling acts contain "net worth" limitations. These net worth limitations either exclude high net worth insureds, and in a few cases, third party claimants, from coverage in the first instance or permit the guaranty fund to recover from the high net worth insured amounts paid on their behalf.

Most of the guaranty funds' enabling acts also require the claim to be timely filed either with the liquidator or the guaranty association. Bar date restrictions vary from state to state and specific state law should be reviewed on this matter. See Section D (3) for more information regarding bar dates.

D. Notice and Proof of Claims

1. Notice

a. Notice to Claimants

Most state receivership statutes give the receiver the primary responsibility for issuing notice to all persons known or reasonably expected to have claims against the insolvent insurer. The guaranty funds have a secondary responsibility in this regard under the P/C Model Act. Because of the extensive interrelationship between the receiver and the guaranty funds regarding claims resolution, the receiver should coordinate the drafting of the receivership claims notice with the guaranty funds so that accurate information concerning the following is included:

- Brief general explanation of the guaranty fund system: the policyholder protection it offers, its anticipated role in the receivership and any delay that will be necessary while the receiver assembles and forwards the files to the guaranty funds.

- Receivership bar date and its legal significance: the fact that many guaranty funds will have no obligation regarding claims filed after the receivership bar date, recommendation to check with the appropriate guaranty fund immediately in order to ascertain whether the guaranty fund has a separate bar date in addition to the receivership bar date.

- Receivership proof of claim form: information, if available, about whether a separate guaranty fund proof of claim form may be required by certain participating guaranty funds; information concerning the address to which proof of claim forms must be sent.

- Clarification that questions regarding the claims determination process should be directed to the appropriate guaranty fund; include here any comments deemed necessary regarding the determination process for claims which are in excess of the statutory maximum coverage of the guaranty funds.

Insolvencies involving long-tail business present notice challenges to liquidators. Company records may not exist to provide addresses for occurrence-based policyholders that were in force from 5 to 25 years ago. Public policy considerations confront the receiver.

A supplemental notice may also be used in situations where additional relevant information becomes available after the first notice has been sent.

b. Notice to the Guaranty Funds

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The receiver must notify the guaranty funds that may become obligated as a result of the receivership as soon as possible. Even if such notice is not a statutory requirement, the receiver should notify all interested guaranty funds as a matter of courtesy. That notice should include a copy of the claimants' notice issued by the receiver, along with copies of the receivership order and any domiciliary injunction which has been entered. The regulator, receiver, and guaranty funds should coordinate and share information well before the liquidation order is rendered. See Section E below for more information in this regard.

2. Proof of Claim

   a. Claims Determination Framework

Nowhere is the interrelationship between the receiver and the guaranty associations more prominent than in the area of claims determination. This relationship is defined in the P/C Model Act that provides that the receiver shall be bound by settlements of covered claims by the guaranty funds. However, Section 703 A of the *Insurer Receivership Model Act* (#555, commonly known as "IRMA") and many state receivership statutes contain provisions that prohibit the receiver from accepting any claim for an amount in excess of or contrary to the terms of the policy.

There has been uncertainty between guaranty associations and receivers as to who determines whether a claim is covered under the policy terms. The receiver and the guaranty funds should discuss questionable coverage issues as they arise in order to prevent subsequent problems.

   b. Forms of Proof

The information to be contained in the proof of claim form is usually established under the receivership statutes in the insolvent insurer's state of domicile. However, some guaranty associations require that each claimant submits a separate proof of claim form, the contents of which will be dictated by the law and practice of the guaranty association's state. This is because statutes creating the guaranty funds contain a series of specific eligibility requirements and limitations on allowability, each of which may require additional information in order to establish the fund's obligation. For this reason, the receiver should coordinate with the guaranty fund prior to any notification to potential claimants regarding the proof of claim form.

   c. Protective Filings via Proof of Claim Forms

Many guaranty funds are not permitted to recognize general proofs of claim, intended as a protective filing for claims that are unknown to the insured at the time of filing, as sufficient notice. These guaranty funds require that specific claim information about known claims must be provided in the proof, including the date and other particulars relating to the insured event.

3. Late-Filed Claims

   a. Rationale

Most receivership statutes contain a provision that requires claims to be filed by the claims filing date established by the liquidation court. See IRMA § 701. If a claim is filed after that date, it is usually not allowed or is subordinated to a lower distribution priority. In addition, many guaranty funds are not permitted to pay claims filed after the earlier of the claims filing date or a bar date established pursuant to the guaranty fund's enabling act.

The receiver may have the ability to allow policyholders to file "omnibus" or "policyholder protection" claims to meet the bar date requirements, but guaranty fund statutes may not allow coverage of such claims.

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b. Extensions

Once a receivership's bar date has been established, guaranty funds generally take the position that the receiver should not extend the bar date, as such an extension may result in guaranty fund coverage issues.

c. Excused Lateness

Some receivership statutes provide a procedure for allowance of late-filed claims which authorizes the receiver to allow such claims under certain circumstances. (See IRMA § 701). The receiver should consider claimant requests on a case-by-case basis, through the specific mechanism established in the receivership statutes. The receiver should also consider giving notice to those guaranty funds that may be affected prior to allowing a late-filed claim in order to provide those guaranty funds the opportunity to address how allowance of the claim would impact them.

E. Claim Files Information

1. Information Needed by Guaranty Funds

The key to the successful handling of filed claims is cooperation between the receiver and the guaranty funds throughout the claim process. Receivers should keep in mind that the guaranty funds require reasonable access to those insurer's records which are necessary for them to carry out their statutory obligations.

Recent experience has shown that pre-liquidation coordination and information exchange are essential for the smooth transition of claims servicing responsibilities to the guaranty funds without disrupting ongoing benefit payments. Regulators, receivers and guaranty associations should coordinate and communicate, even if liquidation of the company is not a certainty. A "two-track" approach is recommended. While efforts continue to revitalize the company, the receiver and the guaranty funds should also be taking steps to ensure a smooth transition to liquidation if liquidation becomes necessary.

The receiver's cooperation in providing information and making files available to the guaranty funds is essential to minimize claim interruption. More specifically, the receiver should locate and forward to the involved guaranty funds the following information (See IRMA § 405):

- A general description of the business written or assumed by the insurer
- Information concerning licensure of the insurer
- Claim counts and policy counts by state and line of business
- Claim and policy reserves
- Unpaid claims and amounts
- Sample policies and endorsements
- Listing of locations of claim files
- Listing of third party administrators, description of contractual arrangements and copies of pertinent executed contracts
- Listing of claims in litigation or dispute and assigned defense counsel
- Such other information as may be needed by the guaranty funds

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Please note, loss adjustment expenses incurred prior to the liquidation order are not covered by guaranty funds, and therefore, should not be sent to the guaranty funds for payment.

2. Claim Files

To facilitate the protection of policyholders and claimants; regulators, receivers and guaranty funds should coordinate transition of claim files well before the company is liquidated. The receiver should forward claim files as soon as possible to the appropriate guaranty funds. Some guaranty funds may require access to or copies of the filed proof of claims forms. Receivers and guaranty funds should consider entering into agreements as to ownership, return of files, auditing rights, inventory controls and reporting.

Most company claim records are held in electronic format. It is essential to address data conversion to Uniform Data Standards (UDS) well before the guaranty funds are triggered. (See Chapter 2 of this handbook.) If there are non-electronic claims records, UDS records will need to be prepared.

Priority should be given to identifying and forwarding all active workers' compensation files and all active files where major litigation or settlement is imminent.

Determination of which guaranty fund should be the recipient of a particular file will depend on a series of factors. Generally, the receiver should deliver the file to the guaranty fund of the insured's place of residence. However, if it is a first-party claim for damage to property with a permanent location, the receiver should deliver the file to the guaranty fund where the property is located. In most instances, if it is a worker's compensation claim, the receiver should deliver the file to the guaranty fund of the state with jurisdiction over the claim.

Claim files sometimes are delivered to the wrong guaranty fund. In this situation, the preferable course of action is for the guaranty fund that received the file to secure from the appropriate guaranty fund their concurrence. After that, either fund will ask the receiver to resend the UDS record to the appropriate guaranty fund or will notify the receiver if the receiver does not make the actual UDS records transfer. The receiver will let the parties know if it prefers the original fund to close the file or to report the transfer with UDS "C" record with transaction code "080". See the UDS Manual[1] for additional information. NCIGF can assist in cases where a high volume of files need to be transferred.

In multi-state insolvencies receivers and guaranty funds should work together on protocols for transmitting files to the appropriate guaranty fund.

F. Unearned Premium Claims

Although most guaranty funds cover unearned premium claims, some do not (see the NCIGF Web site at http://www.ncigf.org at the Guaranty Fund Laws tab for unearned premium coverage by state). For those states where unearned premium is covered, the receiver should prepare and disseminate the necessary calculations as soon as possible. This will allow guaranty funds to make timely refunds to enable the insureds to make arrangements for replacement coverage.

To make payments possible, guaranty funds will need the following information for each potential claimant: policy identification, insured name and address, policy periods and expiration dates, cancellation date, current payment status, and the amount of the unearned premium. If possible, this information should be provided by the receiver by UDS B Record. The initial B Record may not have the calculation but will advise of the "potential" claimants. A subsequent B Record would provide the calculation/audit. In addition, the receiver should forward to the guaranty funds a general explanation clearly showing how the unearned premium was calculated. The calculations should be on a pro rata basis rather than short-rated. The information should be as accurate as possible, given the state of the insurer's records, and should be accompanied by the receiver's initial evaluation of the information's reliability.

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The receiver should be prepared to provide a sampling of the insurer's records and the receiver's calculations to demonstrate the reliability of the unearned premium figures to guaranty funds. Where agents have advanced unearned premium to the insureds in exchange for valid legal assignments, the receiver and guaranty fund should coordinate their positions on acceptability.

It should be kept in mind that where the insured's return premium claim is based on a premium audit or retrospective rating plan, it may not be covered by some guaranty funds. Additionally, net worth limitations embodied in a number of guaranty fund acts may preclude payment of unearned premium claims to certain high net worth insureds.

Premium financing arrangements often create special problems for the affected guaranty funds in processing return premium claims. If the receiver has information concerning premium financing arrangements, the receiver should provide that information to the guaranty funds to facilitate payment of returned premium to the appropriate person or entity.

G. Claim Reporting

How guaranty funds report claims and expense payments, outstanding reserves and administrative expenses to a receiver is an item of concern in every insolvency. This reporting is not only important for the guaranty funds as a creditor, but it also assists the receiver in gathering what is usually the major asset in most receiverships—reinsurance recoverables.

The NAIC in December 1993, adopted the UDS to be used for the reporting of policy and claim information between guaranty funds and receivers. UDS was the result of a joint effort of a number of receivers and guaranty funds to facilitate (1) reporting between receivers and guaranty funds, and (2) reporting to reinsurers by the receiver. The use of UDS file formats to transmit information at the policy or claim level will provide both receivers and guaranty funds with needed information in a uniform, easily usable format. Currently, most guaranty funds and receiverships are able to send and receive information in the UDS format. The NAIC endorsed the use of UDS by receivers and guaranty funds effective March 31, 1995. Most insolvencies instituted prior to that date did not use UDS, nor did they later convert to UDS. It is very important to note that an Operations Manual exists and should be reviewed and used by receivers and guaranty funds for understanding UDS. Version 2 of the UDS was adopted by the NAIC for implementation on Jan. 1, 2005. Version 2 includes many improvements and revisions based upon the collective experience of receivers and guaranty funds with the original version over several years and insurer insolvencies. In 2006, the NAIC adopted the Standardized Financial Report (D Record) for addition to the Uniform Data Standards. A copy of the updated UDS Manual and file formats are at the NCIGF Web site at https://www.ncigf.org/resources/uds/.

It is important to remember that the earlier the receiver determines what information is needed, and communicates those needs to the guaranty funds, the better and more efficient the reporting process will be. UDS, through the implementation of several lettered record formats, has simplified the aforementioned receivers' requirements. The formats were designed by the UDS Technical Support Group (UDSTSD) a group comprised of members of the receiver and guaranty fund communities and approved by the NAIC.

As stated above, almost all claims data for the insolvent insurer will be in electronic format. Security concerns are paramount. The NCIGF addresses the security concerns with a system called the UDS Data Mapper. Using the Mapper, the receivers can map raw data to, or fully created UDS files to UDS record fields in a database. The Mapper will then create new UDS files to be placed in the guaranty associations' SUDS directories. This process has the dual benefit of ensuring UDS compliance and scrubbing the data of any unknown malicious code. This service is available at no charge to the receiver.

Recent estates with significant reinsurance recoveries have found it useful to also develop claims protocols setting out additional information that is needed for reinsurance recovery purposes and dealing with other matters such as new and reopened claims and closed files. Needed information often extends beyond that which can currently be provided by UDS data feeds. Some guaranty funds have agreed to give receivers

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limited, read-only access to their claims database. Assistance from the UDSTSG can also be found by submitting a help request to help@udstsg.org.

H. Claims Exceeding Guaranty Fund Limits and Aggregate Claims

1. Claims Exceeding Guaranty Fund Limits or Claims Excluded from Guaranty Fund Coverage

Under the P/C Model Act and state enabling acts, guaranty funds have per claim limits, or "caps," that can limit the guaranty fund's obligation to an amount less than the insolvent insurer's policy limits. For example, the amount paid in satisfaction of a covered claim (either non-workers' compensation or unearned premium) under the P/C Model Act may not exceed $500,000 per claimant, even if the actual policy limits are greater. The caps vary among the states and the receiver must review applicable state guaranty fund acts. Here, the interrelationship between the guaranty fund and the receiver becomes critical (i.e., both act to pay or determine claims made against the insolvent insurer arising under the same policy and are eventually allowed against the insolvent insurer's estate).

The guaranty fund has a claim against the insolvent insurer's assets for the amounts paid as indemnity and the expenses and costs of handling the claims it pays. Furthermore, anyone with a claim over the guaranty fund's cap, subject to a guaranty fund deductible or subject to a statutory net worth exclusion has a claim against the estate for that portion of the claim not covered by the guaranty fund. From this perspective, the role of the guaranty fund and the receiver are not easily distinguishable. The guaranty fund is concerned with determining and paying its covered claims obligations under its statute while the receiver is determining how much of the claim should be allowed as a claim in the receivership. As a result, whenever a covered claim is filed in excess of the cap, it gives rise to a situation where extra effort and cooperation between the guaranty fund and the receiver will be necessary.

It should be noted here that, in some states, the guaranty fund will not settle a claim without a complete release, which may require participation by the receiver prior to any settlement. In some cases, however, the guaranty fund may pay the claim up to its statutory limit, leaving the excess to be paid by the insured, who will then retain a claim against the estate for the excess amount. Where the insured is unwilling or unable to pay the excess, the claimant may have a direct claim against the estate for the unpaid amount. In either instance, there is a portion of the claim above the cap that is left unsatisfied by the guaranty fund's payment. After approval by the receiver, the "over-cap" claim, as other allowed claims, will be paid as part of a distribution, pursuant to the applicable priority statute.

There may be other situations where the guaranty fund and the receiver will both have an interest in handling a claim. For example, where a claim includes allegations of bad faith or seeks punitive damages, the claim would not be covered by the guaranty fund but may be a claim in the estate.

The successful handling of over-cap claims is dependent upon early communication between the guaranty fund and the receiver. To prevent, or at least minimize, potential conflicts between the guaranty fund and the receiver regarding the payment of over-cap claims, full disclosure, communication and cooperation between the guaranty fund, the insured and the receiver's claims department must begin as soon as it is determined that an over-cap claim may exist. Prior agreement with the receiver should be obtained, where possible, on the amount of the over-cap claim. The guaranty fund has no authority to settle the claim in excess of its limit, and without the consent of the receiver, the claimant or insured (if paid by the insured) is taking a risk that all or a portion of the over-cap claim may be denied by the receiver. In fact, arranging to have the over-cap claims allowed as a claim in the estate may provide the needed leverage to settle the claim.

Receivers and guaranty funds have found it useful to develop specific procedures for dealing with claims where the cap will be exceeded and including such procedures in the claim protocols described above.

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2. Aggregate Claims

Certain types of policies are often written on an aggregate basis. Aggregate policies may be in terms of a policy aggregate, a coverage aggregate, or both. In a policy aggregate, all claims are accumulated until the maximum limit of liability is reached. A coverage aggregate is one where claims against a specific coverage, such as products liability, are accumulated until the maximum coverage limit is reached. When an insurer is solvent, it monitors the erosion of all of its outstanding policies—in other words, the insurer keeps track of how much of a policy's aggregate limit is left as various claims under it are satisfied.

When an insurer is declared insolvent, and one or more guaranty funds begin to satisfy claims against such aggregate policies, problems can arise. The most obvious problem occurs when a guaranty fund paying claims under a policy is not aware that the policy has an aggregate limit. The receiver should take special care to advise the guaranty funds which policies are subject to an aggregate limit. The receiver should not assume the guaranty funds will discover this information on their own.

It is equally important that the receiver and the affected guaranty funds work together to monitor the erosion of aggregate limits. The receiver should advise the affected guaranty funds of claims that have been paid under the policy by the insurer before insolvency and track payments made by the guaranty funds after insolvency. Similarly, guaranty associations should not pay a claim under an aggregate policy prior to coordinating with the receiver. When the aggregate limits are close to being exhausted, the receiver should alert the guaranty funds and require that they obtain prior approval on any payment against such policy. (See IRMA § 706 D).

The following example should help illustrate the problem. Assume that there is a products liability policy with an aggregate limit of $2,000,000. Assume further that there are 10 claimants filing claims under the policy with 10 separate guaranty funds. If each guaranty fund has a cap of $300,000, but is unaware of the other claims, then potentially, payments totaling $3 million could be made, thereby exceeding the aggregate limit. In this situation, regardless of the original extent of an individual guaranty fund's knowledge of a policy's aggregate nature, it cannot independently keep track of the policy's erosion. In situations like this, it is critical that the receiver monitor each guaranty fund's activity closely and keep all affected guaranty funds apprised of the situation as it develops.

When adequate safeguards are not in place, payments may be made in excess of a policy's aggregate limit and conflicts will arise between the receiver and the guaranty fund. Although the guaranty fund may have made the payment in good faith and within its statutory guidelines, the receiver may feel compelled to deny reimbursing the guaranty fund for that portion of the claim in excess of the aggregate limit. These problems are sometimes not discovered until long after the guaranty fund has settled all of its claims. To avoid such problems, the guaranty funds should not pay a claim covered by an aggregate policy without first consulting the receiver. State liquidation acts vary on the handling of estate distributions for amounts paid in excess of aggregate caps. These laws should be carefully reviewed in dealing with these matters. IRMA Section 706 D addresses policies with aggregate limits and provides that the liquidator may apportion the policy limits ratably among timely filed allowed claims or notify the insured, third party claimants and affected guaranty associations of the erosion of the aggregate limit.

In summary, upon taking control of the estate, it is recommended that the receiver institute the following procedures:

- Determine which policies have aggregate limits;
- Determine policy erosion and continue to monitor aggregate accumulations resulting from payments made by guaranty funds;

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- Advise guaranty funds of these policies and keep them apprised of any pre- and post-insolvency erosion;

- Require guaranty funds to determine how much of the aggregate limit remains available before making any settlements under these policies;

- As soon as it appears that the aggregate limit is about to be reached, notify the guaranty funds immediately that all future settlements should be cleared with the receiver;

- Require guaranty funds to immediately report to the receiver any paid or settled claims that affect aggregate limits; and

- Initiate a system that can earmark pending settlements. One of the benefits of the UDS is that it facilitates the tracking of policies subject to aggregate limits (See the Publications tab of the NCIGF Web site at http://www.ncigf.org).

I. Early Access

Most state receivership statutes contain a provision that requires the receiver to submit to the court a proposal to disburse general assets to guaranty funds. Such proposals are commonly referred to as "early access plans," and apply equally to life and health and to property and casualty insolvencies. The statutes typically contain provisions specific to both.

The purpose of an early access plan is to distribute funds from the estate to the guaranty funds as soon as possible and in the maximum amount possible in order to reduce the assessment burdens on member companies. Early access distributions are essential to the guaranty funds' continued ability to fulfill their statutory duties. (See IRMA § 803.)

1. Timing

The standard early access provision requires that the receiver submit an early access plan within 120 days of entry of the liquidation order. IRMA requires that the receiver apply to the receivership court for approval to make early access distributions, or report that the receiver has determined that there are not sufficient distributable assets to make any distribution to the guaranty funds at that time, within 120 days of entry of the liquidation order, and at least annually thereafter. (See IRMA §803 B). In practice, in order for the receiver to make the calculations necessary to demonstrate to the court that there are insufficient assets at that time to make any distribution, receivers should formulate an early access plan and file the form of the plan within the 120-day period for approval by the court. This procedure will fulfill the receiver's statutory obligation for filing a plan and will ensure that a plan is in place to make distributions when assets become available.

2. Reserves

Most early access provisions in state receivership statutes require an early access plan to include, at a minimum, reserve amounts for the expenses of administration and the payment of the higher priority claims. (See also IRMA §803 A(2)). The reserve for expenses should take into account all administrative expenses anticipated to be incurred during the duration of the receivership proceeding. (See specific state statutes to determine if guaranty fund administrative expenses are Class I or Class II; see also IRMA §801 A & B.) The reserve for receivership expenses and for other claims that are at a higher priority than the guaranty funds' claim payments need not, however, be reserved 100% out of current liquid assets of the estate, as long as there are sufficient non-liquid assets that will be liquidated during the course of the receivership proceedings to cover those claims. The receiver should reserve a portion of the liquid assets to cover receivership expenses that will become due in the near term and prior to the liquidation of other non-liquid assets.

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It may be difficult for the receiver of some estates to accurately determine the amount of policyholder claims not covered by the guaranty funds. An absolute determination of the amount is not necessary for purposes of the plan, however, as an estimate for calculation purposes is all that is needed. This estimate will be updated from time to time, and any overpayment to guaranty funds must be returned to the receiver. This "claw back" requirement is mandated by IRMA Section 803 F and should be included in any written agreement between the receiver and the guaranty funds.

3. Liquid or Distributable Assets

Most early access agreements provide for payments from distributable assets, which generally means cash and cash equivalents, less reserves for Classes I and II. In developing early access plans, it is anticipated that the receiver will liquidate non-liquid assets as soon as economically prudent.

The receiver, however, is not required to increase liquid assets for purposes of the plan by making forced or quick sales of non-liquid assets that result in obtaining less than market value. In other words, receivers are not expected to hold "fire sales" in order to generate liquid assets for distribution as early access. It is in the interest of all creditors, including the guaranty funds, for the receiver to attempt to obtain full value for the estate's assets. On the other hand, where an asset can be sold at a fair market price, the receiver should consider liquidating the asset in order to generate early access funds and thereby reduce the assessment burden on solvent insurers and their policyholders. The public policy behind maximizing the value of estate assets and reducing assessment burdens on guaranty funds through early access distributions sometimes conflict and special understanding and cooperation between the receiver and the guaranty funds is necessary to resolve this conflict amicably.

Liquid assets do not include real estate, the book value of a subsidiary, assets pledged as security, special or general deposits held by other states that are unavailable to the receiver, or any assets over which the receiver does not have complete control.

4. Early Access Agreements

Any payment to be made under the provisions of an early access plan typically is conditioned upon the guaranty fund executing and returning an early access agreement to the receiver., IRMA obviates the need for an agreement by incorporating the key provisions of a typical agreement in the statute; however, currently, only a small minority of states have adopted this IRMA provision Such agreements include provisions requiring the guaranty funds to:

- Submit to the exclusive jurisdiction of the receivership court, but only for the purpose of the early access plan;

- Return to the receiver any previously disbursed assets, plus interest if applicable, that are required to pay claims that are of an equal or higher priority; no bond shall be required of any guaranty fund. See IRMA §803 F;

- Periodically report to the receiver: all amounts paid by the guaranty fund on claims to date; the amount of expenses entitled to priority that have been paid by the guaranty fund; the reserves established by the guaranty fund on open claims; the amounts collected by the guaranty fund as salvage or subrogation recoveries; the amounts collected by the guaranty fund from any state deposit; and other information needed by the receiver. See IRMA §803 B; UDS is the platform commonly utilized for the transfer of this data. See Chapter 2 for a broader discussion of UDS.

Calculations and distributions by the receiver should be done at least annually; however, in instances where the guaranty funds are reporting on a quarterly or more frequent basis and sufficient assets are available to make distributions, the receiver may consider making distributions on a more frequent basis.

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5. Expenses

Early access plans typically contemplate that the guaranty funds should receive prompt reimbursement of their administrative expenses. The calculation of liquid assets available for distribution as early access should be made after payment of all incurred receivership and guaranty fund administrative expenses.

Certain categories of guaranty fund expenses may or may not be included in the administrative expense priority class. Therefore, it is necessary to consult the applicable statute to determine appropriate treatment.

In a case where there is disagreement between the receiver and guaranty associations concerning the priority of particular guaranty association expenses, it may make sense to make administrative expense distributions under a reservation of rights, clearly specifying that the priority of certain expenses was a matter of dispute and that such payment does not preclude the receiver from later challenging the priority of particular expenses. Dealing with the issue in this manner ensures that the guaranty associations receive maximum distributions early in the proceeding—when the need for cash can often be critical. Resolution of expense classification issues, which may involve protracted discussions or even litigation, can be conducted while the funds have the necessary cash to pay claims.

6. Basis of Distribution

Most early access statutes provide that distributions to guaranty funds will be based on claims paid and to be paid by the guaranty funds. Some states, however, have based distributions solely on paid claims. In states that follow the reserve language, early access should be based on both paid claims and reserves. This permits a more equitable distribution of assets among the guaranty funds instead of benefiting guaranty funds that make claim payments at an early stage of the receivership proceeding (e.g., a state that has mostly workers' compensation claims). See IRMA §803 A(2)(c).

7. Special Deposits

Early access plans typically take into account state deposits by excluding such assets from the calculation of liquid assets available. Similarly, the plans typically take into account payment to guaranty funds from general or special state deposits by essentially treating such payments as prior early access distributions, thereby reducing the early access distribution to those guaranty funds receiving state deposits. If after receiving early access distributions, a guaranty fund receives payment from a special state deposit, then the guaranty fund may be required to return all or part of the early access distribution. Most early access plans do not allow the receiver to take credit for a special or statutory deposit that has not been paid to or is unavailable to the guaranty fund. See IRMA § 803 G.

8. Salvage/Subrogation

Historically, the majority of receivers have taken the position that salvage or subrogation recoveries collected by a guaranty fund, based on payments made by the guaranty fund, are the property of the guaranty fund. The recoveries are applied to reduce the net guaranty fund payment total that is the ultimate claim of the guaranty fund against the insolvent estate. These receivers accept reimbursement on a pro rata basis in instances where a guaranty fund has made a recovery that includes consideration of both pre-liquidation payment by the insurer and subsequent payment by the guaranty fund. Early access agreements will not be affected when receivers take this position.

A minority point of view is that salvage or subrogation recoveries by a guaranty fund become general assets of the liquidation estate, regardless of whether the payment on which the recovery is based was made by the insurer or the guaranty fund. Specific language to address concerns may be needed in early access agreements when a receiver adopts this view.

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J. Large Deductible Policies

In 2016, the NAIC adopted a white paper titled *Workers' Compensation Large Deductible* Study. The paper revisits and reconsiders issues raised in an earlier 2006 *Workers' Compensation Large Deductible Study.* The 2016 study provides valuable information about how large deductible policies work and special issues that can arise with their use.

As used in workers' compensation coverages, large deductible policies allow employers to retain a certain amount of claims risk, thereby reducing the cost of their workers' compensation coverage. Typically, these policies are administered by the insurer or a third-party administrator paying claims within the deductible and obtaining reimbursement from the insured employer. In the receivership context, where guaranty funds pay claims within the deductible, there is an issue as to the handling of the insured employer's reimbursement of payments within the deductible. That is, should the reimbursement be paid to the guaranty fund outside the receivership distribution scheme, or should the reimbursement be treated as an asset of the receivership estate subject to the claims of all creditors? Several states have provisions in place in their respective receivership statutes which provided that large deductible reimbursements should be paid directly to the guaranty fund outside the receivership distribution scheme.

Where the insolvent insurer wrote large deductible policies, the receiver should be mindful of this issue and should consult with the affected guaranty funds as soon as possible. The receiver should also review those states' guaranty fund statutes where the claims will be processed to determine whether claims within large deductibles are "covered claims" as defined in the appropriate guaranty fund act. Typically, claims under workers compensation policies will be covered. However, claims under policies for other lines of business may not be covered. The availability of guaranty fund coverage is to some extent dependent upon the specific language of the policy involved.

IRMA provides for a different treatment of large deductible collections. Under IRMA §712, payments of such monies to the guaranty funds are treated as early access.

Under the *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) deductible recoveries are paid to the guaranty fund to the extent of their claim payments and are not considered early access distributions. Subsection B of this Guideline states, "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.

K. Coordination among Regulators, Receivers and Guaranty Funds

In 2005, the NAIC adopted a white paper titled *Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System*. The white paper addresses the various issues relating to communication and coordination among regulators, receivers and guaranty associations, and how the parties might better work together to protect consumers.[7]

III. LIFE AND HEALTH GUARANTY ASSOCIATIONS

A. Introduction

In 1970, the NAIC adopted the *Life and Health Insurance Guaranty Association Model Act* (#520) (Life Model Act). Since 1970, the Life Model Act has undergone several major revisions. The most recent

[7] A copy of this White Paper may be obtained from the NAIC at: http://www.naic.org/store_home.htm
Phone: 816.783.8300; Fax: 816.460.7593; E-mail: prodserv@naic.org

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revisions to the Life Model Act were made in 2017.[8] All 50 states, the District of Columbia and Puerto Rico have enacted guaranty association laws based on some version of the Life Model Act. (For summaries of the provisions in each state's guaranty association laws see the NOLHGA Web site at:

https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

The Life and Health Insurance Guaranty Associations were created to protect certain policy, contract and certificate holders (and their beneficiaries, assignees and payees) from loss due to the insolvency or impairment of a member insurer. Life/health insurance guaranty associations pay benefits and continue coverage, subject to statutory limitations, either directly or through a third-party administrator. With early communication, information sharing and coordination between guaranty associations and receivers, the guaranty associations can work with receivers to help develop and put in place the infrastructure and solutions that may be able to provide for a seamless transition into liquidation, thereby avoiding unnecessary delays and disruptions, and maximizing protections for policyholders. Early coordination between the receiver and the guaranty associations will also help minimize confusion, avoid duplication of effort and lead to greater administrative efficiency and lower costs for both the receiver and the guaranty associations.

NOLHGA is a vital resource for receivers in multistate life/health insolvencies. NOLHGA, whose members are the life/health guaranty associations of all the states and the District of Columbia and Puerto Rico, collects and distributes information for its members and receivers. It performs analyses of various alternatives by which guaranty associations can fulfill their statutory obligation to protect policyholders and serves as the guaranty associations' national coordinating mechanism for resolving issues. Through its Members Participation Council, NOLHGA works with its affected member guaranty associations and the receiver to develop and implement plans for the disposition of covered claims and contractual obligations through, for example, assumption reinsurance or claims administration.

Ideally, the receiver and NOLHGA, on behalf of the guaranty associations, should commence planning and coordination efforts at the earliest practicable opportunity. As discussed in the NAIC's 2004 whitepaper on Communication and Coordination Among Regulators, Receivers and Guaranty Associations, cited in Chapter 1 of this handbook, coordination and communication with guaranty associations should begin "no later than when a company is placed into rehabilitation, and in many cases, involvement even earlier will enhance consumers' protection and decrease costs of the insolvency to all stakeholders" subject to entering into a confidentiality agreement as appropriate. NOLHGA can be reached at:

National Organization of Life and Health
Insurance Guaranty Associations
13873 Park Center Rd., Suite 505
Herndon, VA 20171
Phone: (703) 481-5206
Web Site: https://www.nolhga.com

[8] All references in this chapter to the "Life Model Act" are to the 2017 version, unless otherwise specified. As of this writing, a majority of states had adopted or substantially adopted the 2017 amendments, and further legislation is expected in additional states. It is always important, however, to check individual state statutes for variations from the Life Model Act in actual cases.

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B. Triggering Guaranty Associations

1. “Insolvent” Insurers

Under the Life Model Act, guaranty associations are triggered when a member insurer is determined to be an “insolvent insurer,” as defined therein, i.e., it has been placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency. A member insurer is defined in the Life Model Act as “an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn….”[9] Certain types of insurers are excluded from the Life Model Act definition, such as fraternal and mutual assessment companies. Moreover, while a majority of states now include Health Maintenance Organizations (“HMOs”) as member insurers, not all states do. State guaranty association laws will govern whether HMOs are member insurers for purposes of guaranty association coverage in a given state.

2. “Impaired” Insurers

Under the Life Model Act, a guaranty association may act in its discretion if a member insurer is “impaired,” subject to certain conditions and limitations. An insurer is an “impaired insurer” as defined in the Life Model Act, if it has not been declared insolvent but is under a court order of rehabilitation or conservation. In such situations, the Life Model Act provides that the guaranty association may, in its discretion and subject to any conditions imposed by the guaranty association that do not impair the contractual obligations of the impaired insurer, and that are approved by the Commissioner, take certain actions to provide protections to policyholders of the impaired insurer. The primary purpose of the guaranty associations is to protect policyholders, however, not to bail out impaired or insolvent insurers so that they can continue as going concerns. Guaranty associations, therefore, have traditionally been extremely reluctant to provide coverage before liquidation.

There are subtle variations among some state guaranty association triggering provisions which could potentially impact uniform triggering of guaranty associations in affected states. Coordination with guaranty association representatives and NOLHGA (if a multistate insolvency), as early as possible subject to appropriately executed confidentiality agreements before a petition for receivership is filed will help to reduce the risk of complications in regard to guaranty association triggering. or individual state provisions, see the NOLHGA Web site:

(https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

C. Scope of Coverage

1. Covered Policies and Limits of Coverage

Guaranty associations were created to provide a limited, but substantial safety net to protect policyholders from loss as a result of the impairment or insolvency of a member insurer. e Under the Life Model Act, the following coverages are provided:[10]

[9] HMOs were added to the definition of “Member Insurer” as part of the 2017 package of amendments to the Life Model Act. As of this writing, those amendments had been largely adopted in 36 states. However, at least one of those states has continued to exclude HMOs from the definition of Member Insurer.

[10] While there are a few exceptions, these coverage limits have been fairly uniformly adopted in most states. For individual state limits, see the NOLHGA website (https://www.NOLHGA.com/factsandfigures/main.cfm/location/statinfo) or consult the applicable state guaranty association.

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- Life insurance: $300,000 in death benefits, but not more than $100,000 in net cash surrender and withdrawal values, per life. In the case of corporate-owned or bank-owned life insurance, however, overall benefit coverage is capped at $5,000,000 per owner.

- Health insurance: i) $500,000 in benefits for health benefit plans, which are defined to include "any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract", subject to certain enumerated exclusions. The term "health benefit plan" which was introduced in the 2017 amendments to the Life Model Act, replaces the prior reference to basic hospital, medical and surgical insurance and major medical insurance, and includes coverage under health maintenance organization subscriber agreements; ii) $300,000 in benefits for disability income insurance and long-term care insurance; and iii) $100,000 for other health policies not defined as disability income insurance, long-term care insurance or health benefit plans. All limits are applied per life.

- Individual (allocated) annuities: $250,000 in present value of annuity benefits, including net cash surrender and withdrawal values, per life.

- Structured settlement annuities: $250,000 in present value of annuity benefits, per payee or beneficiary. See Chapter 3 for a discussion of structured settlements.

- Unallocated annuities: Coverage for unallocated annuity contracts[11] is typically limited. As of this writing, 28 states provide coverage for limited types of unallocated annuity contracts. The remaining 22 states, plus the District of Columbia and Puerto Rico, do not provide coverage for unallocated annuity contracts. For those states that do provide coverage for unallocated annuity contracts, coverage is typically limited to unallocated annuity contracts issued to or in connection with specific employee benefit plans or government lotteries. Life Model Act §3(A)(3). Coverage limits are stated as (i) $5,000,000 per contract owner/plan sponsor for unallocated annuity contracts issued in connection with either governmental lotteries or private employer employee benefit plans that are not protected by the Pension Benefit Guaranty Corporation, and (ii) $250,000 per plan participant for unallocated annuity contracts issued to governmental retirement plans. Life Mode Act §3(C)(2)(b) and (e). Unallocated annuity contracts are not covered in every state, and the Appendix to the Life Model Act includes alternate Section 3 text adopted by several states that do not provide coverage for unallocated annuities.

- Aggregate limits across policy types: Aggregate benefits covered with respect to any one life for life insurance, individual annuities, and health insurance (other than health benefit plans) are capped at $300,000. Aggregate coverage for health benefit plans and other policy types is limited to $500,000 with respect to any one life.

2. Exclusions

Products excluded from coverage, in whole or in part, are described in Life Model Act Section 3(B)(2). Under the Life Model Act, coverage is expressly excluded for policies or portions of policies under which the risk is borne by the policyholder or that are not guaranteed by the insurer, as well as certain interest crediting rates that exceed the limits described therein. Self-funded employer-provided welfare benefit plans are also among the products excluded, as are unallocated annuity contracts issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation. Reinsurance is

[11] For purposes of guaranty association coverage, an unallocated annuity contract is "an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate." Life Model Act §5(Y).

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also specifically excluded unless assumption certificates have been issued. For a more complete listing of products or portions thereof generally excluded from guaranty association coverage, refer to Section 3(B)(2) of the Life Model Act. For specifics concerning coverage exclusions in any particular state, consult with the guaranty association in that state.

In addition to the product exclusions referenced above, the Life Model Act excludes coverage for policies or products issued by entities that are not regulated under the standards applicable to legal reserve carriers, and, are therefore excluded from the definition of Member Insurer under the model, such as insurance exchanges, assessment companies, fraternals, and hospital or medical service corporations. HMOs were added as member insurers under the Model as part of the 2017 amendments. However, these amendments have not yet been adopted in all states. Moreover, a few states may have separate HMO guaranty associations established under state law. Accordingly, it will be important to review state law to determine whether and to what extent a state provides guaranty association coverage for HMO products. Hospital or medical service corporations that are members of the Blue Cross/Blue Shield Association may be required by their franchise to participate in their state's guaranty association if permitted by statute, or to establish some other form of insolvency protection for their participants. Whether these entities are included as member insurers for purposes of guaranty association protection may vary by state and must be considered based on the circumstances in each case.

3. Residency Requirements

Residency is determined on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer, whichever occurs first. Typically, this results in the state of residence being determined on the date an order of liquidation with a finding of insolvency is issued. If there is a gap between the start of the receivership and the date an order of liquidation is issued, policy and contract holders may relocate, which could affect the situs of coverage.

The Life Model Act generally provides for coverage of policyholders and certificate holders under group policies who are residents of the state, as well as their beneficiaries, regardless of where the beneficiaries reside. It also provides coverage for contract owners of unallocated annuities if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in the state. Nonresident policyholders and contract holders may be covered under certain limited circumstances. If the insolvent insurer's domiciliary state follows the Life Model Act, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty association law and the policyholders in that state are not eligible for coverage there because the insurer was not licensed in that state at the time specified in that state's guaranty association law. An example of such a situation might be a a resident of State A, who owns a policy of the XYZ Life Insurance Company, domiciled in State B, and placed in liquidation in state B. If the State A resident policyholder is not eligible for coverage by the State A guaranty association because the company was not licensed in State A (and therefore was not a member insurer of the State A guaranty association), coverage would be provided by the State B life and health insurance guaranty association.

D. Guaranty Association Claims Administration

In the case of a multi-state insolvency, life/health guaranty associations work through NOLHGA's Members' Participation Council (MPC) to develop and implement a plan for providing guaranty association coverage, whether through transfer of the covered policies to a solvent insurer, making arrangements for providing ongoing policy and claims administration, or some combination thereof.

For multi-state insolvencies, NOLHGA appoints a guaranty association task force that includes representatives from the domestic guaranty association and other state guaranty associations affected by the insolvency. The size of the task force depends in large part on the number of affected state guaranty associations and the size of the insolvency.

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1. Information Needs of the Guaranty Associations

For guaranty associations to evaluate and discharge their functions with the least possible duplication and delay, they must have detailed information about the insurer and its business. While information needs may vary from case to case, NOLHGA typically requests this information from the receiver on behalf of its members and, if necessary, will offer to assist the receiver in obtaining and assembling the information. Types of information routinely requested include:

- All administrative and judicial petitions and orders with attachments or exhibits
- The insurer's most recent annual statement
- The insurer's most recent financial statement, audited or unaudited, and department or independent financial audits or reviews, including identification of assets that are hypothecated or not publicly traded and unbooked contingent liabilities
- A list of states that have terminated or suspended the insurer's license
- A breakdown, by state, of the insurers' estimated liabilities/reserves by line of business
- A list of third-party administrators and administrative offices, identifying the policies, claims and group policyholders they served, and copies of all provider/vendor agreements
- Actuarial evaluations of the insurer's business
- Copies of policy and contract forms
- Copies of reinsurance contracts, assuming or ceding
- Drafts of the receiver's notices to policyholders, including any cancellation notices
- A breakdown of assets, by category, at the most recent market value available and other valuations of assets that would be helpful in cash flow analysis
- The names and addresses of policyholders and certificate holders with in-force coverage during the preceding year, broken down by state, indicating the type of coverage each had, the date to which premiums have been paid, cancellation or non-renewal dates for business that was canceled or non-renewed according to policy terms, copies of cancellation notices, and the date to which claims have been paid [12]
- Policy values (face amounts, cash surrender values, policy loans, interest crediting rates, rate crediting history, etc.)
- Premium files (and status indicators, such as Reduced Paid Up, Extended Term, or Waiver of Premium status)
- Claims data/claims history (including plan of care and related information for LTC lines)

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[12] Specific policy data needs will depend on the facts and circumstances of each case as well as the types of business involved. Initial, critical data needs will typically include all relevant summary policy and reserve information. If the policy master/eligibility records can be provided, that file may contain sufficient information for preliminary coverage determinations and to consider the potential feasibility of an assumption transfer. Additional information will be needed to coordinate coverage and begin planning for implementation of any administration, transfer or other disposition strategies.

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- Rate files/history
- Information concerning the receiver's marketing contacts and expressions of interest received about the insurer's business

2. Notice to Claimants

Shortly after a receiver is appointed, the receiver should collaborate with NOLHGA to provide notices to policyholders. Several notices may be necessary over the course of the receivership. Because of the special nature of life and health insurance guaranty association obligations, the receiver and the guaranty associations should collaborate closely on the contents of all notices to policyholders that involve guaranty association obligations, and may, in some instances, send joint communications to policyholders. Normally, the notices should:

- Provide notice of proceedings against the company
- Explain the existence of the g guaranty associations and their role in the receivership
- Provide basic information concerning guaranty association continuation of coverage, including general reference to the statutory limitations
- Where applicable, advise regarding the possibility that a portion of the policies or contracts may be assumed or reinsured by another insurer
- Provide instructions on filing claims under their insurance policies and remitting future premiums (during rehabilitation)
- Indicate how the guaranty associations intend to treat cancelable policies
- Provide information about conversion policies in the event of policy terminations
- Provide notice of liens or moratoriums
- Identify any applicable claims bar date
- Describe the receiver's handling of claims in excess of guaranty association statutory maximums
- Describe the receiver's handling of claims that are ineligible for guaranty association coverage

When a company goes into liquidation, the guaranty associations will typically send their own notice to policyholders, sometimes as part of a joint mailing with the receiver. The guaranty association notices will provide information about guaranty association coverage and limits, contact information for the state guaranty association providing coverage for insureds in each state, instructions for continuing to pay premiums and submitting claims, customer service contact numbers, and other relevant details depending on the unique facts and circumstances of the case.

3. Notice to Guaranty Associations

In many states, the receiver is required to provide notice of the receivership to all guaranty associations that may be triggered as a result of the receivership. Even if the notice is not a statutory requirement, the receiver should provide NOLHGA (in the case multi-state receiverships) and all affected guaranty associations as much advance notice of receivership as is reasonably possible under the circumstances subject to appropriate confidentiality agreements in order to facilitate the coordination that will be necessary for a successful receivership, and achieve the best outcomes for policyholders. NOLHGA and the affected guaranty associations should also be provided with an advance copy of all notices

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being issued by the receiver to policyholders, as well as copies of the receivership order and any domiciliary injunctions that may have been entered.

4. Proof of Claim

A proof of claim form is less frequently required in life/health receiverships, due in part to the fact that in many instances the guaranty associations will be continuing coverage. Generally, policyholders are not required to file formal proofs of claim for policy benefits. However, policyholders may assert claims for extra-contractual liability against the insurer, such as claims for bad faith. The receiver should consider requiring a proof of claim where extra-contractual liability is involved. Neither the guaranty associations nor assuming reinsurers accept liability for extra-contractual claims.

Receivers and guaranty associations must have data on the policy deductibles and benefit caps under health insurance policies. If the business is transferred to a new carrier, incurred claims will have to be allocated between pre- and post-assumption date periods. In addition, special provisions in the assumption agreement may require additional information in the proof of claim form.

5. Claim Files

The information needs of the guaranty associations generally are addressed earlier in this section of the Handbook. To ensure secure data transfer, receivers or insurance department personnel typically establish a secure website portal or FTP site to provide NOLHGA and its member associations with secure access to the data needed. Otherwise, NOLHGA, or a designated Third-Party Administrator or consultant, can establish a secure file portal where designated users can upload records. Files and records should be made available at the earliest practical opportunity to allow for the planning and coordination needed for a smooth transition and to avoid any disruption to benefits and claim payments.

6. Premiums

The continued and timely payment of premiums is necessary in order for a policyholder to receive continued coverage from a life/health guaranty association. Under the Life Model Act, "premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association." Receivers should work with NOLHGA and the guaranty associations to ensure smooth transition of premium collection. For premiums collected before the liquidation order but providing coverage for periods after the liquidation order, the Receiver should coordinate with the guaranty association to facilitate appropriate allocation of those funds.

E. Early Access

The guaranty associations' administrative costs, like the receiver's, typically have the highest priority in distribution of funds from the insolvent insurer's estate. In addition, guaranty associations have a statutory claim and right of subrogation, allowing them to recover from the estate to the extent they pay covered benefits. Guaranty association claims for the payment of covered benefits are accorded the same priority as policyholder claims (Class 3 under IRMA §801), and are taken into account in the calculation of association benefits as part of a rehabilitation or liquidation plan. The guaranty associations' claims in the aggregate often make the guaranty associations the largest claimants against the estate.[13] In recognition of this fact, most state laws provide for the guaranty associations' "early access" to payments from the estate. See IRMA §803. Early access is typically accomplished by specific agreement, which should include a provision that the guaranty associations will return excess funds.

[13] In some cases, the guaranty associations may also present claims against the estate for the insolvent insurer's unpaid guaranty association assessments. These claims have general creditor status ranking below other guaranty association claims and all policyholder claims.

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F. Claim Reporting

Guaranty associations should make timely reports to receivers of their costs for policy transfers, policy administration, including TPA costs, claim payments and administrative expenses. In multi-state insolvencies, NOLHGA will typically collect the necessary data from the affected guaranty associations and report to the receiver on their behalf in the form of an Omnibus Proof of Claim, which may be updated from time to time.

G. Guaranty Association Obligations During the Formulation of a Rehabilitation or Liquidation Plan

The successful creation and implementation of a plan to protect policyholders requires good communication and cooperation between receivers and guaranty associations. To the extent consideration may be given to restructuring of covered policies or contracts, the receiver should coordinate with the guaranty associations early in the development of the plan to consider whether the proposed restructuring is consistent with the guaranty association statutory obligations with respect to those policies or contracts. Any restructuring needs to be carefully considered in light of all applicable statutory requirements.

H. Reinsurance

The guaranty associations may find it advantageous to keep in-force ceded reinsurance treaties that the insolvent insurer had in place on covered blocks of business. Accordingly, the receiver should not cancel ceded reinsurance contracts with reinsurers or stop paying premium to reinsurers without consulting NOLHGA or the affected state guaranty associations. The existence of a ceded reinsurance treaty covering a block of business may make the business more attractive to prospective purchasers. In the case of health insurance, reinsurance recoveries may lessen the impact of catastrophic claims upon the affected guaranty associations. See Section 8 N of the Life Model Act and IRMA Section§612, both of which provide that the guaranty association(s) may elect to succeed to the rights and obligations of the insolvent insurer under ceded indemnity reinsurance agreements.

J. Special Issues

Under the Life Model Act, guaranty associations have the power and discretion to "guarantee, assume or reinsure . . . the policies or contracts of the insolvent [or impaired] insurer." Relying on this authority, guaranty associations have, on more than one occasion, acted collectively to establish an insurance company for purposes of collectively managing assets and assuming or administering guaranty association covered obligations. Whether similar arrangements may be appropriate in future insolvencies depends entirely on the circumstances.

J. Guaranty Association Procedures for Collective Action

Many individual state guaranty associations may be triggered in connection with a multistate insolvency. Simply communicating with each guaranty association individually would be a difficult task for a receiver's staff. The receiver should work closely with NOLHGA, through the MPC's appointed task force, to communicate and coordinate with the affected guaranty associations. Recognizing the need for concerted action when multiple guaranty associations must cover the insurance obligations of an insolvent company, the guaranty associations have developed and institutionalized procedures that, through NOLHGA, enable them collectively to administer continuing policy obligations, pay covered claims and, ultimately, discharge the covered obligations. These procedures provide a valuable mechanism for entering into binding contracts.

[1] UDS Manual link to be included when published from .ncigf wesite

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I. INTRODUCTION

In each of the other chapters in this Handbook, the authors make two assumptions: first, that the entity placed into receivership is an "insurance company" and is subject to state statutory receivership procedures; and second, that the receivership is administered in the "insurer's" state of domicile. This chapter addresses receiverships where neither assumption can be made.

Many entities engage in the business of insurance without obtaining the requisite license, and are organized as business corporations rather than insurers—or might not even be properly organized as corporations at all. For example, unlicensed entities transacting health insurance business often claim exemption from state licensure requirements under the Employee Retirement Income Security Act (ERISA).[1] Such unlicensed organizations present special problems to insurance commissioners, insurance consumers and, where state law allows the liquidation of such entities, to receivers. The problems stem from a number of factors, some of which include:

1. The fact that such unauthorized activity is ongoing, and not isolated

2. The potential for criminal activity occurring within the business of insurance. This issue arises by virtue of the fact that the insurance codes of many jurisdictions provide that the unauthorized transaction of insurance within the jurisdiction constitutes a crime[2]

3. The adverse economic impact of such activity upon authorized insurers and other insurance licensees

4. The potential for large volumes of unpaid claims due to the dishonesty of plan sponsors, promoters, and others, and from inherent actuarial unsoundness of the plans

5. The absence of guaranty funds or other mechanisms to cover unpaid claims

6. The adverse economic impact upon health care providers and plan participants resulting from unpaid claims

7. The potential adverse impact on the future insurability of plan participants under statutes mandating guaranteed-issue health coverage

8. The lack of comprehensive federal oversight, including licensure and regulation similar to that found in state insurance codes

9. The inability of federal authorities to act rapidly to investigate and terminate illicit operations, and to quickly discipline the perpetrators. This factor is related, in part, to the relatively limited nature and extent of the Department of Labor's jurisdiction over real and claimed ERISA plans

When considering a potential receivership involving one of these unlicensed entities, it must first be determined whether the entity is risk-bearing, and therefore susceptible to treatment as an insurance company. Section 103 (D) of the Insurer Receivership Model Act (Model #555, commonly known as IRMA) states that the Act covers "all other persons organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state." Most states have provisions similar to this based on prior versions of the NAIC Model.

This chapter begins with a general discussion of the issues involved in making these determinations. If the entity is to be placed into receivership, most of the other provisions of this Handbook are applicable or may be adapted to the circumstances presented. In some instances, however, the nature of the entity may warrant the adoption of

[1] 29 U.S.C. Section 1001, *et seq*.

[2] See, for example, Section 626.902, *Florida Statutes*

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different procedures, and this chapter discusses some of those procedures. Finally, many insurers are licensed to do business, and have assets located, in many states. (See Chapter 9—Legal Considerations of this Handbook, section on Liquidation, Jurisdiction and Ancillary Receiverships.) In such cases, "ancillary" receiverships may be established to administer the assets located in states that are not the insurer's domicile. Ancillary receiverships present their own problems and considerations. Finally, insurers organized under the laws of, or having assets located in, other countries create additional issues for a receiver to deal with. This chapter concludes with a discussion of these multi-national (or "cross-border") receiverships.

II. GENERAL CONSIDERATIONS

The receiver of an entity discussed in this chapter frequently must make a number of determinations at the outset: Is the entity entitled to bankruptcy protection? Where should the receivership be initiated? Are there any assets to distribute? What other remedies are available such as injunctive relief, criminal prosecution, etc. Should other regulatory agencies be contacted or involved in the receivership process? This chapter begins with a discussion of these issues, and then continues with a discussion of particular types of entities that may be involved in special receiverships.

Many states do not have explicit statutory language authorizing receiverships of some of the entities discussed in this chapter. In such instances, counsel may have to analogize statutory provisions and similar receivership proceedings in other jurisdictions for guidance and persuasive authority. Proponents of the receivership often must convince the court in their pleadings and proof that the entity is the functional equivalent of an insurer (or some other kind of risk-bearing entity that is clearly within the ambit of the state's insurance code) and, therefore, is subject to the state receivership statutes. Some states have explicit statutory language that allows the insurance regulator to be appointed as receiver of any "insurer," which is defined broadly to include persons purporting to be, or organized or holding themselves out as organized for the purpose of becoming, insurers. This type of language has been invoked to enable the appointment of receivers of entities that are not domiciled in any state (e.g., an alien excess or surplus lines insurer) and might not be licensed or authorized anywhere they transact the business of insurance. For purposes of the discussion in this chapter, we will employ the licensed/unlicensed (authorized/unauthorized, admitted/non-admitted) distinction, and will use the term "insurer" to describe the person or entity in receivership, notwithstanding the fact that there may be an issue whether the person or entity in fact was organized or authorized as an insurer.

A. Federal Bankruptcy vs. State Receivership

Whether an entity may be placed into bankruptcy or a state receivership depends upon whether the entity is determined to be an insurance company or its equivalent. The reason for this rule lies in Article I, Section 8 of the United States Constitution, which provides that Congress shall have exclusive authority to establish uniform laws on the subject of bankruptcies. The United States Bankruptcy Code, 11 U.S.C. § 101 *et seq*. (the Code), is national legislation applicable in all 50 states, the District of Columbia and the U.S. territories. It provides a comprehensive scheme for the resolution of individual and corporate insolvencies. The Code offers debtors four types of relief, but the three that are most likely to apply to the business of insurance are reorganization under Chapter 11, liquidation under Chapter 7, and injunctions and other relief in aid of a foreign proceeding under law relating to insolvency or adjustment of debt pursuant to Chapter 15.

Congress generally has precluded domestic and foreign insurance companies doing business in the United States from seeking relief under Chapters 7, 9, 11, 12 and 13 of the Code.[3] See 11 U.S.C. § 109(b)(2) and (3). However, foreign insurance companies doing business in the United States may seek relief under Chapter 15 of the Code, which is described in more detail in Chapter 9—Legal Considerations of this Handbook.

[3] Chapters 9, 12 and 13 govern adjustment of debts by composition, extension or discharge for municipalities, certain farmers and fishermen, and certain individuals.

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Determining whether an entity may be eligible to be a debtor under the Code, or whether an entity may be placed into a state insurance receivership, depends, in part, upon whether the entity is, or functions as, a "domestic" or "foreign" insurer. Most regulators distinguish between insurers on the basis of: (i) legal form of ownership (e.g., proprietary, cooperative, pools and associations, governmental and other); (ii) their place of incorporation (i.e., domestic, foreign and alien—see Section III.(C) of this Handbook on Alien Insurers in this chapter); (iii) their licensing status (i.e., licensed/admitted vs. unlicensed/nonadmitted); and (iv) the type of their product and service distribution systems (i.e., independent agency, exclusive agency, direct writer and mail order). See generally, Bernard L. Webb, et al., *Principles of Reinsurance Volume I* (1990).

The courts have not developed clear rules for ascertaining whether an entity is eligible for federal bankruptcy relief as opposed to state receivership proceedings. However, the courts have devised several tests for determining whether an entity is excluded from bankruptcy eligibility because it is an insurance company. See 2 *Collier on Bankruptcy*, § 109.03[3][b] (15th ed. rev.). The first test is the state classification test, which is the test favored by most courts. Under this test, the court looks at how the entity is classified under the law of the state in which it is organized. If the entity is classified as an insurance company under state law, the inquiry typically ends there. If the state law does not clearly classify the entity as an insurance company, the court will attempt to determine whether the entity is the substantive equivalent of an insurance company. In doing so, the court will look at the manner in which the entity is actually operated as well as the degree to which the entity is regulated by state law. The higher the degree of regulation, the more likely the courts are to find that Congress intended to exclude the entity from eligibility for relief under the Code. This approach is based, in part, on the recognition that Congress has codified its policy of leaving the regulation of the "business of insurance" to the states in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. See In re *Estate of Medcare HMO*, 998 F.2d 436 (7th Cir. 1993).

The second test is the independent classification test. Under this second test, courts limit their review to the language of the Code itself and, using traditional techniques of statutory construction, attempt to determine whether the entity is an insurance company that is excluded from being a debtor under the Code. See In re *Cash Currency Exchange, Inc*., 762 F.2d 542, 551-552 (7th Cir. 1985).

A third, less-utilized approach looks to congressional intent and public policy factors to determine whether state law provides an adequate scheme for reorganizing or liquidating the entity. If adequate relief is not available, the court may find that the entity is eligible for bankruptcy relief. See In re *Florida Brethren Homes, Inc*., 88 B.R. 445 (Bankr. S.D.Fla. 1988).

Some entities have sought the protection of a federal bankruptcy court either before or during the course of a state receivership. Under federal bankruptcy laws, the policyholders of the debtor would receive no priority and would be treated the same as other unsecured creditors. Unlike most state insurance insolvency laws, under the Bankruptcy Code many federal and state tax claims are given priority over unsecured creditors, including policyholders. This fact often provides impetus for the initiation by unsecured creditors of an involuntary bankruptcy action against an unlicensed insurer. Some state regulators have successfully challenged the federal bankruptcy proceedings of unlicensed insurers and obtained dismissals on the ground that the states have full jurisdiction over the liquidation of licensed and unlicensed insurance entities, and that the Bankruptcy Code specifically exempts insurance companies. However, a jurisdictional battle may ensue and could delay the receivers' efforts to gain control over the records, accounts and operations of the unlicensed insurer, leaving little or nothing to liquidate by the time the order is granted.

Even if the receiver is unsuccessful in challenging the federal bankruptcy proceeding, the receiver should consider continuing an earlier initiated receivership for the limited purposes of preserving its rights on appeal or enforcing its regulatory powers. Although the filing of a bankruptcy petition typically results in an automatic stay of most other legal action against the entity, there are exceptions to this rule. For example, the commencement of a bankruptcy action does not operate as a stay "of the commencement or

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continuation of an action or proceeding by a governmental unit to enforce such governmental unit's police or regulatory power; [or] … of the enforcement of a judgment, other than a monetary judgment, obtained in an action or proceeding of a governmental unit to enforce such governmental unit's police or regulatory power" (11 U.S.C. § 362(b)(4), (5)). Thus, the receivership may coexist with the bankruptcy estate so long as the receivership falls within these exceptions. The receiver should consult with legal counsel regarding how bankruptcy courts have addressed the circumstances of such situations.

B. Jurisdiction and Venue

Once the decision has been made to place an unlicensed entity into receivership, an appropriate jurisdiction (i.e., state, district or territory) must be chosen. Numerous questions arise: Should the domiciliary receivership be initiated in the state (i) in which most of the insurance policies were issued; (ii) in which most of the insurer's assets are located; (iii) where the company is physically located; or (iv) where the books and records are kept? The jurisdictional choice depends upon the relative weight of the facts discovered, as well as the strength of the statutory and regulatory framework in each of the potential jurisdictions. The potential receiver should determine whether a state's insurance regulatory authority has already taken some type of action against the entity, such as by issuance of an emergency cease and desist order, or some other type of administrative proceeding. If so, there will likely exist factual information gathered in preparation for that action, or during the course of discovery, that will assist in this determination. Another source that should be consulted is the consumer assistance bureau of the state insurance regulatory authority. Of course, a particular insurance regulator will likely not be able to put a company into receivership in any other state, but would be able to coordinate with other state regulators on these issues. Many times the issue is not which state, but whether the particular regulator's state is an appropriate jurisdiction to bring receivership proceedings.

C. No-Asset Estates

It is important to determine as early as possible if there are sufficient assets to operate a receivership. Most states' insurance statutes require that the costs and expenses of receiverships be paid out of the assets of the estates, including seized bank accounts. Generally, the receiver of an unlicensed insurer has to rely on the funds held in bank accounts to fund the receivership. Unlicensed insurers frequently have little or no money with which a receivership may be administered. In that case, some states' permanent receivership departments may absorb the regulatory costs of liquidating such entities through a variety of funding options. Consistent with many state statutes, MODEL #555 Section 116 provides for alternative funding in cases where the insurer does not have sufficient assets to pay expenses, either from funds advanced from an appropriation from the state's insurance department, or from a specific fund created for such a purpose. IRMA Section 804 (Alternative 1) provides a mechanism for using residual assets to fund low- or no-asset estates. In either event, the funds advanced are repayable from available monies of the insurer. In some instances, some special deputies or other consultants (e.g., those who have been contracted by the commissioner as receiver in past or current receivership proceedings) have accepted such no-asset receiverships on a *pro bono* or a contingency basis.

In the event that there are insufficient assets, the regulator may elect to forego receivership proceedings. If a receivership is not financially feasible, then the state may seek an injunction to put the unlicensed entity out of business. Frequently, commissioners or receivers discover that the unlicensed entities have moved money from their accounts to other corporate or personal accounts, and the only thing left for a commissioner or receiver to do is aid in any criminal prosecution.

In situations where the risk-bearing entity appears not to have sufficient assets in the jurisdiction, it may be useful to look to some of the ancillary actors. The investigation should include, for example, agents who sold the entity's plan and real or *de facto* third-party administrators who may be holding, processing or transmitting funds for the entity. Frequently, the unauthorized entity will use many such administrators located in various parts of the country. Just as frequently, the entity may use a succession of them. Once

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again, coordination with the state insurance regulators can be useful, as their investigation may have already determined the identity of some or all of those people and organizations.

D. Injunctive Relief, Criminal Prosecutions and Posting Security

In addition to the injunctive relief to protect assets, most states' insurance laws provide for permanent injunctions against the further transaction of insurance business. These laws often allow for actions to be initiated by state law enforcement agencies, including the attorney general and local prosecuting attorneys. The agencies also may become involved in prosecuting unlicensed insurers in criminal actions. Some states' statutes require that an unlicensed insurer post security for liquidation costs before the insurer may file any pleadings in judicial proceedings. This is an effective tool for a receiver to use to prevent frivolous actions which otherwise might exhaust an estate's limited assets.

E. State-Federal Cooperation

Some receivers have successfully coordinated their receivership activities with the activities of federal agencies. A few states have convinced certain agencies, including the Federal Bureau of Investigation (FBI), the Internal Revenue Service (IRS), the U.S. Postal Inspector, the U.S. Department of Labor and the U.S. Department of Justice, to initiate federal investigations into the activities of unlicensed insurers and suspected looters of insurance company assets. These investigations have resulted in the issuance of federal grand jury subpoenas to protect the integrity of books, records and documents originally seized by the receivers and to freeze assets which a receiver may not be able to seize in a cost-efficient or expeditious manner. Joint state/federal investigations are extremely important in obtaining criminal sanctions, forfeitures and restitution orders for those who operate as unlicensed insurers or who have looted insurance companies. It should be noted, however, that once federal or state law enforcement officials begin investigating potential crimes involving individuals related to the insurance company, they may exert control over a significant portion of the receivership's records.

Establishing a working relationship between the receiver and law enforcement officials early on is essential because the objectives of receivers and law enforcement officials are very different. The focus of law enforcement will be on the crime and conviction of the criminal, while the focus of the receiver will be on the recovery of assets for the benefit of the creditors. Good communication can overcome these divergent goals.

The receiver considering whether to approach or cooperate with law enforcement officials frequently must confront a number of issues. One issue is the effect that a criminal investigation/conviction may have upon the receiver's ability to recover, and the timing of recoveries, against the officers and directors of the insolvent insurer (specifically any directors and officers' liability insurance) and under reinsurance agreements. Criminal activity and fraud are frequently excluded from coverage by the applicable directors and officers' insurance policy that the receiver is attempting to reach, and this exclusion may be invoked to support a reinsurer's action for rescission of the reinsurance agreement.

Another issue is control of the insurer's books and records. Prosecutors frequently acquire such books and records by means of a grand jury subpoena or a search warrant. It may be difficult for the receiver to review or copy books and records obtained by such means. Similarly, a criminal investigation or proceeding may involve several enforcement agencies (Postal Inspector, FBI, IRS, and Department of Labor) and several jurisdictions. To the extent that the records are deemed essential to the receivership proceeding, the receiver should immediately attempt to negotiate an agreement to obtain access to and use of the records before relinquishing control over documents or other materials that the applicable authorities are seeking from the receiver. Unless there are strict controls on access to and removal of documents, the documents may be lost or difficult to retrieve. In such cases, the receiver may wish to negotiate and create and implement a file retrieval system. While it may be cost prohibitive in some instances, a receiver should also consider copying all applicable documents and establishing the appropriate chain of custody. Even if the receiver is successful in negotiating continuing access to

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documents, a receiver may have to address the access issue again if different federal agencies or different U.S. attorney offices become involved. Thus, maintaining a copy of the documents may be the best solution.

Overcoming these obstacles may be worthwhile because there are certain advantages to working with law enforcement officials. For example, one of the impediments to the collection of money judgments against culpable persons in multiple states is the fact that the receiver often must enforce its judgment in a foreign jurisdiction. This burden may be overcome by requesting the U.S. attorney, in conjunction with a criminal prosecution, to move for injunctive relief in a civil proceeding to "freeze" all known bank accounts and other assets of the principals and entities controlled by the principals who are the subject of the prosecution. Additionally, the receiver should consider that the federal authority, if convinced to do so, has the ability to freeze assets in multiple jurisdictions in a very expeditious manner. It could sometimes take a receiver weeks or months to freeze the same assets because they are outside of the receiver's jurisdiction, and the receiver may not have immediate access to the appropriate professionals needed to freeze assets in numerous jurisdictions. Thus, although the receiver may experience delay in ultimately recovering an asset because the federal government is involved, they may be able to secure assets for the benefit of the estate that may have been dissipated by the time the receiver was able to freeze them. In such cases the receiver should attempt to reach a written agreement with the prosecutor(s) that any money recovered as a result of the criminal prosecution, either through forfeiture, cooperation with the criminal or other means, will be transferred to the receiver, with all due credit given to the prosecutor. The receiver should be aware, however, that it may be necessary to go beyond the local U.S. attorney to secure the appropriate agreements for assets seized by the federal authorities. Agreements with a local U.S. attorney to deliver forfeited assets to the receiver may not be enforceable. In some instances, agreements to return forfeited assets must be approved by the appropriate division of the Department of Justice in Washington, D.C.

Even when a U.S. attorney who pursues assets at the behest of a receiver cannot forfeit those assets because the defendant claims that the assets recovered did not derive from the criminal enterprise, it is still of benefit to the receivership. This is true because the assets, once seized, are identified for the receiver and thus facilitate the receiver's assertion of a claim, lien or other legal hold on them, notwithstanding the alleged rights of other claimants. Thus, the receiver may be able to prevent a dissipation of the asset without having an opportunity to make a claim to it, which may not have been possible but for the seizure by the U.S. attorney.

Additionally, given the proliferation of unauthorized health insurers posing as ERISA-exempt plans, an extremely useful resource within the U.S. Department of Labor is the Employee Benefits Security Administration, previously known as the Pension & Welfare Benefits Administration (EBSA). Charged with the general oversight and enforcement of both the benefit and welfare plan provisions of ERISA, the EBSA has regional and local offices across the country.[4] The EBSA also has processes by which advisory opinions concerning multiple employer welfare arrangements (MEWAs)[5] may be requested. Utilizing that process can be of enormous assistance in overcoming jurisdictional objections to the commencement and continuation of a receivership.

[4] Employee Benefits Security Administration, previously known as the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210; www.dol.gov/ebsa/.

[5] Office of Regulations and Interpretations, Employee Benefits Security Administration, U.S. Department of Labor, Room N-5669, 200 Constitution Avenue, NW, Washington, D.C. 20210

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III. HOSPITAL AND MEDICAL SERVICE CORPORATIONS

A. Organization and Regulation

Hospital service corporations (such as traditional Blue Cross plans) and medical service corporations (such as traditional Blue Shield plans) do not fit neatly into any category of insurer (proprietary, cooperative, etc.). In some service areas, Blue Cross and Blue Shield are combined into a single plan, and other types of health plans, notably Delta Dental plans, might also be established under state nonprofit health plan laws. Also, many Blue Cross/Blue Shield plans are now organized as stock or mutual insurers and are fully subject to state insurance codes and are not within the scope of this section. This section addresses nonprofit non-stock corporations, often with charitable status, organized for the purpose of contracting with the public and with duly licensed hospitals, physicians, dentists and other health care providers for the provision of health care services to subscribers under the terms of their contracts with the corporation. Since the early 1940s, hospital service corporations have been joined together through reciprocal agreements to provide benefits for members who find themselves hospitalized away from home, to allow free transfer of membership between plans, and to facilitate enrolling national accounts.

B. Blue Cross/Blue Shield Plans

Each Blue Cross/Blue Shield Plan is independent of other Plans. There is no single Plan that operates on a nationwide basis. They have individual corporate names and have designated geographic areas in which they may conduct their operations. Some are statewide, while other Plans include only certain counties within the state or even a metropolitan area. Each Plan has its plan president and board of directors, frequently consisting of community representatives, hospital administrators, physicians and consumer groups. Under some state laws, a Plan is exempt from the payment of taxes and from the operation of the general insurance laws of the state; however, tax exemption may depend on whether the Plan is considered a nonprofit entity. Regulation is limited to those matters the legislature has deemed necessary for the adequate protection of members who subscribe for the services offered by such corporation. Thus, the great majority of Plans are subject to regulation by the insurance departments of various states to the extent that the state insurance department must approve the rates charged to the subscribers, the benefits, payments to hospitals and other contractual details.

The Blue Cross/Blue Shield Association acts as a national coordinating agency for all of the Plans. Headquartered in Chicago, the Association acts as spokesperson or agent for Plans in matters of national or regional concern. All Plans pay dues to the Association, which promulgates national policies, establishes performance standards and contracts for nationwide programs such as Medicare and the Federal Employees Benefit Program. Through the Association, several Plans have established an inner plan service benefit bank to act as a clearinghouse for administering subscriber benefits.

C. Receivership

The receivership of a hospital or medical service corporation is substantially similar to that of a standard health insurer, with the exception of the highly local nature of the insolvency. In the case of a Blue Cross/Blue Shield Plan, the receiver should be aware that the Blue Cross/Blue Shield Association controls the use of the Blue Cross/Blue Shield name and trademark. In addition to the usual claims-handling issues and lack of guaranty fund involvement[6], the most important considerations in the receivership of a hospital or medical service corporation can be insuring continued coverage and controlling the billing practices of the health service providers.

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[6] Model 520 excludes hospital and medical service organization, whether profit or non-profit, as member insurers of guaranty funds.

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IV. UNLICENSED INSURERS

Unlicensed insurers may be separated into two general but distinct categories. The first category consists of insurers or individual risk bearers who, while unlicensed in a state, have complied with that state's surplus lines or excess lines laws and are permitted to insure risks in that state, subject to the provisions of those laws. Such eligible surplus lines insurers may be incorporated or organized either under the laws of another U.S. jurisdiction ("foreign" insurers) or a non-U.S. jurisdiction ("alien" insurers).

The second category includes those entities (domestic, foreign or alien) engaged in the business of insurance or transacting insurance in a state where they are neither licensed nor deemed eligible as excess or surplus lines insurers. This category includes individuals, entities or corporations that may or may not be organized as "insurers" and that may or may not be operating legally. Such entities have included:

- Managing general agents
- Third-party administrators
- Marketing groups
- Servicing organizations
- Intermediaries
- Telemarketing firms
- Trusts
- Benefit funds

Note that some states impose personal liability against agents and other persons who place business with unlicensed insurers.

A. Eligible Surplus Lines Insurers

The terms "authorized" or "admitted" when used in conjunction with an insurer, mean an insurer that is licensed to transact business in the home state of the person, entity or risk to be insured. The terms "unauthorized" or "non-admitted" mean that the insurer is not licensed in the home state of the person, entity or risk to be insured. (For simplicity, "authorized" and "admitted" will both be referred to in this section as "admitted," and "unauthorized" and "non-admitted" will be referred to as "non-admitted.")

"Surplus lines insurance" is a mechanism that allows consumers to buy property-liability insurance from a non-admitted insurer when consumers are not able to obtain the coverage from authorized insurers. Under the surplus lines framework, certain non-admitted insurers are permitted to lawfully offer insurance in the state where the person or risk is located. The surplus lines regulatory framework differs from state to state, so the receiver must become conversant with the rules of the state where the insurer wrote on a surplus lines basis. There are, however, some basic principles that are common to all such frameworks:

1. The purpose is to provide access to insurance that is not readily available from admitted insurers
2. They use specially trained and licensed agents, brokers and surplus lines associations to assist those consumers
3. They establish systems of levying and collecting taxes on the transactions

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4. They authorize the state to establish who may insure risks on a surplus lines basis and the types of insurance they may offer

All surplus lines insurers must be licensed in their home jurisdiction, whether that is within the United States or elsewhere. An "eligible surplus lines insurer" is generally one which, although non-admitted in the state of the insured or the risk, has been determined by that state's regulator to be eligible to write certain categories of insurance in that state.

Surplus lines insurers generally are permitted to write three broad categories of risk that are not readily available in the marketplace: distressed risk, unique risk and high-capacity risk.

Distressed risk consists of exposures that are characterized by unfavorable underwriting characteristics, such as having sustained frequent losses in recent years.

Unique risk consists of unusual types of exposures, including those that do not neatly fit within existing policy forms. Another factor that may make a risk unique is insufficient, or no, loss experience. The latter factor makes it very difficult, and perhaps costly, to price an insurance policy.

High-capacity risk does not relate only to possible or probable claims frequency, but more generally to those sorts of risks that require very high limits, which may be beyond the capacity of the authorized market.[7]

Special rules may govern alien surplus lines insurers. As a condition of eligibility to transact business in a state as a surplus lines insurer, alien insurers are required to execute a trust indenture pursuant to which monies are deposited and maintained with a U.S. trustee bank. The NAIC has a Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers, in which Article 4 of the form governs insolvency proceedings. Most alien insurers have executed the NAIC indenture or similar agreements. A copy of current trust indentures can be obtained from the NAIC website at

https://content.naic.org/sites/default/files/inline-files/IID%20Trust%20Nov%2011%202022%20FINAL.pdf

Eligible surplus lines insurers are subject to the receivership laws of the U.S. jurisdiction in which they are domiciled. The insolvency of an alien insurer is usually triggered by the determination of its domicile regulating agency that it is insolvent. Liquidation proceedings may be commenced if the trust fund falls below a statutory minimum and is not replenished. In general, the insurance regulator in the U.S. jurisdiction in which the trust fund is maintained administers the insolvency proceedings. (Under IRMA, an alien insurer is considered to be domiciled in its "state of entry," and that domicile would undertake its liquidation in the U.S. (See IRMA, Section 104 (H) and 201 (A).)

The domiciliary regulator and the claimants of the company are the only entities to whom the trustee may transfer assets. The duties of the trustee and domiciliary regulator in prioritizing and paying claims are set forth in the indenture. The domiciliary regulator generally will seek a conservation order from a court that will enable the regulator to compel the trustee to pay over the corpus of the trust to the regulator. The domiciliary regulator then will administer the trust corpus for the benefit of those who otherwise would have been beneficiaries of the trust. Any assets remaining in the trust fund after all claims are paid should be transferred to the insurer or to its successor in interest. In some cases where an alien insurer has been placed in receivership in its domicile abroad, the U.S. domiciliary regulator, for reasons of economy, will enter into an agreement with the foreign receiver, whereby the domiciliary regulator will transfer the assets under that regulator's control to the foreign receiver upon being assured that the U.S. trust beneficiaries will receive no less from the foreign receiver than they would have received from the domiciliary regulator. Should the domiciliary regulator decide not to transfer the assets to the foreign

[7] Ibid, pg. 6.

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receiver, the domiciliary regulator will pay all claims in accordance with the priorities set forth in the trust indenture and any governing statute. Any assets remaining after all claims are paid then would be transferred to the foreign receiver.

As of this writing, with the exception of New Jersey, no U.S. jurisdiction has enacted laws providing guaranty fund coverage to policyholders or claimants of eligible surplus lines insurers.

B. MEWAs

A common problem encountered by receivers involves life, accident and health insurance operations ostensibly operating under ERISA as a multiple employer welfare arrangement (MEWA).[8] The purveyors of unauthorized health insurance plans operating as MEWAs routinely invoke ERISA to assert that state insurance codes are inapplicable to their operations, and therefore, that state insurance receiverships cannot be maintained. The receiver's involvement will often arise in the context of plans that claim the exemption, but which, in reality, are MEWAs or other regulated risk-bearing entities subject to state regulation. It is thus vital for the receiver to have a good working understanding of MEWAs and related entities, and how they fit within the context of dual state and federal regulation. Following the adoption of ERISA in 1974 (which had the effect of limiting a state's authority to regulate self-insured employer plans), there was a rapid expansion in the number of self-insured employee benefit plans covering the employees of more than one employer. These plans were then referred to as Multiple Employer Trusts (METs), and claimed exemption from state insurance laws under the preemption provisions of ERISA. State insurance officials viewed these uninsured METs as purely for-profit entities, which were intentionally drafted to fall within the regulatory vacuum created by ERISA. Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, state regulation of the arrangement would have been precluded by ERISA's preemption provisions. However, as a result of the 1983 MEWA amendments to ERISA, states are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan.

State Regulation of MEWAs. The NAIC has adopted the Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation, for the purpose of preventing the operation of illegal health insurers, including illegal MEWAs. In addition, approximately 20 states currently have special licensing laws for self-insured MEWAs that specifically address the solvency concerns of MEWAs. However, these state solvency standards are often weaker than those for traditional insurers. Some state licensing requirements for MEWAs might include:

(1) Surplus and reserve requirements for MEWAs, which are generally much lower than for traditional insurers;

(2) The mandatory purchase of Stop-Loss insurance by MEWAs, in order to protect against unexpectedly large claims or a high frequency of claims;

(3) The requirement that MEWAs file annual financial statements audited by a certified public accountant;

(4) The disclosure by MEWAs to their members that they do not participate in a guaranty association; and

(5) Rate filing requirements.

Even if a MEWA is subject to state licensure, they are exempt from state taxes on premiums and from assessments for state guaranty fund coverage. In addition, some state receivership laws either exclude MEWAs or are vague about the department's authority to assume control over a MEWA in liquidation.

[8] ERISA Section 3(40)(A); 29 USCA Section 1002 (40)(A).

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Without the ability to invoke a receivership, licensed MEWAs may be subject to bankruptcy statutes, which, unlike state receiverships, do not give priority to outstanding health insurance claims. Receivers must initially determine whether state rehabilitation and liquidation laws apply to MEWAs, whether they are specifically licensed or unlicensed. Even if state insolvency laws are not an option, there are informal procedures that state insurance departments can take to assist consumers in such cases. These include:

- Ongoing oversight of the MEWA's financial condition;
- Facilitating discussions with licensed insurance entities to provide coverage for the employees and their dependents; and
- Other strategies to assist employers in finding new coverage and reduce the amount of unpaid medical bills.

Federal Regulation of MEWAs. If an unlicensed entity is attempting to operate as a MEWA under ERISA, in addition to available state remedies, the commissioner should also contact the U.S. Department of Labor (DOL), which has expressed an interest in working with the states to regulate MEWAs. Federal assistance is desirable because a MEWA operating as an unlicensed insurer may also be noncompliant with federal regulations, and federal authorities may have remedies available that provide sources of recovery for the estate.

ERISA does not require MEWAs to be federally licensed, nor does it contain any federal solvency or other consumer protections, similar to those generally found in state insurance law. However, the DOL still may be concerned with the same issues as the state insurance departments. Forms filed with the DOL or the IRS may provide the insurance departments with needed information as to the scope of the operations of the various entities. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established an annual Form M-1 filing requirement for MEWAs. The DOL already may be conducting a review and may be able to provide additional staffing to process some of the necessary paperwork.

Illegal MEWA Schemes. State insurance receiverships of MEWAs, where statutes allow, are becoming more frequent, requiring broadened receiver knowledge and sophistication. Because such schemes can be by their nature unlawful, they are often attended by both manipulation and secreting of assets, thereby making forensic accounting resources increasingly important. The schemes often differ in nomenclature and sophistication, but enough commonality usually exists to permit some generalizations and rules to guide the analysis. For example:

(1) The plans will claim total exemption from state insurance regulation under ERISA.

(2) The only plan structure that is arguably exempt from direct state insurance regulation, including jurisdiction for a receivership, is one that is single-employer based and fully self-insured. That is, the plan can apply only to the employees and their dependents of a single employer, and covered claims must be payable solely from the funds of the employer.

(3) The plans are usually MEWAs, which in a minority of states continue to be referred to as METs. Most state insurance codes define the terms in the following way: *[A]n employee welfare benefit plan or other arrangement that is established or maintained to provide one or more of various insurance benefits (including health insurance) to the employees of two or more employers*.[9] By this definition, a MEWA cannot be a single-employer plan so as to exempt it from state insurance regulation.

(4) Although they may employ terminology such as "single-employer trust" to convey the aura of a single-employer-based plan, the reality is that there is usually an upstream migration and/or

[9] See, for example, Sections 624.436-624.446, Florida Statutes.

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commingling of money, consisting of employer and employee contributions, into the control of an entity that is not authorized in any jurisdiction as an insurer or as a MEWA, and which bears the financial risk of loss of covered claims.

(5) No individual employer, either by employer contribution or by the aggregate of employee contributions, is paying enough to fully self-insure the actuarially expected losses of the group during the period for which the contribution is made. Therefore, if claims are to be paid at all, they will be paid from a pool of funds comprised from the contributions of multiple employers or their employees. Invariably, that "pool" will not be authorized as an insurer or as a MEWA.

(6) ERISA also defines and recognizes MEWAs and has some application to certain kinds of them.[10]

(7) The interplay of (3) and (6) in this section results in concurrent state and federal regulatory authority over most employee benefit plans that are MEWAs.

(8) Special rules of preemption apply to MEWAs that meet the ERISA definition of a MEWA and that are also employee benefit plans:

i. If the plan is fully insured, the MEWA remains subject to state insurance laws that provide standards for the maintenance of specific levels of reserves and contributions so as to ensure the plan's ability to pay benefits when due, and to laws that enforce those standards.

ii. If the plan is not fully insured, the MEWA is subject to all state insurance laws that are not inconsistent with Title I of ERISA, unless it has been exempted from them by other regulations of the U.S. Department of Labor. If the MEWA has been so exempted, it is subject to state insurance regulation in the same manner and to the same extent as a fully insured MEWA.

iii. If the MEWA is not an employee benefit plan (that is, nothing more than a health insurance plan, sold to anyone, but using ERISA terminology), there is no preemption at all, and the plan is subject to complete regulation by the state insurance regulatory authority.

Perhaps the key to addressing issues related to so-called ERISA plans is that unless the plan is both single-employer-based and fully self-insured, it is subject to state insurance regulation either as an insurer or as a MEWA, and therefore is subject to state receivership proceedings. In brief, if the plan purports to provide, or does provide, benefits to two or more unrelated employers and their employees, it is subject to state insurance regulation, including state receivership proceedings. Likewise, if there is pooling of funds (contributions or otherwise) at any level, such that any entity other than a single employer is bearing the risk of loss as to covered claims, the plan is subject to state insurance regulation as an insurer or as a MEWA.

Entities Related to MEWAs. Union Plans are the one significant category of multi-employer plans that are not treated as MEWAs by ERISA and therefore are not subject to state regulation. Collectively bargained multi-employer plans are often confused with METs (multiple employer trusts), which are generally subject to state regulation as MEWAs. As a result, many illegal plans try to pass themselves off as bona fide collectively bargained plans. However, these plans must be recognized by the U.S. Department of Labor under strict standards that have been codified in regulations and, in most—if not all—states, the Department has not recognized any of the plans that have used this defense. The term MET is often used interchangeably with MEWA, along with the term VEBA. However, Voluntary Employee Beneficiary Associations ("VEBAs") are a creature of the Internal Revenue Code and are not an insurance or ERISA concept. Instead, a VEBA is merely a vehicle by which certain employee benefits, including health care benefits, can be funded. It is a tax-exempt (not regulatory-exempt) vehicle that

[10] 29 USCA 1002 (40)(A)

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allows an employer to deduct payments made to the VEBA to fund the payment of employee benefits. VEBAs, however, can be maintained for the employees of more than one employer in certain situations.

Plans maintained by employee leasing firms and Professional Employer Organizations ("PEOs") are generally found to be MEWAs, because the employees are usually determined by the DOL to be the employees of the participating employers, and not the PEO. Finally, to the extent that an insurer, a third-party administrator, or some other licensee of a state department of insurance is involved in or with the plan, the plan remains subject to "indirect" regulation because of the regulator's power over its direct licensee.

C. Alien Insurers

The receivership of unlicensed alien insurers presents special problems not encountered in other receiverships. An alien insurer is an insurer that is incorporated or organized in a jurisdiction that is not a state. See IRMA Section 104 (B) (definition of "alien insurer"). Preliminarily, IRMA provides that an alien insurer is considered to be domiciled in its "state of entry," and therefore that state's regulator would be responsible for insolvency proceedings regarding the insurer. See IRMA Section 104(H) (definition of "domiciliary state"). So while not necessarily admitted, an "unlicensed alien insurer" (meaning one that is not licensed in a particular state and is not eligible to write in that state as a surplus lines carrier) may still be considered "domiciled" in the state in which it initially began transacting business—at least for the purpose of a state's insurance insolvency act.

Often, alien insurers are not subject to adequate financial scrutiny or regulation in their alien jurisdiction, and their certificate of authority may not permit them to transact insurance in that jurisdiction. These facts, coupled with the stringent secrecy laws which prevent access to an alien insurer's corporate and financial information, make offshore locations an ideal haven for alien insurers with thin capitalization or other financial weakness.

When an unlicensed alien insurer is liquidated by its alien regulator for reasons of insolvency, the states in which it was transacting insurance may seek to establish an ancillary receivership. If the alien regulator refuses or fails to place the insurer into receivership, and the insurer is either transacting insurance in violation of a state's insurance laws or a state regulator has sufficient information to determine that the insurer is insolvent or not paying claims, then the state's regulator may petition its receivership court to appoint the regulator as receiver to protect the insureds in that state. Generally, the first state regulator to obtain a receivership order will take the lead in receivership matters over other state regulators that obtain later receivership orders. If a domiciliary receiver has already been appointed over an alien insurer (in the state of the alien insurer's entry), however, IRMA Section 1001(B) provides that another state's regulator may initiate an action against a foreign insurer only with the consent of the domiciliary receiver.

The receiver often encounters difficulty attempting to locate and marshal the unlicensed alien insurer's assets. This affects the receiver's ability to assess the potential to pay claims and administrative expenses. Usually, alien insurers maintain few or no assets in the states where they do business. Prior to placing an unlicensed alien insurer into receivership, the regulator may wish to investigate the insurer's assets, including real property, equipment and bank accounts. It is often difficult to identify and locate assets belonging to such insurers. Therefore, the receiver should immediately identify and locate all banks and financial institutions doing business with the unlicensed alien insurer and should serve the banks and financial institutions with certified copies of the receivership order as soon as possible to freeze the assets. Once the assets are frozen, it is unlikely that the insurer will be successful in attempting to dispose of or send the assets outside of the receiver's jurisdiction. Receivers often are unable to locate and marshal assets sufficient to administer the receivership, let alone to distribute assets to policyholders to pay claims.

Even if an alien insurer has executed the NAIC Standard Form Trust Agreement and purports to be an eligible surplus lines insurer, it may not have legitimate assets in trust for the payment of claims. The

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existence of a trust agreement may lead to a false sense of security for the receiver who really is dealing with an unlicensed insurer. Often, the bank that entered into the agreement did so without understanding the responsibilities it agreed to undertake on behalf of the insureds and upon which the regulators and insureds may have relied. Some unlicensed alien insurers open the requisite accounts in this country but only deposit worthless notes and stocks.

An unlicensed alien insurer's solvency or ability to pay claims may not be the only concern of regulators. Transacting insurance in a state without the proper certificate of authority or approval is often a criminal offense.

D. Unions

1. Organization and Regulation

ERISA preempts most state insurance laws as they relate to bona fide union-sponsored plans. Although such a plan may in fact afford health benefits to the employees and their dependents of multiple, unrelated employers, and hence be a MEWA, it is saved from state insurance regulation under ERISA language pertaining to "multi-employer plans."[11] A union sponsored plan will come within the exclusive jurisdiction of ERISA, however, only if the Secretary of the Department of Labor (Secretary) expressly finds that the plan was established and is maintained pursuant to a bona fide collective bargaining agreement. In the absence of such an express written finding, the plan is subject to state insurance regulation as a MEWA. The Secretary has never made such a finding on any of the union-sponsored plans in existence. Nonetheless, state insurance regulators have not routinely exercised authority over these union arrangements, at least if they are paying benefits exclusively to union members.

In recent years, however, bona fide unions have attempted to expand their membership by marketing health benefits to non-union members through "associate membership" programs. Unscrupulous entrepreneurs have also organized sham unions and marketed health benefits under the rubric of the sham union in an attempt to escape state regulation. Both instances have attracted greater scrutiny on the part of state regulators because participants/members have often been left with unpaid claims.

The DOL has responded by revisiting ERISA's preemption of state regulation in the context of union-sponsored plans. The DOL has issued proposed regulations which define the term "collective bargaining agreement" and limit participation of associate members in union-sponsored plans. The policy thrust of regulation by the DOL is that all arrangements marketing health benefits to the public are presumed subject to state regulation until the party proves that it is a bona fide union-sponsored plan and not a MEWA.

Similarly, many state insurance regulators have actively pursued these schemes. One of the best examples of state-federal partnership occurred in precisely this area. In a closely coordinated effort, the Florida Department of Insurance administratively terminated a Florida-based sham union health plan, and the following day, the Department of Labor obtained a temporary restraining order against the union, the plan, and all operatives, and the appointment of an Independent Fiduciary.

2. Receivership

The presiding U.S. District Court appoints an Independent Fiduciary to perform duties similar to those in an insurance receivership, including management of the entity, marshaling of assets and adjudication of claims. Periodic status reports are required by the court, including information on the actions of the Independent Fiduciary, the current financial position of the entity(ies), and the financial results for the period.

[11] ERISA Section 3(40)(A)(i)

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As there are no surplus requirements, there usually are limited assets available to discharge the obligations of the union and related welfare fund. Guaranty fund coverage is not afforded. ERISA requires specific notification of any amount denied on a claim, the reason for the denial, and the right of appeal by the member. The Department of Labor has historically required strict compliance with ERISA on this claim process. There is no specific language in ERISA that addresses liquidating distributions. Therefore, the required notification and right to appeal applies to liquidations as well as any ongoing claim processing. Liquidating distributions are typically on a pro rata basis for all obligations of the union and related welfare fund. The Independent Fiduciary generally prepares a plan of liquidation with the presiding court which sets forth the proof of claim process and proposed pro rata distribution.

E. Other Unlicensed Entities

The problem encountered by regulators and receivers are further compounded when the entity involved was not organized as an insurer, but is conducting business that is regulated as insurance. For ease of discussion, however, the term "insurer" again is used in this section to identify the entity.

Generally, a regulator faced with such an unlicensed entity must consider the following when deciding how to proceed: (i) will state regulatory action be effective in preventing further violations of state insurance laws; (ii) will receivership action through the courts be necessary to prevent further violations of state insurance laws; and (iii) should the activities of the unlicensed insurer be referred to state or federal law enforcement agencies for further investigation? The advantages of enforcing the receivership law and its provision for *ex parte* conservations may include: (i) the availability of a rapid procedure for injunctive relief and the seizure of records or assets without advance notice; and (ii) available assets may be used to pay policyholders and other creditors in an orderly manner.

Many practical problems arise once an illegal insurer is placed into receivership. Once the insurer has been placed in receivership and the proper financial analysis and accounting groundwork has been laid, the receiver may be able to pursue the personal assets of the principals. There also may be hidden assets or potential causes of action that are not readily apparent at the time a decision must be made with regard to appointing a receiver. The criteria for appointment in that case may be that the entity has enough known assets to fund a search for unknown assets or to prosecute a cause of action against owners, operators or related companies which might have received fraudulent transfers. Often, the search for a list of policyholders or potential claimants will continue after the appointment of a receiver. As discussed in earlier chapters of this handbook, receivers typically do not find a complete policyholder list or indications of potential claims at the entity's office upon takeover.

In cases where an alien insurer has been placed into receivership, it may be appropriate to bring other persons and entities into the receivership net. In some instances, the alien insurer contracted with individuals and entities to facilitate the transaction of insurance statewide. These individuals and entities may include premium finance companies, third-party administrators, managing general agents and management companies. In other instances, the alien insurer may have set up affiliates and other entities which share common control and ownership. These alter egos of the alien insurer often commingle their assets with those of the alien insurer in an attempt to hide assets from U.S. regulators. If the receiver believes that these other entities may have assets belonging to the alien insurer and can demonstrate that the entities appear to be alter egos of the insurer, then these other entities also may be placed into receivership (most likely conservation, to enable the receiver to investigate their books and records). Often, premium dollars are funneled through or remain in the accounts of the insurer's affiliates and alter ego entities; making it necessary to seize their assets as well. Once in receivership, immediate attention should be given to tracking the insurance premiums from the point of sale through these various other entities.

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IV. AGENTS

A. Managing General and Other Agents

1. Organization and Regulation

Managing general agents and other types of insurance producers may be subject to receivership laws because they have begun actually underwriting the business of insurance. In other words, they have begun to actually assume risks instead of merely acting as the agent or producer of business for the insurer. Under some states' laws, agents that have intentionally, or even inadvertently in some cases, begun assuming risks by not forwarding premiums to the actual underwriting insurer may fall within the definition of an "insurer." Accordingly, a commissioner may seek receivership of an agent under the same process as an insurer. The grounds for an agent receivership may be insolvency or some other violation of the insurance laws. The receivership statutes of the state in which the agent does business may apply to the agent in receivership.

2. Receivership

Generally, a commissioner will seek receivership of an agent to enjoin the agent's illegal activity (i.e., unauthorized issuance of policies) and to seize control of the agent's books, records and assets. The agent may have engaged in the unauthorized writing of insurance policies independently or on behalf of an insurer which had terminated his appointment. If the agent had apparent authority and premiums were collected, that insurer may be bound by the policies written by the agent even though the agent was not authorized to write such policies. The agent may also have written policies on illegitimate paper (i.e., a fictional insurer or unauthorized insurer) and collected premiums. The primary goals of an agent receivership are to prevent the continued operation of the agent's unauthorized business, to apply recovered assets to any claims under policies of insurance that are not the responsibility of any legitimate insurer, and, more generally, to protect the public.

If the books and records of the insurer are so commingled with those of the agent that to separate them would result in a hazardous situation to the policyholders, the court may order the agent into receivership simultaneously with the insurer. This may be done by substantively consolidating the estates of the agent and the insurer, or it may be done by merely administratively consolidating the handling of the two separate estates in one proceeding. In either case, this empowers the receiver to seize the records and assets of the agent. There are significant legal issues related to this situation, and these should be considered carefully.

The action of the court in placing an agent in receivership generally results in permanent revocation of the agent's license and a permanent injunction against the individual from engaging in the business of insurance. The receiver should cooperate with other state insurance departments, if requested, to establish accurate and supportable findings as a basis for revoking an agent's license for unauthorized insurance activity.

B. Title Agents

A title agent is a person or a corporation that is authorized to act as an agent of a licensed title insurer to solicit insurance, collect premiums, issue and countersign title insurance policies. In some states, the title agent owns or controls an abstract plant. An abstract plant is a facility that maintains real property records, typically by address as opposed to by grantor/grantee records. In some states, a title agent is also an escrow agent and in some states, a title and escrow agent is called an "underwritten title company." Title agents may be subject to laws and regulations specifically governing their operations.

Title agents typically accept, hold and disburse funds deposited by buyers and sellers, or persons acting on their behalf, in connection with real property transactions. The funds may be held in trust or in an escrow account.

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Under most state laws, a title agent is deemed to be in the business of insurance and is subject to receivership statutes. The purpose of receivership of a title agent is to protect the books and records, trust or escrow accounts, and other assets of the agent for the benefit of the creditors and perhaps especially, the escrow or trust depositors. Under state law, trust or escrow funds are under the control of the receiver, but they are not property of the receivership estate and thus they are not distributed pursuant to the priority statutes that apply to insurer insolvencies. Title agent insolvencies can create an immediate and heavy workload for a receiver because of the need to promptly handle escrowed funds and because of the time sensitivity of the transactions to which the funds pertain.

The grounds for receivership of a title agent typically include insolvency, based upon an examination of the escrow accounts, misappropriation of funds and/or unauthorized activity (e.g., the issuance of policies without appointment).

C. Reinsurance Intermediaries

Reinsurance intermediaries are brokers or agents in reinsurance transactions. In addition to the agency issues discussed above, the insolvency of a reinsurance intermediary raises the issue of who should bear the ultimate cost for the reinsurance intermediary's failure. The determination of this issue turns on a question of the law of agency, which most states have answered by statute, and by the terms of relevant reinsurance agreements in which the reinsurance intermediary is named. Those statutes have placed the risk of the insolvency of the intermediary upon the reinsurer. This is memorialized in the "intermediary clause," now required in every reinsurance contract, with respect to which the reinsured seeks statutory accounting credit.

Equally important is the issue of the proper forum for the liquidation of a reinsurance intermediary. This area of the law is largely undeveloped. The several courts which have addressed this issue suggest that the bankruptcy courts of the U.S. are the proper forum. However, the question becomes unclear when the reinsurance intermediary is a closely held or wholly owned subsidiary of an insurer which itself is in receivership.

D. Third-Party Administrators

1. Organization and Regulation

A third-party administrator (TPA) is any person or entity which receives or collects fees, charges or premiums for—or adjusts or settles claims on behalf of—an insurer. TPAs commonly provide such services to self-insured organizations. Over time, TPAs' services have expanded from claims adjudication and handling to that of full risk management services including cost control, auditing, litigation management and regulatory compliance. Some TPAs have also broadened their focus from health care and workers' compensation to property and casualty and professional liability.

Most states require that TPAs be licensed by the insurance commissioners and be subject to regulation by the states' insurance departments. Although some TPAs may also be subject to ERISA laws and supervision by the U.S. Department of Labor, this federal oversight is often ineffective. State insurance statutes usually require that TPAs apply for licensure, submit to examination by state commissioners, and hold all premiums in a fiduciary capacity separate and apart from their general operating funds.

2. Receivership

Commissioners may initiate receivership action against TPAs as a result of their unlawful insurance activities. TPAs are often found in the fray surrounding unlawful insurance activity. Sometimes the line between being an administrator operating on behalf of an insurer blurs when the TPA is performing the functions of an insurer without proper authorization or licensure. In these instances,

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the commissioner may choose to seize the TPA under the state's receivership laws in order to either stop the unlawful insurance business or to shut the TPA down completely.

Receivers are likely to encounter TPAs operating in conjunction with MEWAs, which may attempt to resist state regulation and/or receivership by asserting that they are only subject to federal ERISA statutes. The receiver may wish to contact the U.S. Department of Labor to determine if, in fact, the TPA or MEWA is in compliance with the federal ERISA laws. If the entity has failed to comply with ERISA statutes, then the states may have jurisdiction over the TPA and/or MEWA to initiate receivership action in the appropriate state court.

V. ALTERNATIVE RISK FINANCING MECHANISMS

A. Captive Insurance Companies

1. Organization and Regulation

An ordinary captive insurance company is a risk-financing method, or a form of self-insurance, involving the establishment of a subsidiary entity or of an association organized to procure insurance. Captive insurance companies are formed to serve the insurance needs of a given entity or organization. The insureds normally have a direct involvement and influence over the company's major operations, including underwriting, claims, management policy and investments, although in practice the company usually is managed by a captive manager or attorney-in-fact. Leaving aside special purpose financial captives[12] used in the issuance of insurance-linked securities, the common types of captive insurance companies are:

a. Pure Captive: An insurance company that insures only the property or risks of its parent and affiliated companies.

b. Association Captive: A captive insurance company established by members of an association to underwrite their own collective risks. An association captive usually only insures members of the sponsoring association.

c. Industrial Insured Captive: A captive insurance company that insures the property or risks of the industrial insureds that compose the industrial insured group, and their affiliated companies. An industrial insured is defined by statute, but commonly is one that has a full-time employee acting as an insurance manager or buyer and whose aggregate annual premiums for insurance on all risks total at least $25,000 and who has at least 25 full-time employees.

d. Rent-a-Captive: a rent-a-captive is an insurance company that, by contract with the participants, provides them the benefits of a captive insurance company without the capitalization requirements, administrative costs and legal ramifications associated with establishing and operating an insurance subsidiary. The contract may provide for return underwriting profits and investment income to a participant.

e. Sponsored Captive: A captive insurance company in which the minimum capital and surplus required by applicable law is provided by one or more sponsors, insures the property or risks of one or more participants, and segregates the assets and liabilities attributable to each insurance arrangement in one or more protected cells, sometimes called segregated accounts or segregated cells.

[12] E.g., S.C. Code § 38-90-410, *et seq.*

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A variety of U.S. jurisdictions, as well as some off-shore jurisdictions (such as Bermuda), allow a captive to form in a protected cell structure. In such a structure, a captive insurance company containing separate units or cells is formed with a general surplus and general assets. However, each cell has its own assets and liabilities and the cells are bankruptcy-remote from one another and from the general account—i.e., the assets of one cell cannot be used to satisfy the liabilities of another cell or of the host company.[13] The captive insurance company must generally report an insolvent cell to the state insurance department, usually within 10 days. Actual state laws are neither uniform nor clear as to whether an individual cell can be treated as a free-standing entity for the purpose of insolvency proceedings; however, the definition of persons subject to receivership should be sufficiently broad in most states as to encompass an insolvent cell. The receiver, however, will be obligated to respect the separate nature of the cells.[14] Consequently, it is possible that a policyholder creditor of a given protected cell could receive a 100% distribution while the creditors of other cells or the general creditors of the captive do not. It is clear that the captive insurance company itself is subject to conventional insolvency proceedings.

2. Receivership

Domestic captives are subject to most states' receivership laws. Arguably, off-shore captives also are subject to state receivership statutes when such companies transact insurance business within the state without being properly licensed or authorized under the applicable insurance laws. However, there presently is no guaranty fund protection for insureds of captive insurance companies.

It is possible that captive insurers that are formed under the laws of a tax haven jurisdiction may be subject to the insolvency proceedings in that jurisdiction. As of this writing, the law regarding whether such proceedings can be recognized in the United States if the insurer lacks operations in the tax haven jurisdiction is open to question.

B. Risk Retention Groups

1. Organization and Regulation

A risk retention group is a company which insures similar companies with similar risks and operates nationally without having to be licensed in each state. Generally, every member or company must be insured by the risk retention group, and every insured must be a member of the group. A risk retention group is sometimes formed as a captive insurer in the domiciliary state. The federal Liability Risk Retention Act of 1986 also allowed for purchasing groups that purchase products liability, or completed operations, liability insurance.

Risk retention groups originally were intended to provide insurance to common groups of professionals (e.g., attorneys, bankers, accountants) nationwide without having to comply with each state's licensing requirements. Risk retention groups now cover a gamut of risks, including taxis, limousines and commercial autos, and other commercial liability types of risk.

Risk-retention groups organized or licensed in one state must register to transact business in other states. The risk retention groups are required to comply with the laws of the domiciliary state and certain laws of other states in which they transact business, including their insolvency laws, to the extent permitted by 15 U.S.C. § 3902(a)(1). The requirements for licensing (obtaining a certificate of authority) a risk retention group are less onerous than those for other domestic insurers. For a full discussion on risk retention groups, the NAIC *Risk Retention and Purchasing Group Handbook* is available from the NAIC Publications Department at www.naic.org.

[13] *Accord* NAIC Protected Cell Company IRLMA § 6.
[14] *Accord* NAIC Protected Cell Company IRLMA § 7.

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2. Receivership

A domestic risk retention group is subject to that state's receivership statutes. If there is a challenge to the state's jurisdiction over a foreign entity, a state receiver may be required to initiate regulatory or receivership action against a foreign risk retention group in federal court. Particular attention should be paid to access to records of the risk retention group and issues that may arise with the captive manager. Finally, insureds of risk retention groups are not protected by guaranty funds and are prohibited by federal law from participating in a guaranty association.

C. Group Workers' Compensation Pools

1. Organization and Regulation

A Group Workers' Compensation Pool (GWCP) or group self-insurer is a risk-bearing entity which is permitted to bear workers' compensation risks without being organized as an insurance company. These entities are allowed in a few states. The GWCP must be sponsored by a trade association in most states and must insure a homogeneous group of workers' compensation insureds. A pool administrator or an attorney-in-fact sets up the GWCP as a trust and administers the entity. Typically, the GWCP provides group self-insurance or coverage through an indemnity agreement supported by joint and several liability of the members. GWCPs must prepare and file financial reports with their domiciliary state insurance commissioner or other regulatory agency and be audited annually by a certified public accountant.

2. Receivership

The receivership of a GWCP often is handled like that of any licensed insurer or unlicensed company. One state currently requires its Industrial Commission to administer a prefunded guaranty fund to protect GWCP insureds, thus evidencing the fact that, at least in that state, the GWCP is subject to the state's receivership laws. Some GWCPs are covered by guaranty funds, but the assessment, capacity and guaranty cover of the funds vary. A guaranty fund may be given the authority by statute to require the assessment by one financially impaired workers' compensation pool of that pool's participating employers. Alternatively, the guaranty fund would have to assess all of the pools in the fund to cover claims of an insolvent pool. This arrangement gives the fund incentive to require member pools to assess their own participants to avoid an insolvency.

D. Service Warranty/Extended Warranties

1. Organization and Regulation

A Service Warranty/Extended Warranty Entity is a risk-bearing entity which provides/ administers service warranties and/or extended warranties. The products can be supported by traditional insurance (Contractual Liability Insurance Policy, or CLIP) or the entity is required in those states providing for regulation to maintain reserves and otherwise file quarterly and annual reports with the department of insurance.

2. Receivership

A Service Warranty/Extended Warranty Entity in a few states, such as Florida, is subject to receivership statutes. Otherwise, bankruptcy or other receivership action may be required. Finally, service warranty/extended warranty products are typically not protected by guaranty funds but may be covered by surety bonds or the coverage provided by CLIPs.

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VI. MULTISTATE RECEIVERSHIPS

While this handbook generally assumes that receiverships are conducted in the insurer's state of domicile, in many to most cases insurers placed into rehabilitation or liquidation will have assets located, and creditors residing, in multiple jurisdictions. Note that the term "cross-border receiverships" generally will reference receiverships with issues in several countries, which will be addressed in the next section.

How the administration of a particular troubled insurance or reinsurance company will be affected by these multistate issues depends upon several factors. These include a) the insurer receivership law where the company is domiciled; b) the insurer receivership law in the states in which the company wrote business, held assets or incurred claims; and c) whether these states required the insurer to post special deposits. Several insurer receivership law models have been created to coordinate issues arising in multistate receiverships.

The earliest of these models is the Uniform Insurer's Liquidation Act (UILA), which was adopted by the NAIC as its insurer receivership model law in the 1930s. Created as a result of many insurers failing during the Great Depression, the UILA was designed for the specific purpose of solving certain problems inherent in multistate receiverships. Chief among these problems was that states would seize any assets found within their borders and apply those assets to the claims of residents of that state only. At that time, very few states had statutory insurer receivership laws, and the matters proceeded as equity receiverships in state courts whose jurisdiction was limited by that state's borders. This resulted in widely disproportionate levels of payment of claims and extravagant administrative expenses. The insurance receivership laws in most if not all states can trace their roots to the UILA.[15] In many states, later insurer receivership models were adopted, but the UILA was not repealed. In many other states these provisions were adopted because they were incorporated in the Interstate Relations sections of the NAIC's Insurers Rehabilitation and Liquidation Model Act (the IRLMA). The IRLMA was first adopted by the NAIC in 1968 and was amended several times prior to being replaced by IRMA in 2005. Most states have enacted receivership laws based upon the IRLMA. These acts define the relative rights and responsibilities of state insurance commissioners in their capacities as both domiciliary and ancillary receivers of insolvent insurers.

A. Uniform Insurer's Liquidation Act (UILA)

Under the UILA, the receivership or insolvency proceeding is referred to as a "delinquency proceeding," and defined as "any proceeding commenced against an insurer for the purpose of liquidating, rehabilitating or conserving" a delinquent insurer. The UILA designates the various states that may be involved in any given delinquency proceeding as follows:

- Domiciliary State—The state in which the insurance company is incorporated or organized. If the insurer is incorporated or organized in a foreign country, then the domiciliary state is deemed to be the state in which the insurance company has, at the beginning of the delinquency proceedings, "the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States." The domiciliary state is deemed to be the primary location for the delinquency proceedings.

- Ancillary State—Any state other than a domiciliary state. Ancillary states are those states where ancillary proceedings (i.e., receivership proceedings parallel to those of the domiciliary state) may be instituted. Generally, an ancillary may be instituted in any state where assets of the insurer are located.

- Reciprocal State—Any state that has enacted provisions which are similar in substance and effect to the provisions of the UILA, which: a) state that only the regulator can be appointed as the receiver of an insurer; b) provide for the treatment of voidable preferential and fraudulent

[15] Note that the UILA was withdrawn from recommendation for enactment by the National Conference of Commissioners on Uniform State Laws in 1981 due to it being obsolete.

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transfers; c) provide for the treatment of ancillary proceedings by the domiciliary state; and d) provide for the treatment of claimants residing in other-than-domiciliary states. [16]

The UILA defines certain types of assets and claims involved in delinquency proceedings. "General assets" are defined as "all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons." Assets located or situated in a state other than the domiciliary state are not exempt from classification as general assets by virtue of their location. Assets held in trust or on deposit in an ancillary state for the benefit of all of the insolvent insurer's policyholders are deemed to be general assets. Similarly, reinsurance proceeds typically are deemed to be general assets.

"Special deposit claims" are defined as any claims that have been secured by a deposit made pursuant to a statute for the security or benefit of a limited class of persons. Most states' statutes are designed to protect state residents against foreign insurance companies, and some states require that an insurance or reinsurance company post funds with the state in the form of a "special" or "statutory deposit" before being allowed to do business in that state. The special or statutory deposits can take the form of bonds, trust accounts, escrow accounts, letters of credit, cash or any other form of security approved or required by the state. The states usually require funds sufficient to cover all potential outstanding policyholder (and in some states, general creditor) claims against the insurance company by the residents of that state. In some states, the amount and form of the deposit depend upon the type of insurer involved and the type of insurance risk underwritten.

The UILA has created a framework for simultaneous receivership proceedings in different states with respect to a single insurer. It outlines procedures for delinquency proceedings for both domiciliary and non-domiciliary insurance companies, as well as the duties and responsibilities of the domiciliary and ancillary receivers. The UILA also sets forth provisions governing the filing and proving of claims, priority of creditors' claims, special deposits, and the attachment and garnishment of assets. Overall, these provisions centralize the delinquency proceedings by vesting power in a single domiciliary receiver.

1. Domiciliary and Ancillary Receivers

Once delinquency proceedings are initiated in the state where an insolvent or delinquent company is domiciled, the UILA provides that the court shall designate that state's commissioner of insurance as the domiciliary receiver. Most states have specific requirements for the appointment of a receiver.

Some courts have held that an ancillary receiver cannot be appointed until after a domiciliary receiver has been appointed unless certain steps are taken. Generally, the commissioner of insurance may petition the court for appointment of an ancillary receiver (i) if there are "sufficient" assets of the company located in the ancillary state to justify the appointment of an ancillary receiver, or (ii) if 10 or more state residents petition the commissioner requesting an ancillary receiver. When appropriate, the court appoints the insurance commissioner of the state as ancillary receiver.

Upon appointment of a domiciliary receiver, the court "directs the receiver to take possession of the insurer's assets and administer them." Most states have statutes outlining the specific powers and duties of the receiver as supervisor, conservator, rehabilitator, or liquidator of the delinquent company. In addition, the UILA vests the domiciliary receiver (and successors) with title to all property, contracts and rights of action of the delinquent company, wherever situated, as of the date of

[16] If each state enacted the uniform law, the National Conference of Commissioners on Uniform State Laws reasoned, past embarrassments could be remedied by the following: (1) provision that the insurance commissioner or an equivalent official shall serve as receiver; (2) authority for domiciliary receivers to proceed in non-domiciliary states so as to prevent dissipation of assets therein; (3) vesting of title to assets in the domiciliary receiver; (4) provision for non-domiciliary creditors to have the option to proceed with claims before local ancillary receivers; (5) uniform application of the laws of the domiciliary state to the allowance of preferences among claims; and (6) prevention of preferences for diligent non-domiciliary creditors with advance information. Prefatory Note, Uniform Insurers Liquidation Act, 13 U.L.A. 322 (1986) (superseded).

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entry of an order giving the receiver possession of the company. Upon taking possession of the assets, the domiciliary receiver must proceed to liquidate, rehabilitate, reorganize or conserve the company. Typically, the domiciliary receiver has sole responsibility to operate the delinquent company, to make policy decisions concerning the conduct of the delinquency proceedings, and to create a plan for administration of the company.

If an ancillary receiver is appointed in a reciprocal state, the UILA provides that the ancillary receiver has the same rights and powers regarding assets located in the ancillary state as the domiciliary state would grant to its own ancillary receivers. In addition, the ancillary receiver is deemed to have the sole right to recover assets of the company located in the ancillary state.

The ancillary receiver appointed under the UILA "as soon as is practicable" liquidates from assets in the receiver's possession those special deposit claims and secured claims which are proven and allowed in the ancillary proceedings. Any and all remaining assets of the company then are to be promptly transferred to the domiciliary receiver.

2. Claims, Special Deposits and Priorities

Once receivers are appointed in the domiciliary and ancillary states, the focus of the UILA shifts to the processing and payment of claims. In particular, the UILA provides for the filing of claims generally, the payment of claims out of specially deposited assets, and the relative priority of claimants in the payment process.

a. Filing Claims

Claimants residing in reciprocal states may bring claims against the delinquent company in either the domiciliary proceeding or in an ancillary proceeding in their own states. If ancillary proceedings have not been commenced, a claim against a company in delinquency proceedings must be presented in the domiciliary proceedings. If the claims are controverted, and the ancillary forum is chosen for resolution of those claims, proper notice of the disputed claims must be given to the domiciliary receiver. If such notice is given, the final judgment as to the controverted claim will be conclusive as to amount and perhaps priority in both the ancillary and domiciliary proceedings.

b. Special Deposits

Under the UILA, claimants of a state are given priority against special deposit funds held for their benefit, according to that state's statutes. If the special deposit claims have not been fully paid after all special deposit funds have been fully exhausted, the special deposit claimants may share in the general assets of the company. However, in order to assure equal treatment of all of the delinquent company's creditors, the special deposit claimants who have received a distribution from special deposit funds cannot share in general assets until "general creditors, and claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit."

c. Priority of Preferred Claims

Pursuant to UILA, the preference or priority scheme of the domiciliary state determines which claims will be deemed preferred, regardless of where claims are brought. The priority provisions of the UILA, however, do not replace other principles generally applicable to the payment of claims.

3. Problems Under the UILA

Certain problems have arisen over the years in applying the UILA to multistate delinquency proceedings. Some of these problems have arisen from disputes over the scope of injunctions or stay orders issued by receivers, proper timing of claims, and enforcement of judgments against the

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delinquent company. Other problems have arisen where a nonreciprocal state—a state which has not enacted the UILA—is involved in the delinquency proceedings. The UILA does not address this problem, and courts have struggled to fashion equitable resolutions for the states involved. Most often, courts have held that UILA states have no duty to apply the principles of the UILA with regard to nonreciprocal states.

The UILA has several other "gaps" that have caused difficulties over the years. The UILA does not address the right of a commissioner in an ancillary state to initiate delinquency proceedings in the ancillary state in the event that delinquency proceedings are not initiated in the domiciliary state. Also, the UILA contains no provision governing a domiciliary receiver's remedies in the event that an ancillary receiver refuses to cooperate with the domiciliary receiver in the collection and distribution of assets.

Some of these problems have been addressed in the IRLMA.

B. The Insurers Rehabilitation and Liquidation Model Act (IRLMA)

The IRLMA contains provisions governing all aspects of insurance company receivership regulation in the United States with regard to conservation, rehabilitation and liquidation, including provisions governing multistate proceedings. With respect to multi-jurisdiction receivership, the goals of the IRLMA are to provide improved methods for the rehabilitation of insurers; to make the liquidation process more efficient and economical; to facilitate interstate cooperation in the rehabilitation and liquidation of insurers; and to protect the interests of policyholders, claimants and creditors.

1. Structure of the IRLMA

Ten sections (54-63) of the IRLMA adopt much of the UILA, as well as its policy objective: centralization of delinquency proceedings in the domiciliary jurisdiction. Unlike the UILA, however, the IRLMA no longer refers to the insolvency proceedings as a "delinquency proceeding." Rather, the IRLMA distinguishes between conservation and "formal proceedings," i.e., rehabilitation and liquidation. States are considered reciprocal under the IRLMA if each has enacted the substance and effect of Sections 5 (Injunctions and Orders), 17 (Rehabilitation Orders), 20 (Liquidation Orders) and six of the "Interstate Relations" sections (i.e., 54-56 and 58-60).

2. Domiciliary and Ancillary Receivers

The grounds for appointment of a domiciliary receiver under the IRLMA parallel those in the UILA, i.e., the same grounds for rehabilitation or liquidation set forth in Section 15 of the IRLMA. The two acts differ, however, as to the grounds for appointment of ancillary receivers. The UILA enables the state commissioner to petition for appointment as an ancillary receiver if there are sufficient assets in the state to warrant such action, or if 10 or more residents with claims against the company petition for the appointment of an ancillary receiver. Under the IRLMA, proceedings may be initiated if: (i) there are sufficient assets in the state to justify the appointment of an ancillary receiver; (ii) "the protection of creditors or policyholders in [the ancillary] state so requires"; or (iii) the domiciliary receiver requests such a filing. The ancillary receiver of an insurer domiciled in a reciprocal state may render only such assistance as the domiciliary receiver requests, and has the same powers and duties as the domiciliary receiver when so requested. The ancillary receiver is entitled to payment of his or her costs or expenses, and may enter into agreements with the domiciliary receiver regarding the payment or advancement of such expenses.

3. Receivers of Foreign and Alien Insurers

The IRLMA distinguishes between foreign (those from any other U.S. state, district or territory) and alien (those from another country) insurers. If grounds exist for the commencement of delinquency proceedings against a foreign or alien insurer (i.e., those set forth in Section 15, as well as official

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sequestration of the insurer's property in its domicile, or revocation of the insurer's certificate of authority while residents of the state have outstanding policies or claims) and no domiciliary receiver has been appointed, the IRLMA enables the state commissioner to petition the designated court for appointment as conservator of the insurer's property found in the conservator's state. Under a state court order, the commissioner, as receiver, may conserve (but not liquidate) the assets of an alien insurer that has not established a domicile in the U.S. (but not those of a foreign insurer) found in the state.

4. Receiver's Control Over Assets

Like the UILA, the appointment of a receiver vests the receiver with title to all of the insurer's assets, by operation of law. Under both the IRLMA and the UILA, a receivership is established in which the domiciliary receiver is directed to administer the insurer's assets under the general supervision of the receivership court. However, the IRLMA requires that the receiver provide periodic accountings to the supervising court.

With respect to assets, the IRLMA distinguishes between a domiciliary liquidator appointed in a reciprocal state and one appointed in a non-reciprocal state. A domiciliary liquidator appointed in a reciprocal state is vested with title to, and has the immediate right to recover, all assets in all reciprocal states—except for special deposits and the security on secured claims—upon the filing of the petition for liquidation. However, when a domiciliary liquidator is appointed in a non-reciprocal state, the commissioner of the non-reciprocal ancillary state is vested with title to all of the assets situated in that state and may petition for a conservation order or for an ancillary receivership or transfer such assets to the domiciliary liquidator after obtaining court approval.

5. Claims

The IRLMA and the UILA treat the filing of claims differently. Under the IRLMA, creditors of an insurer under liquidation in a reciprocal state must file their claims in the domiciliary proceeding, subject to its deadlines. However, while the UILA is silent as to the rights of residents in non-reciprocal states to file claims with an ancillary receiver, the IRLMA specifically allows such claimants to file their claims with either the domiciliary liquidator or the ancillary receiver, if the domiciliary state's law permits. Similarly, under the IRLMA, nonresident creditors of an insurer in liquidation in its domiciliary state must file their claims with the domiciliary receiver, subject to the domiciliary state's deadlines. In some states, the in-state residents, including policyholders and general creditors, have a lien on the deposits. The receiver should review the applicable state statutes under which the deposits were created.

The IRLMA also now differs from the UILA in its treatment of controverted claims. Under the IRLMA, controverted claims must be proved and decided in the domiciliary state unless the claimant notifies the domiciliary liquidator in writing that it elects to proceed in the claimant's respective reciprocal state's ancillary receivership. The ancillary court's determination of such a controverted claim is conclusive as to validity and amount, but priority of distribution shall be determined in the domiciliary proceeding. The claimant also may controvert its claim in the domiciliary proceeding.

Secured claimants may surrender their security and file their claims as general creditors, or they can resort to the security and make a claim for any deficiency on the same basis as unsecured creditors in the same class.

The IRLMA now differs significantly from the UILA in the handling of special or statutory deposit claims. Upon the entry of a final order of liquidation or an order approving a rehabilitation plan of an insurer domiciled in the state or a reciprocal state, all deposits must be delivered to the domiciliary liquidator to be held as a general asset for the benefit of all creditors and distributed in accordance with the domiciliary state's law.

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6. Priority of Distribution

Under the IRLMA, general assets are distributed in accordance with the domiciliary state's priority of distribution scheme. The IRLMA was drafted so that the determination of priority by an ancillary liquidator and court is not binding upon the domiciliary liquidator. The IRLMA encourages interstate cooperation by penalizing claimants residing in states if their ancillary receiver fails to transfer any assets to the domiciliary receiver. The claims filed in the ancillary proceeding other than special deposits or secured claims are subordinated to the next-to-last class of claims under the priority of distribution schedule.[17] The UILA contains no similar penalty provisions.

C. Insurers Receivership Model Act (#555, IRMA)

The *Insurers Receivership Model Act*, (#555), commonly known as IRMA, was adopted by the NAIC in December 2005 to replace the earlier IRLMA. There are several areas of change between IRMA and the IRLMA, but probably the subject of the greatest change was interstate relations. Article X deals with this subject in only two sections as compared to 11 in the 1998 version of the IRLMA. Under IRMA, the authority and responsibility for administering the estate of an insolvent insurer is placed on the domiciliary receiver. If a domiciliary receiver has been appointed, an ancillary receivership may be initiated only with the consent of the domiciliary receiver (IRMA Section 1001B).

Prior to the appointment of a domiciliary receiver, any commissioner in any state may petition to be appointed as conservator of the assets of a foreign insurer that are located in that commissioner's state: 1) on the same grounds as would justify the appointment of a receiver in that state; 2) if any of its assets have been seized by official action in another state; 3) if its certificate of authority in the commissioner's state has been revoked and there are residents with unpaid claims or in-force policies; or 4) if it is necessary to enforce a stay under the state's guaranty association laws (IRMA Section 1001A).

An ancillary conservator may use assets of the insurer to pay the costs of administering the estate (IRMA Section 1001E). Once a domiciliary receiver is appointed, the conservator shall turn over all property of the estate to the receiver (IRMA Section 1001D). An ancillary liquidation order can only be issued for the purpose of liquidating assets to pay the administrative costs of the ancillary receivership or to activate the guaranty association in the ancillary state (IRMA Section 1001F).

With the exception of special or statutory deposits established with the state's guaranty association as the sole beneficiary, IRMA provides that the assets of an insurer belong to the domiciliary receiver. The domiciliary receiver is entitled to take possession of those assets (IRMA Section 1002A). Upon the entry of a liquidation order with a finding of insolvency, those special deposits are to be distributed to the guaranty associations as early access (IRMA Section 1002A). All other deposits are to be returned to the domiciliary receiver, who is obligated to administer them in accordance with the law under which they were created (IRMA Section 1002B). Special deposit claims are to be adjudicated and paid by the domiciliary receiver. If the special deposit is insufficient to pay all special deposit claims in full, special deposit claimants may share with other claimants in their priority class, but only after all others of the same class have been paid a percentage of their claims equal to the percentage that the special deposit claimants have received. (IRMA Section 1002C).

IRMA makes all states reciprocal states to the enacting state and directs that all receivership orders and related orders in another state are to be given full faith and credit by the courts of the enacting state (IRMA Section 1002A). This provision is to ensure that stay orders issued in relation to a receivership are honored by the courts in other states.

Reciprocity can be an issue in IRMA. While IRMA provides that a state adopting it would consider all other states reciprocal to that state, the other states may require allowance of their ancillary proceedings

[17] IRLMA § 58

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(which IRMA would not allow) for these other states to consider the IRMA-adopting state to be reciprocal to them. This may be remedied by a state adopting IRMA if it adds a provision for transitioning on reciprocity. Some suggested wording for this follows: "Notwithstanding any other provision of this Act, only to the extent necessary while other states are in the process of adopting Acts similar to this Act, the receivership court may allow for the treatment of ancillary proceedings reciprocal to the laws of any state providing for ancillary proceedings."

NAIC Guideline for Definition of Reciprocal State in Receivership Laws (#1985)

In 2021, the NAIC adopted the *Guideline for Definition of Reciprocal State in Receivership Laws* (#1985) to provide a statutory definition that may be used by state with a reciprocity requirement to effectuate the purposes of the following provisions, which in may states may only apply if the domiciliary state is a reciprocal state.

- The domiciliary receiver is vested with the title to the insurer's assets in the state.
- Attachments, garnishments or levies against the insurer or its assets are prohibited.
- Actions against the insurer and its insureds are stayed for a specified period of time.

The definition provided in Guideline #1985 states that: "Reciprocal state" means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state's insurance commissioner or comparable insurance regulatory official.

Under this definition, any state meeting the applicable Part A standards of the NAIC Financial Regulation Standards and Accreditation Program for state receivership laws will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws and should prevent unnecessary litigation regarding the recognition of a state as a reciprocal state.

Note that Guideline #1985 was adopted to address concerns with reciprocity under IRMA, as noted above, and is available for states to adopt if not already addressed through state statues or other means.

VII. INTERNATIONAL RECEIVERSHIPS

Due to the continued globalization of the insurance industry, insurance companies often may have assets, creditors and debtors located around the world. Therefore, the receiver of a domestic insurance company may be forced to address numerous legal, strategic, practical and political issues related to cross-border insolvencies.

When the insolvent domestic insurer has assets located in a foreign country, the receiver should consult with his or her professional advisors to determine how to administer those assets. Issues to consider include: (1) whether the domestic insurer can repatriate the assets without incurring unacceptable legal risk or significant expense; (2) whether the insurer (or the domestic receiver as legal representative of the insurer), the insurer's creditors, or a foreign regulator can initiate separate insolvency proceedings to ensure the orderly administration of the assets located in the foreign country; and (3) whether the domestic receiver can be granted relief from a foreign court in aid of the domestic receivership proceeding in the form of injunctions, stays, or other relief to prevent creditors from attaching the assets or commencing litigation against the insolvent insurer in the foreign jurisdiction. Additionally, where the insolvent domestic insurer's assets have been commingled with affiliates incorporated in foreign countries, the receiver should consult with his or her professional advisors to ascertain whether it would be possible and prudent to attempt to substantively consolidate the assets and liabilities of foreign entities into the domestic receivership estate, or other available mechanisms for achieving the same result.

When the estate has a claim against an entity that is the subject of foreign insolvency proceedings (such as a reinsurer, retrocessionaire or policyholder with retrospectively related premium or high deductible obligations), the receiver will be confronted with a different set of considerations with respect to the pursuit of its claim. The

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location of the entity's assets and the nature of the insolvency proceedings will be of significant importance. If all of the entity's assets are located in the foreign country, the receiver will need to consider the degree to which the receiver is willing to commit financial and personnel resources to participating in the foreign insolvency proceeding and the risks associated with submitting to the jurisdiction of the foreign court. Levels of participation can range from merely presenting claims in accordance with the foreign court's procedures to contesting the basis for the insolvency proceedings, and the specifics of the relief sought by the entity in the foreign court. If the entity has assets in the United States, the receiver may consider additional options, such as attaching the assets and contesting any relief sought by the entity in the United States in aid of the foreign proceedings.

Insolvency proceedings in foreign countries come in a variety of flavors. This is intended to be neither a comprehensive list nor comprehensive descriptions of the various proceedings. The Common Law jurisdictions in the English tradition (e.g., Bermuda and the United Kingdom) recognize reorganization of both solvent and insolvent companies. Typically, "solvent schemes of arrangement" allow a solvent company to reorganize its liabilities under general corporate law, often in conjunction with an exit from business and often with limited or no court supervision. There are also schemes involving insolvent companies, using the scheme of arrangement mechanism in conjunction with an insolvency proceeding, often involving an insolvency practitioner acting as the provisional liquidator reporting to a court on a periodic basis. Some common law countries also allow court-supervised reorganizations or "orders of administration" similar to a United States proceeding under Chapter 11 of the Bankruptcy Code. European Union jurisdictions recognize a semi-uniform insolvency regime in which a main proceeding coordinates with ancillary proceedings in other member states. The United Kingdom also recognizes a corporate transaction in which a group of insurance policies may be transferred to another company through Part VII of the Financial Services and Markets Act 2000, which provides "for the transfer to the transferee of the whole or any part of the undertaking concerned and of any property or liabilities of the authorised person concerned." As of this writing, the balance of the European Union countries are expected to institute similar procedures.

There are essentially two ways that the orders of a foreign receiver could be enforced in the United States. A foreign receiver may seek recognition under Chapter 15 of the Bankruptcy Code, 11 U.S.C. §§ 1501-1532, or through the doctrine of comity.

Chapter 15 of the Bankruptcy Code is designed to enable "foreign representatives" acting in "foreign proceedings" to enforce orders from those proceedings in the United States. In effect, Chapter 15 opens the traditional bankruptcy tools to a foreign receiver. Chapter 15 replaces the Code's prior mechanism of granting cooperation with a foreign representative under the former Bankruptcy Code § 304.

Chapter 15 was designed to enact the United Nations model insolvency law in the United States. The House Report on the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 describes how the 2005 legislation "introduces Chapter 15 to the Bankruptcy Code, which is the Model Law on Cross-Border Insolvency ('Model Law') promulgated by the United Nations Commission on International Trade Law ("UNCITRAL")." H.R. Rep. No. 109-31, at 105 (2005). The Model Law commentary states: "The purpose of this Law is to provide effective mechanisms for dealing with cases of cross-border insolvency" (Preamble UNCITRAL Model Law). While courts will frequently analogize to case law under the old § 304 when examining Chapter 15 situations, it should be recognized that Chapter 15, by adopting the UNCITRAL Model Law, has adopted an entirely new regime, not simply modified the old one.

Chapter 15 relief is specifically open to foreign insurance companies. A case under Chapter 15 begins with the filing of a petition for recognition of the foreign proceeding. A court may grant a stay of execution on the debtor's assets upon filing of the petition, and prior to the grant of recognition. Chapter 15 provides direct access to U.S. courts for the foreign representative to sue or be sued and mandates that once a foreign representative is granted recognition, the representative will be granted comity and the cooperation of the U.S. courts. If recognition is not granted, the U.S. court may issue orders preventing the foreign representative from acting in the United States. There is an exception to recognition providing that the decision to seek or not seek recognition will not "affect any right the foreign representative may have to sue in a court in the United States to collect or recover a claim which is the property of the debtor" such as collect accounts receivable within the United States.

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Once recognition is granted, a foreign representative may commence either an involuntary or voluntary case under the Code, opening the door to the entire array of bankruptcy powers. Once recognized, the foreign representative may seek a stay of actions against the debtor's assets, and the court may entrust distribution of the debtor's U.S. assets to the foreign representative. Chapter 15 specifically grants the foreign representative the power to avoid transactions as fraudulent transfers or preferences and use the Code's turnover mechanisms for recovery. Chapter 15 gives foreign creditors the same rights as U.S. creditors. Once a foreign proceeding is recognized as a foreign main proceeding, "sections 361 and 362 apply with respect to the debtor and the property of the debtor that is within the territorial jurisdiction of the United States…" 11 U.S.C. § 1520 (a)(1).

Significantly, Bankruptcy Code § 1501(d) provides that "[t]he court may not grant relief under this chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable State insurance law or regulation for the benefit of claim holders in the United States." Under a plain reading of this provision, claimholders should not be enjoined by the bankruptcy court from seeking recoveries out of statutory deposits. As of the date of this writing, there are no bankruptcy court opinions that have considered the question of whether Bankruptcy Code § 1501(d) precludes the court from enjoining a domestic ceding company from seeking recoveries out of a deposit, escrow, trust fund or any other security provided by an unauthorized alien reinsurer to satisfy credit for reinsurance statutes.

One of the unsettled questions at the early stage of the implementation of Chapter 15 is determining what constitutes a "foreign proceeding." A "foreign proceeding" under the Bankruptcy Code is a proceeding "under a law relating to insolvency or adjustment of debt in which proceeding the [debtor's assets and affairs] are subject to control or supervision by a foreign court for the purpose of reorganization or liquidation." 11 U.S.C. § 101(23). While the pre-Chapter 15 definition of "foreign proceeding" and the revised definition may appear similar, it is clear that Congress intended to fully scrap the prior definition in favor of the UNCITRAL Model Law. In fact, the current definition of "foreign proceeding" in the Bankruptcy Code makes clear that it applies only to proceedings "under a law relating to insolvency or adjustment of debt." Therefore, a receiver should consider whether there is a basis for challenging a Chapter 15 petition on the grounds that the foreign restructuring is merely a corporate reorganization rather than a true insolvency proceeding under a law relating to the adjustment of debt.

Additionally, Chapter 15 contains a specific public policy exception: "Nothing in this chapter prevents the court from refusing to take an action governed by this chapter if the action would be manifestly contrary to the public policy of the United States." 11 U.S.C. § 1506. However, this exception is to be narrowly construed. A receiver should consider whether to oppose the Chapter 15 petition on the basis that the relief being sought by the entity in the foreign proceeding is contrary to public policy, such as applicable state insurance regulations.

It is also possible that a U.S. court may grant assistance to a foreign representative under the doctrine of comity when a case lies outside of those contemplated by Chapter 15. Comity is the recognition that one nation allows within its territory the legislative, executive or judicial acts of another nation, having due regard both to international duty and convenience, and to the rights of its own citizens, or of other persons who are under the protection of its laws. Comity is a flexible doctrine, but the courts are inclined to enforce foreign judgments unless they are contrary to public policy. Comity will not be granted when a foreign proceeding tramples on rights granted by the U.S. Constitution. However, other violations of U.S. law must pass a high threshold to prevent a grant of comity.

In summary, due to the complex nature of cross-border insolvency issues, there may be additional legal, strategic, practical and political issues that a receiver may need to address in order to ensure the orderly administration of the estate and the maximization of recoveries for creditors. Once the estate is confronted with issues related to insolvency proceedings in foreign countries, the receiver should consult with his or her professionals to identify potential problems and solutions.

<u>Internationally Active Insurance Groups and Communication with International Regulators</u>

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U.S. based insurance holding company systems that operate internationally are designated Internationally Active Insurance Groups (IAIGs) if they meet certain criteria, generally based on size and writings, but may include other criteria[18].

For each IAIG, a group-wide supervisor is designated, which may not be a U.S. state regulator. Additionally, for each IAIG, supervisory colleges and crisis management groups are formed to meet periodically to discuss and exchange relevant information about the group. One key benefit to supervisory colleges is establishing routine communication channels with appropriate company personnel and regulators in other jurisdictions.

The NAIC through the state regulators has defined a supervisory college as a regulatory tool that is incorporated into the existing risk-focused surveillance approach when a holding company system contains internationally active legal entities with material levels of activity and is designed to work in conjunction with a regulatory agency's analytical, examination and legal efforts. The supervisory college creates a more unified approach to addressing global financial supervision issues. Supervisory colleges may also be formed for groups with international activity that do not fully meet the definition of an IAIG, at the discretion of the relevant jurisdictions' insurance regulators, often referred to as "regional colleges".

Additionally, the group-wide supervisor will establish a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG.

In the event a U.S. insurance entity within an IAIG becomes financially troubled and/or insolvent, the U.S. domestic state insurance regulator and group-wide supervisor (if not the same) should utilize the communication channels established by the supervisory college and crisis management group when beginning a receivership process.

The group-wide supervisor, in consultation with the CMG, determines whether to require that the IAIG develop a formal recovery plan[19] to establish in advance the options to restore the financial position and viability of the IAIG in a crisis. If a recovery plan is in place, it can be used by the CMG and the IAIG to take actions for recovery if the IAIG comes under severe stress. Regardless of whether a formal recovery plan is required, the Own Risk and Solvency Assessment (ORSA) Summary Report should discuss at a high level the severe stresses that may identify recovery options available and provide information for the state insurance department in the event of severe stress.

Resolution plans[20] are put in place at IAIGs where the group-wide supervisor and/or resolution authority, in consultation with the CMG, deems necessary. If a resolution plan is in place, it should contain information from relevant legal entities and other jurisdictions to aid in the receivership process. There may be in pace coordination agreements that outline roles and responsibilities of members of the CMG and the process for coordination and cooperation, including information sharing, among members of the CMG. Refer to Appendix xxx for a template for development of a resolution plan that describes the U.S. receivership system.

Refer to the NAIC *Financial Analysis Handbook* and the *Troubled Insurance Company Handbook* (regulator only publication) for more details on group-wide supervision, supervisory colleges, CMGs, and recovery and resolution planning.

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[18] A discussion of IAIG criteria and other analysis and regulatory considerations for grup-wide supervision is included in the NAIC *Financial Analysis Handbook* and the *Troubled Insurance Company Handbook* (regulator only publication).

[19] Refer to IAIS Insurance Core Principle (ICP) CF 16.15 and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)

[20] Refer to ICP CF 12.2 and 12.3 and the Application Paper on Resolution Powers and Planning for more background information and possible best practice guidance, including the approach to determining if resolution plans are needed and key elements of a plan (e.g., resolution strategies, financial stability impacts, governance, communication, and impact on guaranty fund systems). (https://www.iaisweb.org/home)

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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 the 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.

---

[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~~, commonly 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~~commencement of proceedings~~ 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 ~~§~~Section 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, ~~§~~Section 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 ~~§~~Section 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 §Section 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 §Section 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 §Section 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 §Section 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 requesting that the insurer be either released from conservation or placed in rehabilitation or

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liquidation. The motion must be filed within 180 days of the conservation order, unless the court grants a 180-day extension. See IRMA §Section 302. The conservator is required to coordinate with guaranty associations to ensure an orderly transition in the event of liquidation. See IRMA §Section 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 §Section 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 which can be financial such as RBC levels or non-financial grounds. Per §Section 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 §Section 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, §Section 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

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

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rehabilitation. Additionally, the order should be served on all financial institutions where the insurer maintains accounts or has other assets.

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, §Section 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; §Section 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

[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).

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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]

IRMA ~~§~~Section 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 ~~§~~Section403 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~~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.

[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. 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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5. Hardship provisions.

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 ~~§~~Section 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

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should work closely with the Department of Insurance to ascertain the viability of the business 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:

- Payment of administrative expenses, including staff salaries,
- Notice to creditors and other interested parties,
- Coordination of data transfer from the insurer's data processing system to the receiver's system,
- 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. ~~§~~Section 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 their insurer has been placed in receivership, is to withdraw their cash value and purchase insurance from another company at the earliest opportunity.

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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~~§~~ Section 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~~§~~ Section 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 ~~§~~Section 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 to attempt to rehabilitate the insurer as a prerequisite to seeking an order of liquidation.[11] In liquidation, the

[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).

[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).

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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 ~~§~~Section 501. State statutes describe the effect of the order of liquidation upon contracts of the insolvent insurer, IRMA ~~§~~Section 114, ~~§~~Section 209 B and ~~§~~Section 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, ~~§~~Section 502 makes specific provisions and distinctions as to cancellations of property/casualty coverages and continuations of life and health coverages.

[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, ~~§~~Section 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 §Section 208 and §Section 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, §Section 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, §Section 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 rights 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 ~~§~~Section 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 ~~§~~Section 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, ~~§~~Section 701B and ~~§~~Section 801. The liquidator may be permitted to request the court to set a date after which no further claims may be filed. See IRMA, ~~§~~Section 701B. Many receivership acts also contain provisions permitting claimants to file unknown, unliquidated or contingent claims. See IRMA, ~~§~~Section 704 and ~~§~~Section 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

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deposit claims, Deposit Claimants may share in the general assets of the estate only after estate creditors 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 §Section 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]

[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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Under ~~§~~Section 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. 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. ~~§~~Section 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

[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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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 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

[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,

[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.

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 ~~§~~Section 504 and to whom notice should be given in ~~§~~Section 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 ~~§~~Section 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 insurers 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 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

[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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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 Health Insurers and HMO plans has added new elements to the overall receivership picture. Medicare and Medicaid Health Insurers and HMOs offer eligible enrollees services similar to those of a conventional Health Insurers and HMO rather than the benefits set out by statute or regulation in the fee-for-service programs. Health Insurers and 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 Health Insurer and 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 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.

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

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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 Health Insurers and 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 Health Insurer or 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 health 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 Health Insurers and 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 Health Insurer and 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 Health Insurer or HMO in receivership will thus be able to move their business to another carrier serving that market without risking loss of coverage or gaps in coverage. The same is generally

[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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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 Health Insurer and 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 Health Insurer or -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 ~~§~~Section 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 ~~§~~Section 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 ~~§~~Section 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 ~~§~~Section 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 must 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 §Section 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,

[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.

~~§~~Section 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.

~~§~~Section 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.

~~§~~Section 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 coordinated 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.

~~§~~Section 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 ~~§~~Section 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 ~~§~~Section705 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, ~~§~~Section 39 of the Liquidation Model Act and ~~§~~Section 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

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date in the statute. IRMA ~~§~~Section 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~~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~~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.

~~§~~Section 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 §Section 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

[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 ~~§~~Section104 CC, defines "special deposit" as "…a deposit established pursuant to statutes for the security or benefit of a limited class or classes of persons." ~~§~~Section 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 ~~§~~Section 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 ~~§~~Section 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.

[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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Investment Company Act of 1940 ("1940 Act")

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

[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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contracts that is next computed after the insurer receives the purchase, withdrawal, or transfer request in good order.

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.

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- 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)

- 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.

NAIC *Modified Guaranteed Annuity Regulation* (#255)

- 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.

Insurers Rehabilitation and Liquidation Model Act (1999) (IRLMA), ~~§~~Section 3 (K):

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

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(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.

(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

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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.

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.

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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,

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.

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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

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,

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

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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 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~~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.

[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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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 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).

- Determine standards governing the Guaranteed Benefits. 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.

[70] But see footnote 65.

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- Determine the TIC's financial risk not supported by a Separate Account. 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:
        - 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.
- Determine the TIC's financial hedging transactions to support its Guaranteed Benefits and other obligations under its Variable and SEC Registered Products.

c. Evaluate Options

- Are the TIC's hedging programs adequate?
    - 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?
- What administrative systems are in place to match daily the value of the Separate Account to each Variable Product?
    - 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~~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

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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.

- 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.

- <u>Cash Out Offer with Waiver of Remaining Surrender Charges?</u>

  - 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.

- <u>What Guaranty Association coverage for the Variable Products might be available?</u>

  - 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.

- <u>Are TIC's Separate Accounts UITs or Managed Separate Accounts or Exempt SAs?</u> 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?

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- 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) 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 https://www.sec.gov/investment-management ~~*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

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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 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

[71] See also footnote 64.

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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 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]

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

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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 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.

[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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- 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.

- 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.

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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 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

[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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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.

(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.

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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.

(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

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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. 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.

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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 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

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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).

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.

- ~~§~~Section 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. ~~§~~Section 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.

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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.

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

[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.G of this chapter on Priority of Claims.

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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 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 ~~§~~Section 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

[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.

[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).

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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.

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 ~~§~~Section 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 ~~§~~Section 47] through the use of equitable remedies," or by ~~§~~Section 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 Agreements[89]

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

[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).

[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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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 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* (#440) (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] 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.[91] 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.[92]

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

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[90] See NAIC Insurance Holding Company System Regulatory Act §§5A(1), 5A(4), 5 (A)(6)

~~91 Holding5(A)(6).~~

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

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

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solvent. However, if the subsidiary is insolvent, generally there is a contrary result.[93] Second, when corporate affiliates are operated as if they constitute a single business enterprise, courts recognize that, in certain circumstances, all affiliates benefit from the synergistic effort of the grouping.[94] 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.[95] 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.[96] 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.[97]

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.[98]

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.

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[93] 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).

[94] 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).

[95] 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).

[96] 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).

[97] 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).

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

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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 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.

On Aug. 17, 2021, the NAIC adopted a new provision, Section 5A(6), of the *Insurance Holding Company System Regulatory Act* (#440), which provides that the affiliated entity whose sole business purpose is to provide services to the insurance company is subject to the jurisdiction of the receivership court. This applies to affiliates performing services for the insurers that are an integral part of the insurer's operations or are essential to the insurer's ability to fulfil its obligations. See Section VIII.G.5 below for additional explanation of the Model amendments related to affiliated transactions.[99]

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 associations 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

[99] The full text of Section 5A(6) of the *Insurance Holding Company System Model Act* (#440) is available at *https://content.naic.org/sites/default/files/MO440_0.pdf*. The 2021 NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

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and surplus lines carriers generally are not covered claims. (See Model #540 ~~§~~Sections 5G(1), 5G(2), optional 5G(3) define covered claims, and section 5H definition of insolvent insurer~~H~~[100], 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

    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. [101]

    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.[102] 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~~claims vary~~ies~~ from state to state. Model~~The~~ #540 ~~§~~Section 5~~G~~H 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

[100] The definitions of covered claims in section 5G and insolvent insurer in section 5H of Model #540 were amended in December 2023. Note the definition of covered claims includes three sections, including one optional section. As these amendments are recent, not all states may have adopted them yet, therefore the receiver should refer to the applicable state's law.

[101] *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).

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

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> 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."

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. ~~1.~~ Court of Competent Jurisdiction

Ordinarily the 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.[103] 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 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. ~~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.[104]

c. ~~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

[103] 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).

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

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Guaranty association coverage under Model #540 definition is not triggered unless there is final order of liquidation with a finding of insolvency.[105] 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.[106] However, if an order of liquidation is not appealed, it is final on the date issued.[107]

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 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—§Section 5GH[108]

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

d. An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and:

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

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

(2) Covered claim includes claim obligations that arose through the issuance of an insurance

[105] 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).

[106] *Id.*

[107] *Id.*

[108] The definitions of covered claims in section 5G and insolvent insurer in section 5H of Model #540 were amended in December 2023. Note the definition of covered claims includes three sections, including one optional section. As these amendments are recent, not all states may have adopted them yet, therefore the receiver should refer to the applicable state's law.

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policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:

f. The original member insurer has no remaining obligations on the policy after the transfer;

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

(c) The claim would have been a covered claim, as defined in Section 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and

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

[Optional:

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

g. A merger in which the surviving company was a member insurer immediately after the merger;

(b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or

(c) A transaction entered into pursuant to a plan approved by the member insurer's domiciliary regulator.]

~~(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~~3) Except as provided elsewhere in this section "covered claim" shall not include;

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

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(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

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

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.[109] This requirement is primarily to prevent excessive or duplicative claim payments.[110] 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.[111]

i. ~~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.[112] 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

[109] 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).

[110] 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).

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

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

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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.[113]

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.[114] 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.[115] Whether the insured later satisfied the judgment creditors with the insurance policy proceeds was outside the guaranty association's scope.

b. Within the Coverage

All guaranty association acts require that to be covered, a claim must "arise out of and be within the coverage."[116] This provision requires that a claim meet a policy's coverage requirements before it will be paid.[117]

i. ~~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:

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

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

[115] *Id.*

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

[117] 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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(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.

(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.[118] 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.[119]

However, the insured's legal obligation to the ~~third party~~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.[120]

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

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

[119] *Id.* at 38.

[120] *Id.*

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case, a corporation's subsidiary was found liable for wrongful death.[121] 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.[122]

Generally, "[a] corporation is an entity separate and distinct from its stockholders and from other corporations with which it may be connected."[123] 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.[124]

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."[125] 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 $5 million is tied to a cost of living adjustment (COLA) adjustment.[126][) This graph should be amended when cyber provisions adopted by NAIC.It should also be noted that the 2023 amendments to Model #540 add a statutory cap for cybersecurity insurance coverage of $500,000.[127]

[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.

d. 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.[128] 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.

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[121] 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).

[122] *Id.* at 910.

[123] *Id.*

[124] *Id.*

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

[126] 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.

[127] As these 2023 Model #540 amendments are recent, not all states may yet have adopted them, therefore the receiver should refer to the applicable state's law.

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

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The court found that bad faith claims are not covered claims.[129] 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.[130]

e. ~~D.~~ Unearned Premiums

Most guaranty association acts and the Model #540 specifically allow claims for unearned premiums.[131] 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.

i. Assignments Allowed

In a New Jersey action, a claimant bank had financed insurance premiums.[132] 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.[133] While the applicable act distinguished reinsurers' claims from others, it did not distinguish between individual and corporate claimants. Had the legislature intended to differentiate between individuals and commercial assignees, it would have expressly done so.[134]

ii. ~~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.[135] 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.

iii. ~~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.[136] 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.

[129] *Id.*

[130] *Id.* at 528.

[131] Model #540, at § 5H.

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

[133] *Id.*

[134] *Id.* at 986.

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

[136] See Model #540, at § 5H(1)(a).

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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.[137] 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 anothe~~571nother 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.

iv. ~~ii.~~ Location of Property

Guaranty association acts generally require that the property from which the claim arises must be permanently located in the state.[138] 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.[139] 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.

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.~~ 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

[137] 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).

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

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

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rating plan; or due any reinsurer, insurer, insurance pool or underwriting fund as subrogation recoveries, reinsurance recoveries, contribution, indemnity or otherwise.[140]

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. Other than coverages that may be set forth in a cybersecurity insurance policy, iInsurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

F. Title insurance;

G. Ocean marine insurance;

H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such 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.[141]

[140] See Model #540, at § 5H(2)(c).
[141] 1990 Ga. Laws Section 33-36-3(2)(g).

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Michigan also has a net worth exclusion. The U.S. Court of Appeals has addressed the constitutionality of Michigan's net worth exclusion.[142] 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."[143] 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,"[144] 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 claim for the return of unearned insurance premiums on policies canceled due to an insurer's insolvency.[145]

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.[146] 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

[142] 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).

[143] 1983 Mich. Pub. Acts Section 500.7925(3). Michigan's current statute has a $25 million net worth exclusion for first and ~~third party~~third-party claimants which is subject to annual increases based on the consumer price index.

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

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

[146] *Id.* at 337.

to recover from the insured proceeds paid on behalf of those insureds that exceed a statutorily provided net worth amount (see Model #540 ~~§~~Section 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 ~~§~~Section 14B of Model #540 as follows:

> Any person having a claim which may be recovered under more than one insurance guaranty ~~association~~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.[147]

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

Jurisdictions may vary on specifics of claim notice requirements. The local guaranty association should be consulted.

The 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.[148]

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

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

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

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precluded from filing a claim against the guaranty association.[149] 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.[150] 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.[151]

- Contingent and Policyholder Protection Claims

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

  In an Illinois case,[152] 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

[149] 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).

[150] 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).

[151] *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).

[152] 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).

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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.[153]

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.[154] In a Massachusetts action,[155] 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 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.[156]

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.[157]

4. ~~NAIC Proposed~~ Reporting Guidelines

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[153] 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).

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

[155] *Id.*

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

[157] *Id.*

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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~~refer to Exhibit 9-1 – ~~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;

Class 6. General creditor claims;[158]

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;

[158] 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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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 of IRMA 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 claims and expenses as well as reduce the necessity for assessments against solvent member insurers. ~~§~~Section 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.[159]

North Carolina has addressed the question of which associations will be subject to the early access statute.[160] 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.

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

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

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In another case,[161] 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 §Section 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.[162] 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.[163]

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.[164]

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

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

[162] 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).

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

[164] See NAIC Model 540 at Section 13.

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Act (#520) is used as a basis for this discussion, and factual examples are drawn from cases.[165] 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.[166]

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.[167]

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.[168]

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.[169] 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.[170] 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.[171] 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

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

~~[166] See *New Mexico Life Insurance Guaranty Assoc. v. Moore,* 93 N.M. 47, 596 P.2d 260 (1979).~~

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

[168] *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).

~~[169] See *Maryland Life and Health Insurance Guaranty Association v. Perrott,* 301 Md. 78, 482 A.2d 9 (1984).~~

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

~~[171] *In the Matter of the Liquidation of American Mutual Liability Insurance Co.,* 417 Mass. 724, 632 N.E.2d 1209 (Mass. 1994).~~

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invalid because the fiduciary breach claims were not expressly and knowingly assigned to the guaranty association.[172]

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.[173]

D. Triggering of Guaranty Associations

Guaranty associations primarily act after the entry of an order of liquidation with 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.[174] 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 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."[175] 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

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

[173] ~~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).~~

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

[175] See Model #520, *supra* note 147, at, Section 2 ~~8L~~.

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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.[176] 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.[177] Finally, an emerging legal issue is the coverage eligibility of residents who are not citizens of the U.S.[178] Under Model #520, the situs of coverage for unallocated annuities is the state of the principal place of business of the plan sponsor.[179] The situs of coverage for structured settlement annuities is the residency of the payee.[180]

~~K~~H. 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.[181] This preservation of statutory priority to guaranty association claims over those of the federal government was confirmed in *Ruthardt v. United States of America*.[182] 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.[183]

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[176] See Model #520, at Section 3A.

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

[178] 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.

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

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

[181] 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.

[182] *Ruthardt v. United States of America*, 303 F.3d 375 (1st Cir. 2002).

[183] "[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.*

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I. 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.[184]

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.[185] 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.[186]

NJ. 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.[187]

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.[188]

K. Other Guaranty Association Topics

Refer to Chapter 6—Guaranty Funds/Associations for other topics such as:

- Eligibility of Insurer
- Exclusions from Coverage
- Benefit Limitations
- Early Access

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 partythird-party administrator agreements), transfers and conveyances so that the receiver

[184] 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 the Agreement of Restructuring for the liquidation of Executive Life Insurance Company of New York.

[185] *Lawrence v. Illinois Life & Health Guar. Assn.*, 688 N.E.2d 675 (Ill. App. Ct. 1997).

[186] 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.

[187] *Aetna Life Ins. Co. v. Washington Life & Dis. I.G. Ass'n.*, 83 Wash. 2d 523, 520 P.2d 162 (1974).

[188] 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.

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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).[189] 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 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.

[189] 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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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."[190] In Section 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 Section 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 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

[190] Fed. R. Civ. P. 34(a).

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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 amendmentsThe 2021 amendments to the NAIC Model Holding Company aAct (#440) 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. RecentThe *Financial Condition Examiners Handbookation* outlines procedures Guidelines alsothat address data segregation and convertibility to UDS for troubled companies.[191]

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.

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

[191] NAIC Holding Company Act, See also General Examination Guidance, Chapter 3, General Examination Considerations of the *Financial Condition Examiners Handbook*.

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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 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.

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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 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

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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 §Section 402 and §Section 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.[192] 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.[193]

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.[194]

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 action may be found to be personal to the injured creditors and the receiver may not have standing to bring the action.[195]

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

[192] E.g., *Schacht v. Brown,* 711 F.2d 1343, 1346 n.3, (7th Cir.), *cert. denied,* 464 U.S. 1002 (1983).

[193] 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."

[194] 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).

[195] 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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right must be paramount and exclusive so as to avoid disorder and confusion in the administration of the insolvent insurer's affairs. ~~§~~Section 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.

   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.

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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.[196]

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 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

[196] 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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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.
- 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

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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 ~~§~~Section 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 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.

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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.[197]

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 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.

[197] See *Wilcox c. CSX Corp*, *70 P.3d 85*, *473* Utah Adv. Rep. 25, 2003 UT 21(2003*)*.

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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.

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. ~~§~~Section 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

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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 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

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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. Insurance Holding Company System Regulatory Act (#440)

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 may never pierce its own veil.[198] 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

[198] *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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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.[199]

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 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

[199] E.g., *Omaha Indemnity Company v. Royal American Managers,* 777 F. Supp. 1488 (W.D. Mo. 1991).

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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.

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.

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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.)

5. Transactions Between Affiliates

Sections 5A(1)(g) and (h) of the NAIC Model *Insurance Holding Company Systems Act* (Model #440) and Section 19B(7) of its companion ~~model *regulation*~~*Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (Model #450) were amended in 2021 to clarify the rights of a receiver to the data of an insurer managed or held by an affiliate. The amendments provide that: (i) books and records of an insurer maintained by affiliates are property of the insurer, (ii) that data and records should be identifiable and capable of segregation, (iii) that if a Commissioner deems an insurer to be in a statutorily defined Hazardous Financial Condition, he or she may: require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party's ability to fulfill the contract in the event of a liquidation, (iv) premiums are the property of the insurer with any right of offset subject to receivership law, (v) affiliates are subject to the jurisdiction of the receivership court and the Commissioner may require the affiliate to agree to this in its written agreements with the insurer, (vi) and includes provisions relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate. In the event of a receivership, including supervision and conservatorship, (i) the rights of the insurer extend to the receiver or guaranty fund, (ii) the affiliate will make essential personnel available to the receiver, and must continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work, and (iii) requires affiliates to maintain necessary systems, programs or infrastructure and make them available to the receiver for as long as the affiliate receives timely post-receivership payment unless released by the receiver or receivership court.

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 Atc~~t;~~
- 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.[200] RICO claims against the insurer's attorneys, solicitors, reinsurers, agents, brokers and shareholders have also been sustained.[201]

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.[202] 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.[203]

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.

[200] 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).

[201] 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).

[202] *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.

[203] 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.[204] IRMA ~~§~~Section 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.[205]

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 have ~~currently~~ responded to this defense by attempting to distinguish between conduct that injures the corporation and conduct that benefits it.[206]

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.[207] 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.[208]

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.

[204] 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).

[205] *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).

[206] 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.

[207] E.g., *FDIC. v. Ernst & Young,* 967 F.2d 166 (5th Cir. 1992).

[208] 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.[209]

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.[210]

Preliminarily, it should be noted that an affirmative claim against the receiver may be barred by the liquidation order.[211] There is also a recognized distinction between the regulator and the receiver.[212] 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.[213]

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.[214]

[209] E.g., *Rollins v. Ellwood,* 141 Ill.2d 244, 565 N.E.2d 1302 (1990).

[210] 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.*

[211] *Id.*

[212] *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.)

[213] *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).

[214] 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. [215]

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.[216]

K. Discovery Issues

1. Receiver's Right to Preliquidation Documents

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.

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).

[215] 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.

[216] 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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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.[217] IRMA ~~§~~Section 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.

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

[217] 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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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.[218] 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.[219]

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 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.

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[218] 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*.

[219] 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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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, ceded and assumed, 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.~~

B. 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.[220] Receivers should be aware of case law regarding the legal effect of providing late notice of claims to reinsurers .[221]A

[220] See *Christiana General Insurance Co. v. Great American Insurance Co.,* 745 F.Supp. 150, 161 (S.D.N.Y. 1990).

[221] Certain Underwriters at Lloyd's of London v. Home Ins. Co., 783 A.2d 238 (N.H. 2001); Unigard Sec. Ins. Co., Inc. v. North River Ins. Co., 4 F.3d 1049 (2nd Cir. 1993); and North River Ins. Co. v. CIGNA Reinsurance Co., 52 F.3d 1194 (3d Cir. 1995) evaluated whether the ceding insurers' failure to provide notice of the reinsured claims warranted denial of reinsurance coverage for such claims. The courts concluded that if the reinsurer denies reinsurance coverage based on a reinsured's failure to provide timely notice of reinsured claims, the

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small number of courts 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.[222] 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.[223] 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.

C. 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.

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reinsurer must prove that it was prejudiced by the reinsured's lack of notice, or that the ceding insurer acted in bad faith, meaning that the reinsured acted with gross negligence or recklessness in not providing proper notice of the reinsured claims.

[222] *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).

[223] *Liberty Mutual Ins. Co. v. Gibbs,* 773 F. 2d 15 (1st Cir. Mass. 1985).

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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 may be security (often referred to as "reinsurance collateral") 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.

The United States reinsurance regulatory framework has undergone significant changes in the last decade, first in 2011 when reinsurance collateral requirements were reduced for certified reinsurers domiciled in qualified jurisdictions, and then again in 2019 when collateral requirements were eliminated altogether for certain reinsurers that are licensed and have their head offices in reciprocal jurisdictions. If an unauthorized reinsurer is neither a certified reinsurer nor a reciprocal jurisdiction reinsurer, then it must continue to post 100 percent collateral on all U.S. reinsurance assumed. These changes affected the amount of reinsurance collateral readily available with respect to non-U.S. domiciled reinsurers and reduced it from the previous 100 percent requirements for all unauthorized 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.

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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 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

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cover the reinsurer's U.S. liabilities.[224] 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 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.

D. 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.

E. 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 ~~§~~Section 114 and ~~§~~Section 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

[224] 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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provide guaranty associations with valuable financial support in transferring policy obligations to an assuming insurer. Model #520 and IRMA §Section612 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.[225]

F. 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.

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.[226] 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."[227] 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.

[225] Model #520, at Section 8.N.

[226] 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).

[227] *Id.*

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G. 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.

~~§~~Section 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.

H. 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

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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;
- 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.

I. 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.[228] 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

[228] See e.g., *Selcke v. New England Ins. Co.* 995 F.2d 688, 689, 690 (7th Cir. 1993).

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otherwise.[229] 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 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.

J. 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.[230]

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.[231]

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.[232] Some cases have noted, however, that the Foreign Sovereign Immunities

[229] 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.).

[230] See e.g., *Morgan v. American Risk Management, Inc.*, 1990 WL 106837 (SDNY July 20, 1990).

[231] *Morgan v. American Risk Management, Inc.,* 1990 WL 106837 (SDNY July 20, 1990);

[232] *John Hancock Property & Casualty Insurance Co. v. Universale Reinsurance Co.,* 1993 U.S. Dist. LEXIS 9411 (SDNY July 12, 1993).

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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.[233]

Additionally, some courts have held that arbitrators have broad authority to require pre-hearing security.[234] 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.

K. 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.[235] Insurers and reinsurers have also contested production on the basis that the information was proprietary and confidential.[236]

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.[237]

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.

L. ~~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 ~~§~~Section 801 C(1) of IRMA and ~~§~~Section 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).

[233] See e.g., *Stephens v. National Distillers and Chemical Corp.,* 69 F.3d 1226 (2d Cir. 1995).

[234] *Pacific Reinsurance Management Corp., v. Ohio Reinsurance Corp.,* 935 F.2d. 1019 (11th Cir. 1991).

[235] See e.g., *Leski, Inc. v. Federal Ins. Co.,* 129 F.R.D. 99, 106 (D.N.J. 1989).

[236] See e.g., *National Union Fire Ins. Co. v. Stauffer Chemical Co.,* 558 A.2d 1091, 1097 (Del. Super. Ct. 1989).

[237] *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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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—Commencement of the ProceedingsTakeover 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 (Model #555, commonly known as 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

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payment of policy benefits for six months without filing a rehabilitation plan, IRMA requires the rehabilitator to file a liquidation petition.

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 Internal Revenue Service (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.

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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.

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

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"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.

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.

[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 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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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 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.

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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 (e.g., 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 of IRMA) and the shareholders, in their capacity as owners, become creditors of the estate (Section 501 of IRMA). 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 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.

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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.

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

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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 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

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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

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 §~~Section 802 C of IRMA).

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.

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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

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~~;~~
- Statu~~s~~;
  - 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 and Chapter 2—Information Systems. 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

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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.

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 Incurred But Not Reported (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.

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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;
- 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;

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   - 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 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.

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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-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 repo~~s~~rting requirements ~~under IRMA~~ are set out in Section ~~§~~117 of IRMA.

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 (e.g., 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

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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.

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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Highlighted references will be confirmed and updated upon adoption of all chapters.

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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

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[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 (#245555, commonly known as) (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. See Chapter. 1, ~~§~~Section IV~~-~~(A) of this Handbook~~, 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.

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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 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~~enterprise risk reporting,[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.

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[18] The NAIC ~~Model~~ *Insurance Holding Company Regultory Model Act* (#440) requires that annual enterprise risk reports to the regulator identify material risk within the holding company systems that could pose a financial or reputational contagion to the insurer. The NAIC *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) requires the filing of annual reports for certain large insurers and insurance groups on the insurer or insurance group's assessment of risks.

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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 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.

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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. See Chapter.1, Section VI(A) of this Handbook. ~~Ch. 1, § V(A), Receivers Handbook.~~ This cooperation and advance planning among the Regulator, the receiver and ideally also the company itself is especially 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 Chapter.1, ~~§~~Section VI(A) ~~Receivers~~of this 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 Chapters. 8~~,~~ and 9 ~~Receivers~~ of this 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.

[19] *www.fdic.gov/analysis/quarterly-banking-profile/fdic-quarterly/2011-vol5-2/lehman.pdf*

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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 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

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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 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.

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- 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.

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 #24555 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.

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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):

- 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

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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.

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 the power to vote 25 per centum or more of any class of voting securities of the bank or company;

[20] 12 U.S.C. 1813(w)(6).

[21] 12 U.S.C. 1813(w)(5).

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(B) the company controls in any manner the election of a majority of the directors or trustees of the bank or company; or

(C) the Board determines, after notice and an 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 NAIC *Insurance Holding Company System Regulatory ~~a~~Act~~s~~* 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

---

[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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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 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 the *Insurance Holding Company System Regulatory ~~a~~Model Act~~s~~* 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;

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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.

---

(3) assuming or guaranteeing the obligations of the covered financial company or any covered subsidiary to 1 or more third parties;

(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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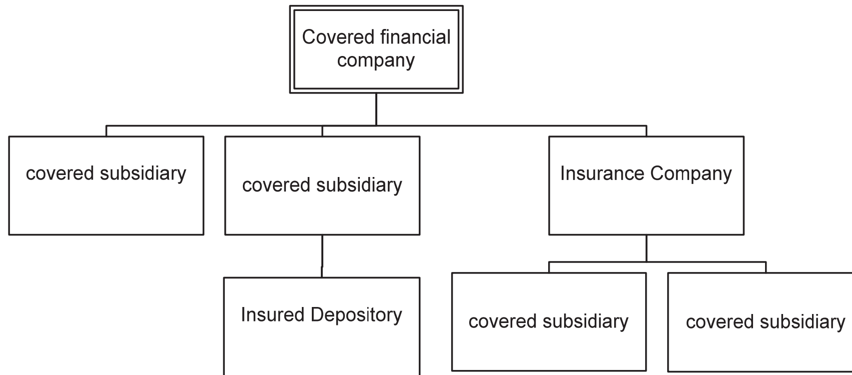

The FDIC adopted Regulation § 380.6[33] regarding its lien authority under § 204(d) as applied to insurance companies and their subsidiaries. The Regulation was amended from its original proposed form, in response to comments by the NAIC, NOLHGA/NCIGF and others, to provide that liens would only be imposed, 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* (#1700) ("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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Exhibits and Checklists from the Receivership Handbook

Chapter 1	**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	**CHECKLIST 1**—Pre-Commencement~~Takeover~~ **CHECKLIST 2**—Commencement~~Takeover~~ **CHECKLIST 3**—Human Resources and Payroll **CHECKLIST 4**—Property, Real Estate, Records and Facilities Control **CHECKLIST 5**—Customer Service **CHECKLIST 6**—Underwriting **CHECKLIST 7**—Information Systems **CHECKLIST 8**—Accounting **CHECKLIST 9**—Tax and Compliance **CHECKLIST 10**—Claims **CHECKLIST 11**—Large Deductible Policies **CHECKLIST 12**—Reinsurance **CHECKLIST 13**—Legal
Chapter 3	**Exhibit 3-1:** Example of Financial Reporting Format **Exhibit 3-2:** Example of Daily Cash Flow **Exhibit 3-3:** Example of Budget-Projected Liquidation Expenses	
Chapter 4	**Exhibit 4-1:** Potential Recovery from Unrelated Third Parties Matrix of Relationships	
Chapter 5	**Exhibit 5-1:** Linear Summary of Claims Administration **Exhibit 5-2:** Claimant Notice via Postcard **Exhibit 5-3:** Assignment of Claims Issues Guidance	
Chapter 6	~~**Exhibit 6-1:** NOLHGA Sample Early Access Agreement~~ ~~**Exhibit 6-2:** NCIGF Sample Liquidators Proposal to Disburse Assets~~ ~~**Exhibit 6-3:** NCIGF Sample Refunding Agreement~~ ~~**Exhibit 6-4:** Large Deductible State Code Examples~~	
Chapter 7	**Exhibit 7-1:** Treaty Master Abstract **Exhibit 7-2:** Reinsurance Matrix	
Chapter 9	**Exhibit 9-1:** NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers **Exhibit 9-2:** Considerations for Separate Accounts – Receivers' Checklist	
Chapter 10	**Exhibit 10-1:** Interim Liquidating Balance Sheet **Exhibit 10-2:** Closing Liquidating Balance Sheet	
Chapter 11	**Exhibit 11-A:** Initiation of Orderly Liquidation of Insurance Company Under Dodd-Frank **Exhibit 11-B:** State Receivership Initiation Process **Exhibit 11-C:** Guideline for Implementation of State Orderly Liquidation Authority	

The following are appendices revised by staff. See highlighted and track changes portion of the tables below.

Checklist 1—Pre-Commencement	Project Assigned To	Date Completed	Completed By	Notes
Obtain from the Department of Insurance • Its most recent examination work papers, • The insurer's most recent annual and quarterly statements, • Audited financial statements with auditor's opinion, • Actuarial certifications, • Any SEC filings, • Tax returns and any other financial statements, • Group Profile Summary (i.e., Holding Company Analysis), • Most recent Insurer Profile Summary, • 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 As, Form Ds and other applications, etc.				
Obtain list of management, including officers and directors, along with biographical affidavits on file with the Department.				

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: • Cell phones • ~~Pagers~~ • ~~PDAx~~ • ~~Blackberries~~ ▪ Laptops and Tablets ▪ Flash drives ▪ Vehicles ▪ Security ▪ Maintenance agreements ▪ Copiers ▪ Office equipment				

RECEIVER'S HANDBOOK FOR INSURANCE COMPANY INSOLVENCIES

Revisions to the following chapters and exhibits of the Handbook were adopted by the Receiver's Handbook (E) Subgroup on:

—July 19, 2022, Chapters 1, and 2
—December 21, 2022, Chapters 3, 4, and 5
—August 18, 2023, Chapter 7
—November 9, 2023, Chapters 6, 8, 9, 10, 11, and exhibits

Due to the size of the Handbook, the revised chapters are posted separately to the Receivership and Insolvency (E) Task Force webpage at https://content.naic.org/cmte_e_receivership.htm

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OVERVIEW

Each state and territory have a statute that provides for the appointment of the state's insurance regulator as the receiver of an insurer that is placed in a delinquency proceeding. This Handbook is intended as a guide for state insurance regulators and others who assist with carrying out the receiver's duties.

The Handbook is organized by subject matter. Each chapter contains an introduction to the subject, followed by an in-depth discussion. At the end of the publication, an appendix includes, checklists, exhibits, or appendices are referenced as an aid to implementing the actions described and is referenced by chapter.

References are provided in each chapter to the applicable provisions of the NAIC model receivership laws and relevant case law. As the legal references reflect the NAIC models and case law existing at the time the Handbook was drafted, a practitioner should always review the current state of the law.

While receiverships typically share essential principles and elements, there are important variances:

- Each state's receivership statute may contain unique provisions that are not derived from an NAIC model act or shared with other states.
- Case law interpreting the statutes governing receiverships can vary between states.
- A receivership is a court proceeding, and the judicial process is governed by the state's court system and rules of procedure.
- Each state insurance department is structured to meet the circumstances of the particular state, and the administrative process for handling receiverships may differ between the states.
- As receiverships vary in size and complexity, a range of approaches may be appropriate.

A practitioner should be aware of the process for handling a receivership in the relevant state and how it may differ from the examples provided in this Handbook. As described above in the disclaimer, this Handbook is not an instructional manual for handling a receivership but rather should be viewed as guidance.

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Table of Contents & page numbers will be updated upon final publication. Highlighted references will be confirmed and updated upon adoption of all chapters.

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CHAPTER 1—COMMENCEMENT OF THE PROCEEDING

I. INTRODUCTION

Insurer receiverships are governed by state law rather than federal bankruptcy law. Although the proceeding is governed principally by the law of the state in which the insurer is domiciled, the laws of the various states and other jurisdictions in which an insurer conducted business, has assets, or has creditors may also be implicated. Consequently, during the commencement and administration of proceeding involving a troubled or insolvent insurer, it is important for the receiver to consider the laws of those states and jurisdictions.

Most states have enacted statutes that govern the conservation, rehabilitation, and liquidation of insurance companies that are patterned at least in part after one of three model acts that have been adopted by the NAIC over the years: the *Uniform Insurers Liquidation Act* (Uniform Act); the *Insurers Rehabilitation and Liquidation Model Act* (IRLMA); and the NAIC *Insurer Receivership Model Act* (#555, also known as IRMA)[1]. In this Handbook, the model acts will be referred to collectively as the "NAIC Model Acts."[2] Because of their widespread influence, the NAIC Model Acts are basis for discussion of issues involved in the commencement and administration of troubled or insolvent insurers. Even so, the laws of the individual states may deviate from the models, in whole or in part. In some jurisdictions, affiliated service providers (e.g., agencies, premium finance companies, administrative service providers) whose purpose is to provide services solely to the insolvent insurer may be subject to the laws that apply to impaired or insolvent insurers.[3]

Receivership proceedings[4] are usually commenced against an insolvent, financially impaired, or otherwise troubled insurer in the insurer's domiciliary state (i.e., the state in which the insurer is incorporated) and in specific courts within that state, generally either the court in the judicial district encompassing the state's capital or the judicial district of the insurer's principal office. The NAIC Model Acts require that the chief insurance regulator of the insurer's domiciliary state be appointed receiver of the insurer to administer the receivership under court supervision. The chief insurance regulator in the individual state may be referred to as commissioner, treasurer, superintendent, or director. For purposes of this Handbook, the term "regulator" is used to encompass all such officials. If the insurer is an "alien" insurer admitted to the U.S. market through a "port of entry," the state through which the insurer was admitted will administer the receivership.

See Chapter 9—Legal Considerations for each type of proceeding.

II. FORMS OF PROCEEDINGS

207. Administrative Supervision

Most states authorize the regulator to issue short-term administrative supervision orders against insurers operating in a manner that poses a hazard to policyholders, creditors, or the public. Under such orders, the regulator or their special deputies serve as administrative supervisor of the insurer. In states where administrative supervision orders may be issued without formal court proceedings,

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[1] Refer to Exhibit 1-5 for a chart outlining key differences between the Uniform Act, IRLMA, and Model #555.

[2] Refer to the NAIC website for state charts that provide state law citations to determine which version of Model #555 a state has adopted. (See *https://content.naic.org/model-laws*.) Note that some states that have not adopted Model #555 in full, but they may have adopted specific provisions from it.

[3] In 2021, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) that bring affiliate service providers deemed "integral" or "essential" to an insurer's operations under the jurisdiction of a rehabilitator, conservator, or liquidator for purposes of interpreting, enforcing, and overseeing the affiliate's obligations under the service agreement.

[4] The NAIC Global Receivership Information Database (GRID) provides publicly available information about insolvent insurers, including receivership orders (conservation, rehabilitation, and liquidation). (See *https://isiteplus.naic.org/grid/gridDisc.jsp*.)

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the orders are subject to administrative review and are often confidential. Administrative supervision can enhance regulatory oversight while the insurer overcomes what is envisioned as a temporary challenge, such as a crisis in the broader economy. It is also useful in temporarily stabilizing a deteriorating situation prior to the entry of an order of rehabilitation or liquidation. Where administrative supervision is authorized, statutes typically empower the regulator to prohibit the insurer from doing any of the following during the period of supervision, without the prior approval of the regulator:

- Dispose of, convey, or encumber any of its assets or its business in force.
- Spend more than specified spending limitations.
- Close any of its bank accounts.
- Lend any of its funds.
- Invest any of its funds.
- Transfer any of its property.
- Incur any debt, obligation, or liability.
- Merge or consolidate with another insurer.
- Enter any new reinsurance contract or treaty.
- Terminate or cancel reinsurance.
- Terminate, surrender, forfeit, convert, or lapse any policy or contract of insurance (except for nonpayment of premiums due) or to release, pay, or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy or contract.
- Make changes in the senior management team.
- Make extraordinary changes in staff.

In addition, supervision orders frequently impose heightened regulatory reporting requirements, such as monthly financial reporting, increased market conduct reporting, and specified special reporting such as changes in reinsurance or performance of invested assets. Supervision is often also a vehicle for more intense analysis of an insurer's affairs and condition. If the insurer fails to comply with the order of administrative supervision, other grounds exist under the applicable statute, or the company is found to be insolvent, the regulator may petition for a receivership order.

B. Seizure Orders

In many cases, the proceeding begins with a seizure order. (See Section 201 of Model #555). Some statutes enacted prior to Model #555 may use different terms for this order, such as a "conservation order" or "receivership order." In Model #555, this order is referred to as a "seizure order"; the term "conservation order" refers to an order entered under Section 301 of Model #555.

In the majority of states, the regulator may obtain a seizure order from a court of competent jurisdiction. Generally, a petition for a seizure order must allege: 1) the existence of one or more statutory grounds justifying a formal delinquency proceeding; and 2) that the interests of policyholders, creditors, or the public is endangered by a delay in entering such an order. Specific requirements for obtaining a seizure order vary. The thrust of a seizure order is preservation of the insurer pending further analysis and proceedings. Such orders are not intended to be the final stage in regulatory action for a troubled insurer. In the rare case in which further analysis reveals the

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absence of grounds for additional proceedings, or that the problems have been corrected, the regulator will move for dissolution of the seizure order and return control of the insurer to management. More frequently, analysis leads the regulator to seek commencement of formal receivership proceedings.

A seizure order may be issued by the court *ex parte*—without notice—and without a hearing upon allegations of statutory grounds. However, in such cases, a hearing is typically set shortly thereafter to permit the insurer to demonstrate that seizure is not appropriate.

Following issuance of a seizure order, if the regulator determines that further court orders are necessary to protect policyholders, creditors, the insurer, or the public, the court may hold hearings to extend or modify the terms of the order. However, the court must vacate the seizure order as soon as practicable or where the regulator, after having had a reasonable opportunity to do so, has failed to institute rehabilitation or liquidation proceedings.

Most state statutory schemes allow the regulator to apply to the court *ex parte* for an order of seizure. In these circumstances, the proceedings are often sequestered and remain confidential until the court orders otherwise. The *ex parte* application allows the regulator to take over the insurer without giving notice, thereby preventing the potential diversion of funds and dissipation of assets, while the continued confidentiality of the proceedings allows the receiver to assess the insurer's current status. Confidentiality allows the receiver to discharge the seizure and, if appropriate, return to normal business operations without public knowledge and the resultant harm to the insurer's business. A seizure order gives the regulator the power to make an immediate hands-on determination of an insurer's condition, as well as preserve and protect its assets. The order is designed to maintain the status quo of an insurer while the regulator decides whether to release the insurer or initiate formal receivership proceedings, whether conservation, rehabilitation, or liquidation. State statutes may require that all records and papers relating to a judicial review of a seizure be confidential. (See Section 206(A) of Model #555.)

If the regulator determines that formal receivership proceedings are not needed, or if the regulator is successful in resolving the insurer's difficulties, they can release control and return the insurer to its previous management without seriously damaging the insurer's business. If, however, creditors and the public become aware of an insurer's potential problems, the insurer could suffer irreparable harm even though the condition requiring seizure has been removed.

C. Receivership Proceedings Generally

Model #555 incorporates three distinct receivership actions: 1) conservation; 2) rehabilitation; and 3) liquidation. In many states, the statutes only contemplate receivership proceedings for rehabilitation or liquidation.

A receivership order authorizes the receiver to conserve, rehabilitate, or liquidate the insurer, with various statutory and judicially imposed restrictions that may vary from state to state and case to case. Subject to these restrictions and to the supervision of the court, the receiver controls all aspects of the insurer's operations, from the initial order until the receiver is discharged. The receiver's responsibilities extend to policyholders, creditors, regulators, and other interested parties. The receiver should communicate with these parties and keep them informed of the progress of the receivership.

Section 207 of Model #555 lists 22 independent grounds, any one of which suffices for the issuance of a receivership order. Many of the same grounds support such orders in most states. A troubled company does not move systematically from one form of receivership to another, but rather, the regulator may choose to petition for the form of receivership appropriate to the circumstances at any given time.

Receivership proceedings are commenced at the behest of the regulator. In some states, creditors and other interested persons may also request that the commissioner be appointed receiver. Such

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proceedings may seek rehabilitation or liquidation of the insurer or may initially seek conservation, deferring election of one of these other paths until a later day.

1. Control of the Insurer

Per Section 104(X) of Model #555, the receiver in a receivership proceeding means liquidator, rehabilitator, conservator, or ancillary receiver, as the context requires. Section 209© of Model #555 states a receiver may appoint special deputies that have all the powers and responsibilities of the receiver.

A seizure, conservation, or other receivership order that vests in the receiver control of the insurer also has the effect of making the receiver responsible for the company. Even while conducting further analysis to ascertain the company's financial condition and prepare for any hearing, the receiver must implement measures to safeguard the insurer's property and affairs. Such measures include:

- Providing physical security for the insurer's facilities, including proper controls and limits on staff access.
- Establishing security for information systems and obtaining a forensic backup of company information.
- Familiarization with company staff responsibilities, capabilities, and potential to interfere with receivership proceedings.
- Identification of cash-flow pressures.
- Control of company investment, financial institution accounts, and other assets.
- Notification of policyholders, claimants, and other interested parties as ordered by court or allowed by statute.
- Communication with landlords and other providers of essential services.
- Court filings are necessary to impart notice to the public.
- Other measures identified as necessary for the preservation of the *status quo*.

2. Preparation for the Hearing

Apart from relying on documents in the insurance department's control (e.g., filed financials and examination reports) and those available from third parties, much of the case in support of receivership may consist of the insurer's own documents. It is important that receivership or supervision staff consult with counsel about the manner of gathering and preserving such documents so that they will be admissible evidence. At the same time, the key problems should be identified, and steps taken to assure that they do not worsen pending resolution of the challenge to the receivership.

3. Contents of the Order

Generally, the receivership order directs the regulator to take possession and control of the property, books, accounts, documents and other records, and assets of the insurer. Further, the order usually gives control of the insurer's physical premises to the regulator. The order is usually accompanied by an injunction prohibiting the insurer, its officers, directors, managers, agents, and employees from disposing of property or transacting business, except upon the regulator's permission or further court order. The order may enjoin anyone having notice of its provisions from interfering with the receiver or the proceedings, may suspend pending litigation involving the insurer, and may require that all claims and proceedings against the insurer be brought exclusively in the receivership court. In addition, the order may include

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special provisions like moratoria on cash surrenders, authority for disavowal of executory contracts, and prohibition of creditor self-help.

4. Duration

The duration of a seizure order can vary. In rare cases, the order will specifically prescribe the time period that it is to remain in effect. Typically, however, the order prescribes that it will remain in effect pending the court's further orders or for such time as the receivership court may deem necessary for the regulator to ascertain the insurer's condition and to request authority to rehabilitate or liquidate the company.

5. Review

If the proceeding commenced with a temporary seizure order and the insurer wishes to contest the proceeding, it may petition the court for a hearing and review of the order. Section 201(F) of Model #555 provides that the court shall hold such a hearing within 15 days of the request.

6. Conservation of Property of Foreign or Alien Insurers

Most states also authorize the regulator to apply to the court for an ancillary order to conserve the property of an alien or foreign insurer. (See Section 10015 of Model #555.) 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 foreign or alien insurer has had property sequestered by official action in its domiciliary state or a foreign country, or if its certificate of authority in the state has been revoked or had never been issued, the regulator may seek an order of seizure or conservation.

Commencement of the proceedings may be by agreement with company owners and management (uncontested) or may be contested vigorously when the insurer maintains that there are insufficient grounds for receivership under applicable law. Most frequently, such contested cases focus on disagreements over the insurer's financial condition and prospects. When the proceedings are contested, much of the work done before the hearing will be in preparation to establish the adequacy of grounds for receivership. That work can also commence during the insurer's supervision.

D. Conservation

In some states, a court of competent jurisdiction may enter an order of conservation upon the petition of a regulator. (See Section 301 of Model #555.) An order of conservation is designed to give the regulator an opportunity to determine the course of action that should be taken with respect to the troubled insurer. Within 180 days, or up to 360 days if allowed by the court, of the issuance of the order, the regulator/conservator must file a motion to release the insurer from conservation or petition the court for an order of rehabilitation or liquidation. (See Section 302 of Model #555.) Unlike a seizure order, a conservation, rehabilitation, or liquidation order constitutes the commencement of formal receivership proceedings, which is not an *ex parte* proceeding.

E. Rehabilitation

A rehabilitation proceeding is a formal proceeding, commencing with a complaint filed by the regulator. (See Section 401 of Model #555.) Rehabilitation can be used as a mechanism to remedy an insurer's problems, to run off its liabilities to avoid liquidation, or to prepare the insurer for liquidation. The regulator will allege the specific statutory grounds in a complaint for placing the insurer in rehabilitation based on the grounds cited in the state's receivership act, which can be financial such as RBC level or non-financial causes. The insurer is served with a complaint and summons. The insurer may respond and must be afforded an opportunity to be heard. When judgment is entered, the losing party may appeal. Note that in some states, the time for filing notice of an appeal may be much shorter than in other causes of action—perhaps just a matter of days.

Refer to Chapter 9 of this Handbook for further description and guidance regarding rehabilitation.

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1. Coordination with Guaranty Associations

Early coordination with the life and health insurance guaranty associations and the property/casualty (P/C) guaranty funds (collectively the "guaranty associations") is essential for maximizing protections and achieving optimal outcomes for policyholders and claimants whenever guaranty association covered business is involved. The importance of early coordination with the guaranty associations is reflected in Model #555 and was also the subject of a 2004 NAIC white paper.[5] Ideally, such coordination should begin as soon as it appears that there is a significant possibility of liquidation. As noted in the NAIC white paper, the need for coordination among regulators, receivers, and guaranty associations may occur even before the insurer is placed under administrative supervision or in conservation or rehabilitation.

At a minimum, Section 208 of Model #555 requires notice to all potentially affected guaranty associations upon issuance of any order for conservation, rehabilitation, or liquidation. Model #555 also specifically contemplates and requires consultation and coordination with potentially affected guaranty associations upon entry of an order of conservation or rehabilitation *to determine the extent to which guaranty associations will be impacted by or may assist in the efforts to conserve/rehabilitate the insurer,* and *to provide appropriate information to the guaranty associations to allow them to evaluate and discharge their statutory responsibilities*. See Section 303 and Sections 404–405 of Model #555. Confidentiality agreements, addressed both in Model #555 and in the NAIC white paper, are commonly used to protect the information disclosed.

This early coordination is essential for several reasons:

- On the life and health side, advanced planning and coordination provides opportunities for guaranty associations to obtain necessary policy data and related information to evaluate, develop, and implement strategies for maximizing consumer protections and avoiding disruption to the provision of policy benefits. These strategies could involve negotiated assumption reinsurance transfers of covered blocks of business, which may be timed to coincide with the liquidation order or having in place the infrastructure, including third-party administrators [TPAs], where applicable, needed for seamless policy and claims administration by guaranty associations immediately upon being triggered.

  In the case of covered health business, policy administration could involve the retention or replacement of providers, such as hospitals, health care providers and pharmacy benefit networks, as well as pre-certification and other related service providers. In certain circumstances, the life and health insurance guaranty associations have created captive insurers to administer large blocks of covered business. While guaranty associations have in some cases had to respond to a liquidation with short notice, the best outcome for policyholders occurs when guaranty associations have the lead time necessary to identify, develop, and prepare to implement strategies that will maximize value for policyholders and avoid any disruption in benefits. Whatever solution or approach is used, it will require time to coordinate, plan, and execute the necessary steps to provide coverage to policyholders on a timely basis.

- On the P/C side, successful, secure data transition is essential for policy and claims administration. Data is typically voluminous in modern insolvencies and may reside on unique or legacy data processing systems, which may be under the control of one or more third parties and in different locations. Working together, the receiver and guaranty funds can effectively transition data and work out any third-party contractual or practical issues that may arise. However, this must be done well in advance of liquidation in order to avoid

[5] The NAIC's Receivership and Insolvency (E) Task Force published a white paper dated Aug. 12, 2004, and titled *Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System*.

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disruption in benefits and claims payments. The P/C guaranty funds and the National Conference of Insurance Guaranty Funds (NCIGF) use the Uniform Data Standards (UDS) and have developed processes to facilitate UDS data transition that may be helpful and result in cost savings for the transition process.

Where the regulator determines that such sharing is permitted under current law, the regulator and the guaranty fund may want to enter into a Memorandum of Understanding (MOU) in order to memorialize the agreement to share information. An MOU template for use in a property and casualty liquidation is available in Exhibit 1-4.[6] The template is an optional tool that can be customized for the state insurance department and the circumstances of the liquidation.

- Modern insurance policies and coverage programs can be complex (e.g., there may be blocks of cyber liability business, large-deductible policies, variable annuity policies with guaranteed living benefits (GLBs), or long-term care (LTC) policies that have unique policy terms or servicing obligations). There may also be related, ceded reinsurance treaties in place that would have to be evaluated and considered for purposes of life and health insurance guaranty association election rights to assume such reinsurance. Identifying and understanding these complex policies and programs to assure uninterrupted policy and claim handling can require extensive advance planning, coordination, and due diligence.

- The amount of lead time needed for guaranty associations to prepare for a liquidation varies based on the facts and circumstances presented in each case, including the type of insurance business written by the insolvent company. The P/C guaranty funds need to analyze the data to adequately protect policyholders—more in complex situations or very large cases. For complex life, health, and annuity companies, the lead time needed may be substantially longer.

- In addition to the benefits of early coordination to prepare for liquidation, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the life and health insurance guaranty associations can provide valuable technical expertise and assistance to receivers and regulators considering possible non-liquidation solutions. This includes analyzing financial issues, evaluating reserves, and identifying potential acquiring entities for blocks of business.

See Section G(4) below for a discussion of guaranty association triggering and Chapter 6 on the guaranty associations' role and specifics of coordination and information sharing.

2) Rehabilitation Plan

The threshold criteria that a proposed plan of rehabilitation must meet is that claimants against an insolvent estate will fare at least as well under the proposed rehabilitation plan as they would if the insurer were placed into liquidation. *See Neblett v. Carpenter*, 305 U.S. 297, 304, 59 S. Ct. 170, 173–74, 83 L. Ed. 182 (1938) ("The order of the Superior Court recites that the [rehabilitation] plan makes adequate provision for each class of policyholders, for the creditors, and for the stockholders; that the plan is fair and equitable; that it does not discriminate unfairly or illegally in favor of any class of policy holders; that the intangible assets conserved by the plan are worth several million dollars and that if the old company were dissolved and its assets sold, their value would be substantially less than the amount which will be realized from them under the plan.") The so-called Carpenter rule, named after the aforementioned U.S. Supreme Court decision, provides that a rehabilitation plan must be fair and equitable, and that it does not discriminate unfairly or illegally in favor of any class of policyholders. *See also, Foster v. Mut. Fire, Marine & Inland Ins. Co.*, 531 Pa. 598, 613, 614 A.2d 1086, 1093–94 (1992) ("Under *Neblett,* creditors must fare at least as well under a rehabilitation plan as they would

[6] The MOU template is also available on the NAIC Receivership and Insolvency (E) Task Force webpage, https://content.naic.org/cmte_e_receivership.htm

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under a liquidation, …"); and *In re Frontier Ins. Co.,* 36 Misc. 3d 529, 532, 945 N.Y.S.2d 866, 869 (Sup. Ct. 2012) (*Neblett* "requires a plan of rehabilitation to provide claimants with no less favorable treatment than they would receive in liquidation.").

F. Considerations Common to Both Conservation and Rehabilitation

1. Issues to Be Addressed

The receiver's review of the insurer's operations should be made at least in part with a view toward identifying and developing a plan to remedy its weaknesses. Areas to be considered include:

- Undercapitalization.
- Mismanagement by directors and officers.
- Uncollectible assets.
- Assets of minimal value.
- Dishonest or incompetent agents.
- Insolvent or weak reinsurers.
- Reinsurance disputes.
- Intercompany, affiliate, or subsidiary indebtedness.
- Unprofitable business.
- Long-tail or long-term liabilities.
- Rate increases are needed on the business and the insurer's ability to secure those increases from regulatory authorities.
- Marketing.
- Deceptive or misleading practices.
- Insurance management experience.
- Claim adjustment experience for lines of business being written.
- Risky investments.
- Non-admitted assets.
- Software and hardware problems.
- Inadequate reserves.
- Reserving practices.
- Excessive operating expenses.
- Staffing problems.
- Backlog of mail and filing problems.

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- Market conduct studies.
- Unfunded agents' balances or finance notes.
- Management of the insurer's assets and investments.
- Numerous/recent changes in information technology (IT) or software applications, particularly accounting, claims, or policy management systems.
- Failure to collect all outstanding reinsurance receivables.
- Failure to collect all balances due from agents.
- Failure to collect outstanding judgments in favor of the insurer.

In addition, the receiver may bring causes of action on behalf of the estate, including to prevent or reverse preferences; voidable transfers; fraudulent transfers; other improper conveyances; fraud; misrepresentation by directors, officers, management, and auditors; and negligence, gross negligence, and mismanagement by directors, officers, management, and auditors. (See Chapter 4—Investigation and Asset Recovery.) The receiver also may diversify the insurer's investment portfolio, coordinate with guaranty associations, and prepare the insurer for future business operations for sale or liquidation.

In cases of limited liquidity, the receiver should evaluate which assets can be marshaled and which liabilities compromised in order to provide sufficient cash flow to administer the insurer's day-to-day operations. Generally, the receivership prevents the insurer from incurring further liabilities and increasing the impairment or insolvency. Conversely, it is essential that the insurer's profitable lines of business be identified and maximized for underwriting profit, cash flow, and possible sale to investors. A determination should be made whether there is an opportunity for a contribution by the owner, an outside investor, or purchaser to stabilize the insurer's cash-flow problems pending a comprehensive corrective action plan to conserve or rehabilitate the insurer. Once the insurer's cash flow is stabilized, the receiver should continue efforts to marshal the insurer's assets and reduce outstanding liabilities.

2. Operational Issues

The receiver may need to make periodic budget projections and cash-flow studies to establish whether the insurer has sufficient cash flow for its operational needs and to determine the amount of money that would be required from an investor to fund the insurer's future operations and meet statutory surplus requirements. The rehabilitation of the insurer might depend upon the valuation of certain assets or the future profitability of the insurer's book of business. It may be necessary to value those assets in accordance with generally accepted accounting principles (GAAP) and statutory accounting principles (SAP) to determine their value in a rehabilitation, acquisition, merger, or asset sale. It may be prudent to prepare a balance sheet based on current market values. (See Chapter 3—Accounting & Financial Analysis and the exhibits thereto.) A determination may need to be made as to the diversification of the receivership's investment portfolio as of the date of the receivership.

The receiver should assess the marketability of the insurer or its assets, including its subsidiaries and investments in affiliates. There should be some focus on the value of the insurer's book of business and its agency network. A decision needs to be made as to whether the insurer will write or limit new or existing business. The strengths and weaknesses of the business need to be determined. Actuaries may need to be retained to perform rate studies and other evaluations, including an evaluation of whether new or pending changes in the law will affect the profitability of the insurer's products (e.g., no fault laws).

In order to preserve the value of the books of business, the payment of claims and cash surrender requests (if applicable) need to be carefully analyzed by the receiver. In some

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situations, claim handling may be continued in the normal course of business. In life and health insolvencies, the receiver should also consider whether a moratorium on cash surrenders, policy loans, and dividends should be imposed.

3. Possible Sale of Insurer

During conservation/rehabilitation, the sale of the insurer to outsiders may be considered, if allowed by state law. A plan for the sale of the insurer should identify the areas that a receiver or investor should cover in any bid or proposal to acquire or invest in the insurer. Among those subjects that should be addressed in a proposed acquisition are the following:

- The purchaser/investor's financial stability and ability to fund the transaction from existing or readily available funds.
- The source of the funds for the acquisition.
- The identity and background of the acquiring party.
- The ability of the purchaser to comply with statutory and regulatory requirements.
- The expected impact of the transaction on the insurer's policyholders and creditors.
- The likelihood of success in completing the transaction.
- Whether the transaction presents other regulatory or public policy concerns.
- Whether the proposed transaction would adversely affect guaranty association/guaranty fund coverage available to policyholders in the event of a future liquidation.

G. Liquidation

The regulator may petition the court for an order of liquidation when any of the grounds set forth in the applicable statute exists (Section 207 of Model #555), or, if the company is in rehabilitation or conservation, the regulator believes that further attempts to rehabilitate or conserve the insurer would substantially increase the risk of loss to policyholders or the public or would be futile. In liquidation, the liquidator must identify creditors and marshal and distribute assets in accordance with statutory priorities and dissolve the insurer.

1. Order of Liquidation

Once a petition for liquidation is filed, the company will have an opportunity to defend itself, which can result in a trial or an evidentiary hearing. If the court determines that the regulator has sufficiently established any of the statutory grounds for liquidation, it shall enter an order of liquidation, appointing the regulator as the liquidator of the insurer and vesting the liquidator with title to all of the insurer's assets and records. The order enables the liquidator to control all aspects of the insurer's operations under the general supervision of the court. Orders of liquidation may be appealed by management and/or shareholders of the insurer.

Statutes in most states 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. State statutes may describe the effect of the order of liquidation upon contracts of the insolvent insurer.

Upon entry of the order of liquidation, the receiver is charged with the duty to secure, marshal, and distribute the assets of the estate. The power to perform these duties is provided by the order of liquidation and the state receivership statute. It is important for the order of liquidation to include certain other items, which should be determined by applicable provisions of the law in the state of domicile of the insurer. These items typically include provisions for: the appointment of the liquidator; delineation of the powers of the liquidator as provided by state

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statute; the immediate delivery of all books, records, and assets of the insurer to the liquidator; and enjoinment of other parties from proceeding with actions against the liquidator, the insurer, or policyholders. In addition, it may provide for notice to policyholders and cancellation of policies.

2. Effect on Policies

The cancellation of policy obligations raises several legal issues with respect to the obligations of P/C insurers and the cancelable obligations of life insurers. In general, the courts enforce the statutes that provide for the cancellation of insurance policies upon liquidation. Several cases have considered the question of whether a policyholder's claim would be accepted if filed after the bar date established in the order. 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. However, the insolvency of a life insurer presents a unique situation. The NAIC Model Acts provide for the continuation of life, health, and annuity policies. Typically, life and annuity contracts (and, to a lesser extent, health contracts) are transferred to solvent third-party insurers.

3. Powers and Duties of the Liquidator

The liquidator is granted certain powers by statute and/or court order, which include the following:

- Vesting the receiver with title to all assets.
- Authorizing the receiver to marshal assets.
- Authorizing the receiver to sue and defend in the receiver's name or in the name of the insurer.
- Enjoining lawsuits in other courts, whether in the same jurisdiction or elsewhere.
- Enjoining interference with the receivership.
- Enjoining creditor self-help.
- Appointing one or more special deputies.
- Authorizing the retention of attorneys, consultants, accountants, and other specialists as necessary.
- Authorizing the sale, abandonment, or other disposition of the insurer's assets.
- Borrowing on the security of the insurer's assets.
- Coordinating with guaranty associations.
- Coordinating with the NCIGF and/or NOLHGA, as necessary.
- Entering into and canceling contracts.

Most jurisdictions hold that the liquidator generally steps into the shoes of the insolvent insurer and possesses the rights and obligations of the insurer. There is also authority for the proposition that the standing of the receiver is broader than that of the insurer to the extent they also represent the interest of policyholders and creditors. Several cases have focused on the liquidator's specific duties. These cases allow liquidators to compound or sell any uncollectible or doubtful claims owed to the insolvent insurer, to disaffirm fraudulent conveyances, to disavow leases and other executory contracts, to act as statutory receiver of the insolvent

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insurer's property, to sell the insurer's property, to conduct business using the insurer's assets, and to control bonds and mortgages held as collateral security.

4. Triggering of Guaranty Associations

As a general rule, the guaranty association laws provide for the mandatory triggering of coverage by guaranty associations upon the entry of an order of liquidation with a finding of insolvency against a member insurer. Advanced coordination with affected guaranty associations and/or NOLHGA (in life and health cases) or the NCIGF (in P/C cases) with respect to the liquidation petition and proposed liquidation order will help to ensure consistency in triggering in multistate insolvencies.

On the life and health side, there are a small number of states where mandatory triggering may also occur, under certain circumstances, during rehabilitation if the member insurer is not timely paying claims. In P/C cases, guaranty fund triggering normally occurs upon an order of liquidation with a finding of insolvency. There are a minority of states that can be triggered with a finding of insolvency only.

Most of the state life and health insurance guaranty association laws also provide a mechanism for permissive triggering, at the discretion of the association, where a member insurer has been placed under an order of rehabilitation or conservation. Generally, no such permissive triggering exists in the P/C state laws. These provisions are based on Section 8(B) of the NAIC *Life and Health Insurance Guaranty Association Model Act* (#520), which provides the guaranty association discretion to provide coverage if a member insurer is an impaired insurer (i.e., placed under an order of conservation or rehabilitation). This authority is subject to any conditions imposed by the guaranty association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner in the guaranty association's state. Some state statutes also provide life and health guaranty associations limited discretion to act in cases where the impaired insurer has been deemed by the commissioner to be potentially unable to fulfill its contractual obligations. This language dates back to the original definition of "impaired insurer" in the 1970 version of the NAIC Model Act. This language was later removed from the Model Act as part of the 1997 amendments but still remains in a small minority of state statutes.

Given the possibility of subtle variations in triggering provisions in place from state to state, it is important to coordinate with affected guaranty associations and the NOLHGA or the NCIGF for purposes of confirming guaranty association triggering. Refer to Exhibit 1-1 and Exhibit 1-2 for recommended liquidation order language to ensure consistent guaranty association triggering.

5. Notice

Most state statutes set forth the minimum requirements for notice to creditors and all persons known, or reasonably expected, to have claims against the insurer. The receiver must give notice to the regulator of each jurisdiction in which the insurer does business, affected guaranty associations, the agents of the insurer, and policyholders at their last known address. The liquidator may also be required to give notice by publication, usually 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 bar date specified in the notice.

Disputes may arise when the claimant alleges that he or she did not receive notice of the liquidation. The cases addressing this issue turn on the specific facts. Courts have allowed late claims where the receiver should have known of the claimant's existence and should have provided notice.

See Chapter 5—Claims for additional discussion.

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6. Deadline for Filing Claims

Unless established by statute, the court establishes a deadline for the filing of claims against the assets of the insolvent insurer. In Model #555, the date is not later than 18 months after the entry of the liquidation order, unless extended by the receivership court. (See Section 701(A) of Model #555.). The liquidator may be required to permit a claimant to file a late claim under certain circumstances. (See Section 701(B) of Model #555.) If a claimant does satisfy the criteria for filing a late claim, the claim will be subordinated to a lower distribution priority. (See Section 801(I) of Model #555.) Some statutes enacted prior to Model #555 may provide that such a claim is barred from participating in a distribution. Policyholders covered by guaranty associations typically are not required to file claims with the liquidator.

See Chapter 5—Claims for additional discussion.

7. Ancillary Proceedings

Liquidation of an insurer is conducted by the liquidator in the insurer's state of domicile. When an insurer is licensed to do business in another state, that state may have authority to establish an ancillary receivership. Receivership statutes typically permit the commissioner of a state where an insurer is licensed to commence an ancillary proceeding if the insurer is placed in liquidation in the domiciliary state. Some statutes also require the commissioner to commence an ancillary proceeding upon the request of certain residents of the state who have claims against the insurer. If the court grants the petition for an ancillary proceeding, the commissioner of that state is appointed as the ancillary liquidator.

The ancillary liquidator is generally entitled to recover the insurer's assets in the ancillary state and pay claims of residents in the state with such assets. Some statutes permit a claimant who resides in an ancillary state to file a claim in either the domiciliary or ancillary proceeding.

Owners of secured claims can be affected when there are one or more ancillary proceedings. The owner of the secured claim is entitled to surrender his security and file his claim as an unsecured creditor. Any deficiency in the claim is treated as a claim against the insurer's general assets on the same basis as claims of unsecured creditors.

Model #555 clarified the procedures for ancillary proceedings and the handling of deposits. Under Section 1001 of Model #555, the need for an ancillary receivership has been curtailed. Model #555 allows the appointment of an ancillary conservator under limited circumstances. A domiciliary receiver is automatically vested with title to property in any state adopting Model #555, and the test of whether a state is a "reciprocal state" has been eliminated. Model #555 also clarifies the procedures for handling deposits. However, most states have not adopted Section 1001. The 2021 Model *Guideline for the Definition of Reciprocal State in Receivership Laws* (#1985) provides a statutory definition of reciprocal state that may be adopted by states to effectuate the coordination of receiverships involving multiple states. Note that due to its recent adoption, states may not have adopted Guideline #1985.

While an ancillary proceeding is required in limited circumstances, the regulator often has discretion to initiate it. When deciding whether to commence an ancillary proceeding, several issues should be considered, particularly if it involves a pre-Model #555 statute. As an ancillary proceeding requires the separate administration of the insurer's assets and claims, it generally will increase costs. It can also complicate the processing and payment of claims, and potentially confuse claimants. Separate distributions to claimants from ancillary and domiciliary receiverships may differ, which can result in disparate payments to creditors in the same class. Finally, the insurer's debtors may be reluctant to pay amounts owed to the insurer due to the potential for competing claims by domiciliary and ancillary liquidators. To address these potential problems, the domiciliary and ancillary liquidator

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can enter into an agreement to facilitate the coordination between the proceedings. An agreement could cover matters such as bar dates, claims procedures, the liquidation and disposition of deposits, and the collection of other assets.

See Section E(9) of Chapter 9 – Legal Considerations for additional discussion.

III. INTERESTED PERSONS

A. Guaranty Associations

Guaranty associations have been established in each state, as well as the District of Columbia, Puerto Rico and the U.S. Virgin Islands, to provide a measure of protection to policyholders in the event of the impairment or insolvency of an insurer. When guaranty association covered business is involved, it is beneficial to begin coordination as soon as it appears there is a significant possibility of liquidation or that guaranty associations will be triggered.

See Section II(E)(1) in this chapter and Chapter 6 for additional discussion.

B. Parent Company and Affiliates

An insurer may have a parent company and/or affiliates that may or may not be insurance companies. The interaction of these companies should be reviewed and analyzed carefully, including any service agreements, management agreements, pooling agreements, tax sharing agreements, and reinsurance agreements. Under certain circumstances, the receiver may want to obtain control of these other entities through substantive consolidation.

See Chapter 4—Investigation and Asset Recovery and Chapter 9—Legal for further discussion.

C. Government Agencies

Federal, state, and local government regulations may require notice of the proceeding and are potential creditors.

The Federal Priority Act (31 U.S.C 3713) imposes personal liability on the representative of persons or estates to the extent that other debts are paid (or otherwise compensated) prior to claims of the federal government. A 3713 release from the U.S. Department of Justice (DOJ) may be requested. As much of the information required for the release is historical, the receiver should start collecting the information at the inception of the liquidation.

See Chapter 5—Claims, Chapter 9—Legal and Chapter 10—Closing Estates for additional discussion of federal government involvement.

IV. RECEIVERSHIP ADMINISTRATION

A. Planning

The regulator who expects to successfully administer a receivership action must become familiar with the insurer's operations and business as soon as possible. The checklists included in the exhibits at the end of this chapter include a list of documents that should be reviewed.

1. Identify Problems

It is critically important to meet with the regulator's staff before the receivership order is entered to discuss the perceived causes of the insurer's difficulties and the potential for a successful rehabilitation or liquidation. While state statutes may prevent the regulator's staff from sharing documents not available to the general public with non-regulators, insight from financial examiners, financial analysts, market conduct examiners, and licensing agents might assist in determining the causes of the insolvency.

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It is also important to meet with the insurer's officers and/or directors, when possible. These meetings are usually clear indicators of how cooperative or hostile the insurer's management will be after appointment. Hostile environments require additional personnel and security measures at the company location to secure the assets and records. In some circumstances, it may be important to maintain confidentiality about an intended action, in which case a meeting with management may not be possible.

2. Identify Key Transitional Elements

As previously discussed, coordination with guaranty associations is essential. When liquidation is reasonably foreseeable and guaranty association covered business is involved, that coordination becomes critical to maximizing protections and achieving optimal outcomes for policyholders and claimants. With proper confidentiality arrangements, this can and should occur even while liquidation is a possibility, but there are still other alternatives that might salvage the company. Particular attention should be given to definitions of "covered claim" or "covered policy" for each guaranty association.

The insurer's officers, directors, and employees may be willing and able to advise about the existence of service providers and outside consultants employed by the insurer, including legal counsel, accountants, and actuaries. Access to the insurer's records and contracts with all consultants and service providers should be secured and determination made regarding which, if any, of the various service providers to retain. It should also be determined if the insurer is a member of a Federal Home Loan Bank (FHLB) and, if so, identify key individuals at the insurer and at the FHLB.

It is also beneficial to obtain employee agreements and other documents regarding personnel arrangements. The receiver will have to develop a plan to maintain required positions and retain key staff. See Section IX—Human Resources in this chapter for additional discussion.

Additional steps to consider during the planning phase are in the checklists included in Exhibits xxx.

3. Working Business Plan

During the planning phase of a receivership, it may be helpful for the receiver to develop an internal working business plan with reasonable timeline and objectives that consider multiple paths, taking into consideration claimants, policyholders, taxpayers, and stakeholders (e.g., lenders, shareholder, affiliates, etc.) The development of a multi-option plan (e.g., option A, B, or C) in order of most beneficial may help in planning for and supporting each phase of the receivership process and in ultimately developing the rehabilitation plan required by the rehabilitation order.

4. Monitoring and Progress Report

Once the receivership proceeding commences, the receiver should consider maintaining weekly or monthly progress reports that serve as high-level report cards of the key issues and the progress made in servicing policyholders and the effectiveness of the working business plan. The progress reports include a view of the whole insurance company (financial and operational), highlight key data about company activities of each division, and identify critical compliance areas for financial, operational, legal, and statutory guidelines. Included in this monitoring process may be specific accomplishments and updates that should be made available to policyholders and claimants and the courts. Depending on complexity of the receivership, a weekly meeting of managers/staff is recommended to exchange information between the receiver and the managers/staff.

B. Receivership Order

A receivership order may be issued because the insurer is impaired (generally, a conservation or rehabilitation) or insolvent (liquidation or, in special circumstances, a rehabilitation). The order

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may also be issued to protect an insurer operating under severe financial impairment, as evidenced by a variety of factors, such as investments in an undiversified portfolio of stocks or bonds, writings to surplus in excess of the allowable amount, issuance of total insurance business by one managing general agent (MGA) or third-party administrator (TPA), or entering into non-risk bearing surplus relief contracts. A receivership may also be instituted if current management is found to be detrimental to the management and/or financial stability of the insurer.

Some common issues addressed in receivership orders are:

- Writing of new or renewal business.
- Handling of reinsurance.
- Dividends or transfer of assets without the receiver's approval.
- Payments to affiliates.
- Limitations on new investments.
- Seizure of physical and liquid assets.
- Liquidation of certain investments.
- Change or dismissal of officers and/or directors.
- Ownership of records and data of the insurer or related entities.
- Cancellation of certain MGA, TPA, or general agency agreements.
- Limitations on funding by premium finance companies.
- Injunctions.
- Payment of loss and loss adjustment expense, etc.
- Triggering of the guaranty associations, if intended.
- Provisions to prepay ongoing claims benefits such as workers' compensation indemnity benefits while claims data is being transitioned to the guaranty associations.
- Moratoria on claims, cash surrenders, withdrawals, policy loans, etc.
- Worker Adjustment and Retraining Notification (WARN) (state and federal) if layoffs of existing staff are anticipated.
- Hardship provisions. (Refer to state statutes, state guaranty associations, or *www.ncigf.org* and *www.nolhga.com/*).

Once the receivership order is entered, the receiver is empowered to operate the insurer. Officers may be retained or terminated, and directors may be relieved of duties, though these actions must be carefully evaluated because of possible adverse effects on litigation involving directors and officers. In fact, a careful evaluation prior to termination of any employee is recommended. An immediate determination may be made as to the need for outside consultants or professionals, such as accountants, actuaries, computer specialists, attorneys, investment counselors, etc.

The insurer may remain in receivership for a fixed period of time or until the occurrence of specified events (e.g., the rehabilitation of the insurer or the liquidation of the estate and the discharge of the receiver).

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C. Notices

Notice of the insurer's status should be in accordance with the receivership court's direction. The court may direct the notice to be issued by mail and/or by publication in a newspaper of general circulation. In the case of a conservation (under Model #555) or rehabilitation, the notices may be issued to assist the receiver in informing the policyholders and sustaining the business of the insurer. Notice may be sent to the following persons, among others, when the court requires, as their rights or interests are affected:

- Policyholders and beneficiaries.
- Agents.
- Guaranty associations.
- State insurance departments.
- Third-party claimants.
- NAIC.
- IRS.
- U.S. Department of the Treasury (Treasury Department).
- DOJ.
- State and local offices.
- Banks.
- Brokerage or investment banking firms.
- MGAs, general agents, and all agents of record.
- Reinsurers.
- Intermediaries.
- Creditors, including secured creditors. (This includes the FHLB, if applicable.)
- Claim adjusters.
- TPAs.
- Premium financiers.
- Vendors.
- Accountants, actuaries, lawyers, and other professionals.
- Landlords and tenants.
- Officers and directors.
- Stockholders and other equity holders.
- Other necessary parties.

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Notice may vary depending upon whether the insurer is in rehabilitation or liquidation. Under Model #555, conservation is similar to rehabilitation, and the notice requirement is the same. If the notice is preapproved by the court, it will avoid potential claims of nondisclosure or omission of material facts.

D. Implementation of the Order

The order typically includes provisions that enable the receiver to prevent additional financial drain. Throughout this period, the receiver should pay particular attention to preventing illegal preferences, unauthorized set-offs, fraudulent transfers, and improper conveyances or distributions.

It is vital that the order be served immediately on the insurer. The receiver should take steps to maintain the integrity of the insurer's assets, books, and records as of the date of the order and to control the insurer's operations so that the assets, books, and records are not removed, dissipated, or destroyed. The checklists in Exhibit xxx include some of the initial steps that may be taken to ensure the receiver's control.

E. ASSETS

1. Initial Asset Control

A principal objective in the initial phase is to identify and secure the assets and determine the liabilities of the insurer. The insurer's annual and quarterly statements, along with the current general ledger and chart of account listings, should help in locating some of the assets.

Once the assets have been identified and secured, the short-term emphasis shifts to the cash and invested assets, those being the most liquid. These assets should be tightly controlled to prevent any theft or misappropriation. Examples of the various types and forms of assets, as well as immediate actions that can be taken, are provided in the checklists in Exhibit xxx. However, as stated, the primary emphasis at this stage should be assets easily converted to cash, such as petty cash, operating bank accounts, and investments. Usually, the remaining illiquid assets will be addressed in the ongoing management and administration of the estate. These types of assets will be the focus of various accounting, collection, and legal efforts in the endeavor to marshal all assets of the estate.

It is important to immediately institute appropriate controls and procedures for the processing of cash and cash receipts. The objective of controlling all cash receipts and subsequent processing is to ensure that cash, the most liquid asset, does not disappear. This requires more stringent controls, including immediate deposit of all cash and an accurate daily accounting. Therefore, the receiver should immediately institute procedures for the routing of daily cash receipts, such as creating a receipt log. With respect to life and health insolvencies (including health maintenance organizations [HMOs] if covered by the triggered guaranty association), consideration should be given to coordination with the guaranty associations and/or NOLHGA regarding the treatment of premium billings, reinsurance payments, and any other matters necessary to keep the policies in force, pending the sale of the business or assumption of the business by the guaranty association(s). In the case of an HMO insolvency, direct coordination with the entities providing health care protection to the members is crucial. The receiver may find it necessary to open bank accounts in the name of the receivership in order to have complete control of the cash. In a health insurance-related insolvency, the receiver should check on the status of coordination of benefits (COB) receivables and hospital credit balances. The receiver should also check the state's Treasury Department to see if any providers have escheated funds on behalf of the health insurer. In order to ensure no misappropriation of funds, the receiver must also institute effective controls over disbursements. This includes instituting new check issuance procedures, including the establishment of new check signing and wire transfer authority, and the issuance of new passwords for electronic banking.

The valuation and control of the remaining assets in the estate will necessarily fall into the continuing management and administration stages. Those assets are less liquid in nature and are, therefore, more difficult to value, marshal, and misappropriate.

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2. Administration and Ongoing Asset Management

Once the initial phase has been accomplished and control has been instituted over the liquid cash and other invested assets, attention should be directed toward the remaining assets and potential assets of the estate. Immediate identification of some of the remaining assets may be accomplished by reviewing the balance sheet, general ledger, and chart of accounts. The identification of these assets has been accomplished to a degree in the initial phase. The receiver should take a physical inventory, including laptops and mobile devices, office equipment, computer hardware, and office furniture. The various checklists in Exhibit xxx provide details of types of assets to look for and steps to take with those assets.

Aside from the traditional or listed assets on the balance sheet, insurer operations need to be reviewed to identify any potential nontraditional assets. Simply stated, the receiver is responsible for identifying value in the operations and evaluating the potential for the recovery or collection and conversion of this value. This concept will become clearer as the various categories of assets are revealed. Some of the issues to be considered include the following:

3. reinsurance

With respect to life insolvencies, it is critical that the receiver immediately analyze whether to continue or cancel ceded reinsurance contracts. Model #520, the life and health guaranty association statutes in most states, and Model #555 give the life and health guaranty associations the authority to continue ceded reinsurance contracts that relate to covered obligations of the associations in order to facilitate a sale of the business or to minimize the association's exposure. The affected guaranty association must make the election to allow a particular treaty to expire or continue within a statutorily established time. If the treaty is continued, the guaranty association becomes liable for the payment of the ongoing premiums. The guaranty association may transfer the reinsurance agreement to a solvent insurer that assumes the underlying policies. (See Section 612 of Model #555 and Section 8(N) of Model #520.)

4. Audit Premiums

Certain P/C premiums are based on loss experience, sales volumes, or payroll amounts. This criteria will differ depending on the type of policy being issued. For example, a "minimum" or "deposit premium" is paid upon issuance of the policy. Final premiums are billed after audit on the basis of loss experience. The additional premium generated is known as audit premium or retro-rated premium and may represent a significant asset of the estate.

Life insurance premiums may be affected by the amounts of dividends paid or by the difference between current billed premiums and maximum billed premiums allowed by the contractual guarantees in the policies. In life insurance insolvencies, the receiver should consider the possibility of Phase III tax liability. (See Chapter 3—Accounting and Financial Analysis, Section VIII.)

5. Taxes

Value to the estate may be generated through the sale of the corporate charter or shell. An analysis of any net operating loss situation and qualification under IRS rules should be made with the advice of tax experts, both in the accounting and legal fields.

Also review the validity and correctness of other state and local taxes paid. A review of prior returns and state tax authority records may uncover overpayments and possible recoverable amounts.

Tax sharing agreements with affiliates and any prior consolidated tax returns should be secured, if possible, and reviewed to determine if any refunds paid to the parent should be remitted to the estate.

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6. Property/Casualty Salvage and Subrogation

With respect to P/C insurers, a determination should be made as to how the insurer identified and recovered salvage and subrogation. This amount will not be readily identifiable from the statutory statements, as statutory principles prohibit the recognition of salvage and subrogation until it is collected. However, many insurers maintain salvage/subrogation logs, which are a good source for identification of such receipts or potential recoverables. Salvage and subrogation on claims where reinsurance has been received may be held in a segregated account. Because these aggregated funds may be subject to setoff, a portion of the funds may be due the reinsurer.

7. Indemnity

A surety, prior to issuing a bond, will usually require indemnity agreements from the principal and other indemnitors in order to secure the surety from any claims that may be made against the bonds. The agreement is a contractual obligation that provides security for the surety. The indemnity agreement sets forth and expands upon the separate common law obligations between the principal and the surety. A separate indemnity agreement may be issued for each bond. However, more frequently, the parties enter into a general indemnity agreement covering any bonds that the surety may issue to that principal.

Accordingly, all indemnity agreements should be secured and reviewed to identify potential recoverables.

8. Deductibles

Many P/C insurance policies contain deductibles that are to be paid by the insured. If the insurer (or a guaranty association) pays the full amount of the loss to an injured third party, the amount of the deductible becomes a claim against the insured. The receiver should evaluate the likelihood and cost of collection and, if appropriate, attempt to recover the amount paid within the deductible. It is important that the collection process be resumed as quickly as possible. Most often the receiver is best situated to continue the collection process as they are in possession of the related records. In some cases, the insured will have posted some form of collateral to secure its obligations under the deductible. Pursuant to statute in some states, or agreement between the receiver and the applicable guaranty associations, the amount collected is delivered to the associations that paid the claim. For a fuller discussion of large deductibles, see Chapter 6—Guaranty Associations.

9. Excess Expense Payments, Especially Over-Billed Loss Adjustment Expenses

A complete review of historical expense payments should be made, paying close attention to the rates charged, hours worked, necessity of work performed, and supporting documentation for expenses itemized in defense attorney bills. Reimbursement should be sought, as appropriate.

10. Voidable Preferences/Fraudulent Transfers

Early in the administration of an estate, the receiver should review the insurer's recent pre-receivership transactions for purposes of determining whether potential voidable preferences or fraudulent transfers of assets were made. See Chapter 9—Legal Considerations, Section VIII(C) and (D), for a discussion of voidable preferences and fraudulent transfers.

F. Take Control of Books and Records

One of the receiver's first steps should be to locate, control, and organize certain files. Securing and organizing the records of an insurer in receivership is of paramount importance to successfully completing the receivership.

A plan to deal with records, including all electronic records, should be developed. The plan should provide for the creation of a records inventory. The plan should identify the data to be captured

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from the insurer's records—i.e., the names and locations of insureds, reinsurers, etc.—and should deal with both the location and maintenance of the files.

It is best to have experienced personnel and legal counsel with an insurance operations background develop this plan. In crafting the plan, the receiver should consider:

- Establishing a central clearing house for all records or having the receiver's staff review records in each department to identify and secure key records. In this manner, the receiver will be able to ensure that all records are recovered, reviewed, and appropriately maintained for further use.

- Determining the location of various records, such as those of MGAs, TPAs, agents, independent adjusting firms, attorneys, branch offices, and subsidiaries.

- Determining the various categories of documents—such as policies, claims, data processing, banking, accounting, corporate, and state, as well as federal tax, marketing, personnel files, reinsurance files, and administrative files—and how they should be maintained.

Checklists in Exhibit xxx identify items that should be secured and organized under each area.

It is important to limit access to the premises or other facilities to preserve the integrity of the books and records and to prevent the dissipation of receivership assets. It is also essential to provide notice to consultants used by the insurer—such as accountants, actuaries, and lawyers—of the receivership order, demanding that all records of the insurer in their possession be turned over to the receiver. Failure to turn over the insurer's records to the receiver is a violation of most state statutes. (See Section 118(A) of Model #555.) In the event a consultant is unwilling to turn over records of the insurer, the receiver should consult with legal counsel.

G. Inventory

The receiver should inventory the assets, books, and records as soon as possible. This inventory may not only be required by state law, but also it may be useful in determining whether items have been misplaced or were later removed from either the insurer's premises or the receiver's offices and facilities. The inventory should be conducted at the insurer's offices. The items listed in the checklists included in Exhibit xxx should be itemized and secured.

While conducting the inventory of books and records, the receiver should begin identifying documents relative to the cause of the insurer's insolvency. Statute of limitations vary by state. The receiver may have a limited amount of time to file actions against other parties. The NAIC and FBI have developed a questionnaire to be used by a receiver in reporting fraud and other white-collar crimes to the DOJ for the purposes of initiating a criminal investigation. (See Exhibit 1-3.) Among the typical causes of insurer insolvency are:

- Undercapitalization.

- Uncollectible, illiquid, or inflated assets.

- Insufficient loss reserves for risks assumed.

- Misappropriation or conversion of insurer funds by management, affiliates, agents, TPAs, or others.

- Commitment to unprofitable business by uninformed or undisciplined agents.

- Collectability of reinsurance.

- Negative cash flows due to unprofitable lines of business.

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- Poor underwriting.
- Unnecessarily risky investments.
- Fraudulent transactions.
- Other forms of mismanagement.

Any indication of fidelity bonds, directors' and officers' policies, error and omission policies, or other indemnification coverage should be identified, segregated, and made accessible to the receiver and receivership counsel. The documents should be reviewed immediately, and carriers placed on notice to preserve the rights of the estate.

H. Move to Consolidate

Consolidation of the receivership's offices and storage facilities could result in increased productivity and reduction of labor and storage costs. For that reason, an assessment of the value of maintaining the insurer's offices and storage sites should be made in the early days of the receivership. Consolidation of the books and records should take place only after: 1) an inventory is completed; 2) the receiver has considered the impact upon the insurer's ability to handle claims in an orderly and efficient manner; and 3) the receiver has considered the potential impact upon the insurer's relations with any existing agency network. If the insurer is in conservation or rehabilitation, the receiver should weigh the effect a consolidation might have upon the insurer's marketing program.

I. Coordination With Ancillary Receivers

Any assets of an insurer in liquidation that are held by a non-domiciliary state should be returned to the domiciliary receiver of the insurer. Under Section 1001 of Model #555, the need for an ancillary receivership has been curtailed. Model #555 allows the appointment of an ancillary conservator under limited circumstances. A domiciliary receiver is automatically vested with title to property in any state adopting Model #555, and the test of whether a state is reciprocal has been eliminated. Model #555 also clarifies the procedures for handling deposits.

The NAIC models prior to Model #555 permit reciprocal states to establish receiverships ancillary to the domestic state's receivership. Typically, an ancillary receivership would be established to distribute assets in the ancillary state—i.e., statutory deposits—to claimants residing in that state. However, an ancillary receivership may be established for purposes unrelated to claim handling. In certain instances, the domiciliary receiver may request that an ancillary receivership be established for a variety of reasons (e.g., to assist the domiciliary receiver in selling real property located in the ancillary state or to assist the domiciliary receiver in handling litigation pending in the ancillary state).

State statutes based upon NAIC models prior to Model #555 allow or may require ancillary receiverships under certain circumstances. If an ancillary receivership is not required by statute, it should be opened only after carefully evaluating the additional administrative costs that would be incurred by the insolvent insurer. The activities of the domiciliary and ancillary receivers should be coordinated to minimize the cost of the ancillary proceedings.

Domiciliary receivers must consider the following issues, which commonly occur between the domestic and ancillary receivers:

- The security of the insurer's assets and records.
- The security of the insurer's out-of-state offices or storage facilities.
- Consistency and reciprocity of authority.
- Coordination of the transfer of policy/claim files to guaranty associations.

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- The need for a receivers' agreement. (See the discussion in this chapter below regarding a receivers' agreement.)
- The need for local counsel in other jurisdictions.
- The status of litigation by the ancillary receiver.
- The method of funding and payment of approved ancillary claims.

To facilitate coordination, the ancillary receiver should request copies (certified, if available) of all domiciliary pleadings and orders, together with the names, addresses (including email addresses), and phone and fax numbers of personnel in the domiciliary state.

Legal counsel for the domiciliary receiver should review the proposed ancillary petition and order as soon as they are received to assure that: 1) under the order, the rights of the ancillary receiver are subordinate to the rights of the domiciliary receiver; and 2) the ancillary receiver's bar date is no later than the bar date established by the domiciliary receiver. Some state statutes permit ancillary receivers to establish shorter claim filing periods but prohibit claims deadlines that exceed those established by the domiciliary receiver.

In the event that the proposed ancillary order is not acceptable to the domiciliary receiver, the domiciliary receiver should request a revision. If the ancillary receiver refuses, the domiciliary receiver may be required to file an objection in the ancillary proceeding, asserting that the ancillary order violates the law of either or both states.

1. Receivers' Agreement

In some situations, it may be possible to negotiate a receivers' agreement, with the goal to consolidate functions and to clarify the authority and obligations of the domestic receiver and the ancillary receiver concerning:

- Coordinating the preparation of a jointly acceptable proof of claim form.
- Filing and processing proofs of claims.
- Funding and maintaining an account for payment of approved claims.
- Identifying and locating TPAs and MGAs licensed by the insurer in each state.
- Identifying and locating all bank and financial accounts.
- Locating outstanding claims files and arranging for shipment of files between states.
- Coordinating policy cancellation and impairment order dates.
- Collecting agents' balances.
- Controlling director and officer litigation by the domiciliary state.
- Administering and closing out-of-state offices.
- Marshaling assets located in the ancillary receiver's jurisdiction.
- Determining the disposition of assets collected by the ancillary receiver.
- Controlling and securing information (e.g., claim files, policy files, premium volume in the ancillary state, etc.) is essential for the orderly administration of the estate.
- Coordinating the oversight of the insurer's out-of-state litigation.

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2. Claim Handling

When there is no ancillary receivership, citizens of non-reciprocal states should file their claims in the domiciliary state. Some pre-Model #555 state statutes provide that a resident of an ancillary state has the right to file a claim in either the domiciliary or the ancillary proceeding. Other states leave the decision to establish a claims procedure in the ancillary state to the discretion of the ancillary receiver.

3. Ancillary Proceedings Without a Domiciliary Receiver

Ancillary receiverships are usually established only after a domiciliary receiver has been appointed. However, some states do not have the limitations imposed by Model #555, and even when no domestic receiver has been appointed, they do permit the establishment of an ancillary conservatorship or liquidation, provided that the non-domestic regulator can prove one or more of the grounds required to establish a domestic receivership. Nonetheless, the ancillary receivership order operates only upon the assets found in the ancillary jurisdiction.

V. ACCOUNTING

Please refer to Chapter 3—Accounting and Financial Analysis and Chapter 4—Investigation and Asset Recovery when reviewing this section.

Upon taking control, one of the receiver's primary responsibilities is to secure the insurer's assets—particularly the most liquid assets, such as cash and securities. This responsibility includes identifying lines of credit, limiting, or removing access to company credit cards and preparing an inventory of all accounting records and documentation as soon as possible. The accounting area will also be responsible for financial statement analyses to determine the true status of the insurer and the continued reporting of financial information for internal decision-making processes.

A. Secure Assets

Because cash and securities are liquid, the receiver must quickly identify, locate, and secure assets. The receiver should immediately notify all depositories and custodians of the receivership order, provide the new authorized signatories, and establish the procedures to be implemented for all financial transactions. Letters of credit (LOCs) should be identified and secured by the receiver. Once the assets are secure, the receiver will evaluate and value them.

B. Inventory Accounting Records

As soon as practical, the receiver should identify and secure the on-site and off-site books, records, systems, and documents necessary to maintain and review the accounting functions of the insurer and to determine the actual financial condition of the insurer. These should include most recent insurance department examination workpapers if allowed under state law and certified public accountant (CPA) audit workpapers.

C. Investigation of the Insurer's Financial Statements

The receiver should develop an understanding of the accounting organization, including evaluation of the staff. Flowcharts and narratives of the accounting procedures should be obtained or completed with particular attention to the areas of cash receipts and cash disbursements focusing on decision points and internal controls. To the extent procedures need to be modified to protect the assets, new procedures should be put in place as quickly as possible. From the information developed here, the receiver should begin to investigate the make-up of the balance sheet line items, validate the existence of the assets, and value them.

D. Financial Reports

Accounting and financial reporting by the insurer will continue to be necessary and important. Financial reports will be required by the receivership court, and cash flow and budget information will be essential for the day-to-day operations of the receivership. Continued filing of the various

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types of tax forms is mandatory (although some may be eliminated) during the existence of the estate. Additionally, the continued reporting of paid claim information for reinsurance billing and actuarial reserving will also be crucial.

At the beginning of the receivership, the appropriate parties should determine the type of information to be reported to various entities, the frequency of the reporting, and the formats the information should take.

VI. INFORMATION SYSTEMS AND TECHNOLOGY

Please refer to Chapter 2—Information Systems when reviewing this section.

This section highlights the activities that should take place for a receiver to understand and take control of the insurer's systems. To the extent possible, the receiver should not allow anyone access to the insurer's computer system until a complete backup of the system is complete. It is not uncommon for the insurer's computer systems to be intertwined with that of its affiliates. Therefore, legal consultation is advised prior to taking any action that may affect the affiliates' operations.

Detailed tasks are listed in the checklist included Exhibit xxx.

A. Evaluating Hardware/Software

For any hardware/software owned by the insurer, the receiver should determine whether to maintain it or sell it. Prior to the sale of any equipment, the receiver should determine if that equipment is required to support any ongoing or contemplated litigation. A sale may require court approval.

B. System Shut Down

The receiver should arrange for the orderly shutdown of the computer system. Prior to shut down, the receiver should ensure that all records have been updated and all final reports have been run. It is suggested that a data processing checklist of all reports and programs to be run be completed prior to the shutdown period.

With all data updated, the receiver should make certain the information systems department performs a full system backup prior to the clearing of all files on the system. Once completed, the system may be powered down.

VII. CLAIM OPERATIONS

A. Take Control of Claim Processing and Payment

A receiver should plan to put in place appropriate controls over claim processing and payment authority of the insurer's claim department and establish the capability to control and review the insurer's claim records. Claim records may be contained in hard copy files, electronic records, or a combination of both, and they may be under the control of the insurer's claim department at its main office, branch offices, or by a TPA.

Some of the initial goals in establishing control may include a review of claim policy and procedure manuals, the coverage confirmation process, claim reserving methodology, settlement practices, and applicable electronic claim processing systems. If written documentation of the insurer's claim policies and procedures does not exist, the receiver may wish to interview key claim personnel to develop and document claim processing procedures.

For health receiverships additional considerations include prior authorization requirements, capitated arrangements and referrals, and outside claim handling by pharmacy benefit managers (PBMs), mental health, and/or durable medical equipment (DME).

B. Develop an Understanding of Claim Operations

A receiver needs to understand the operations of the claim department, including its organization

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and workflow, processing systems and data, type, and nature of claims, and gather key information on the number of pending claims and outstanding reserves by category of business.

C. Review of Claim Handling

A receiver may wish to review the claim handling process by obtaining or preparing an overview of the typical workflow for processing a claim. This workflow might include a summary of all key interactions between claim personnel and other departments. If workflows vary by claim type and product line, the preparation of a separate workflow summary for each product line may be necessary.

The receiver should determine whether the insurer uses an active diary system for claims. Such a system monitors the claim handling process and records the dates of each step in the process. As part of the claim diary system investigation, obtain an overview of the diary functions, including the relationship between the manual and the electronic elements of the processing system.

With a basic understanding of claim handling policy and procedures, a receiver may wish to determine whether there are any constrictions in the claim resolution process such as:

- Setup of new claims.
- Correspondence files.
- Claim diaries.
- Indemnity payments.
- Loss adjustment expense (LAE) payments.
- The handling of insurance department complaints.
- Reinsurer claim inquiry.
- Reporting to reinsurers.
- Subrogation and salvage recovery.
- Inventory of unprocessed claims including those claims not yet entered on the claims system.

D. Review Outside Involvement in Claim Handling

In addition to TPAs, several other types of outside parties may participate in claim handling (e.g., legal counsel, independent adjusters, appraisers, investigators, etc.). A receiver should review these roles and determine whether to confirm or reject contracts with such vendors.

E. Claim Handling in Conservation/Rehabilitation

Depending upon the insurer's financial position and liquidity, circumstances may require a receiver to impose a moratorium on the continued ordinary payment of claims, defense of insureds, cash surrenders, policy loans, or dividends. In such circumstances, consideration may be given to hardship exceptions for claims that meet certain established criteria for continued payment or partial payment, such as claim category or payment percentage. Hardship exceptions to a claim payment moratorium should be approved by the supervising court and based on exigent circumstances such as disability of an employee or policyholder, the impoundment of an automobile undergoing repairs, or the future availability of guaranty association coverage.

For detailed information on how to handle claims in a liquidation, see Chapter 5—Claims.

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F. Uniform Data Standards

In December 1993, the NAIC adopted the UDS for use in reporting policy and claim information between P/C guaranty associations and receivers for P/C receivership estates. UDS is a defined series of electronic data file formats that facilitate data exchange between receivers and guaranty associations related to the insurer's unearned premium, claims, and LAE. The UDS operations manual provides an explanation of the current reporting format. A copy of the UDS operations manual P/C (Claims Manual) can be downloaded from the NCIGF website (*www.ncigf.org*) for free.

Refer to Chapter 2—Information Systems and Chapter 6—Guaranty Funds for further information on UDS.

VIII. REINSURANCE

Please refer to Chapter 7—Reinsurance when reviewing this section.

Understanding reinsurance is critical to the receiver's ability to marshal this asset. With respect to P/C insurers, reinsurance receivables usually represent the largest asset of the estate. With respect to life insurers, reinsurance may be critical to the rehabilitation or liquidation proceeding, and generally all ceded reinsurance agreements should be continued. See Section 612 of Model #555 and Section 8(N) of Model #520. This asset may require immediate attention upon commencement of the receivership.

A. Location of Reinsurance Documents

Before the receiver can begin to marshal reinsurance receivables, it is necessary to understand the insurer's reinsurance relationships. To accomplish this, the receiver must first locate and categorize the various documents reflecting the insurer's reinsurance arrangements. The receiver should take control of original reinsurance contract documents. These records should be secured, copied, or scanned and then inventoried. The receiver may create working copies for use during the receivership. The integrity of the original records should be maintained in the event they are needed in the future.

B. Letters of Credit and Trust Agreements

LOCs and trust agreements must be located and placed in a secure area. These documents should be reviewed as soon as possible to determine whether any immediate action is necessary to ensure the continuation of the LOC or trust agreement. Under certain forms of LOCs, the LOC may expire by its own terms, although it is more common that they renew automatically. In some instances, the original LOC must be presented to the issuing financial institution to draw against the LOC.

C. Role of Intermediaries

It may be in the best interests of the receivership to continue working with intermediaries. The intermediary has at its disposal detailed information that the receiver may not have. The intermediary should be notified of the insolvency proceedings immediately and instructed as soon as possible on duties and responsibilities it should continue to perform for the receiver.

The duties of the intermediary need to be clarified. The receiver may decide to instruct the intermediary to take one or more of the following actions:

- Advise all reinsurers or cedents of the status of the insolvent insurer.
- Turn over all funds in their possession due to the insurer.
- Turn over original LOCs.
- Continue to render accounts to receivers and reinsurers.
- Assist in the collection of funds from reinsurers.

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- Transmit claims and other notices to the receiver and the reinsurers.
- Establish procedures for the handling of reinsurance inquiries.
- Cease netting of accounts among insurers.

Under certain circumstances, the receiver may find it preferable to discontinue the use of the intermediary. In this event, the receiver should deal directly with the reinsurers, with appropriate notice to the intermediary.

D. Identification of Funds Held

The receiver should prepare a list of insurers that are holding funds of the insolvent insurer, as well as a list of insurers for which the insolvent insurer is holding funds.

E. Payments to Reinsurers

One of the key issues facing the receiver in the short term is whether to continue to pay reinsurers on a current basis and/or cure prior defaults. This may be necessary to continue the reinsurance in effect, particularly if there have been pre-receivership defaults. This is a legally intensive problem, and the receiver needs to engage legal counsel on these matters as soon as possible. The decision will depend on an array of factors, including the terms of the reinsurance agreements, applicable state law, and the payment status of the contract.

IX. HUMAN RESOURCES

A. Open Lines of Communication

The commencement of a receivership can be difficult for an insurer's employees. Many employees are not aware of the circumstances that have led to the receivership. Productivity and employee morale often decline. Meetings with employees at the commencement to explain the receivership process, as well as the receiver's current objectives, is important. Establishing an open dialogue and clear lines of communication will minimize the spread of misinformation and mitigate untimely staff departures.

B. Personnel, Payroll, and Benefits

It is important that a receiver assume oversight of an insurer's direct employees, payroll, and employee benefits with minimal disruption to existing processes. A receiver may also need to assume oversight of pension or 401(k) plans and, over time, establish new benefit programs for direct employees. Additionally, a receiver may need to consider whether to continue, replace, and wind-down existing employee benefit programs. A summary of the critical human resource tasks is contained in the checklists included in Exhibit xxx.

Employees may be employed by an affiliate or holding company, rather than as direct employees of the insurer. In such cases, a receiver will need to review existing cost-sharing arrangements or contracts for reimbursement with the affiliate. In such instances, a receiver typically would not have direct responsibility for the employee benefit programs pertaining such employees.

C. Staffing Plan

One of the receiver's responsibilities will be to develop a staffing plan for the receivership that identifies both short- and long-term personnel requirements. A receiver may wish to develop an organizational chart, comprehensive job descriptions, and personnel files for receivership staff. As responsibilities and job functions may change during the receivership process, including transitions from conservation, rehabilitation, and liquidation, a receiver may be required to periodically assess and update the receivership staffing plan.

D. Retention of Legacy Staff

Legacy staff can be well positioned to provide a receiver with institutional and operational

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knowledge that will benefit the future operations of a receivership estate. A receiver may accordingly wish to look to legacy staff to augment the short- and long-term receivership staffing plan. Staff resignations and reductions in force are typical during a receivership as certain operations begin to wind-down and the insurer is no longer perceived to be a going concern. A receiver's staffing plan may also include the retention of certain legacy employees until their requisite knowledge and expertise are no longer necessary for the operation of the receivership estate. In such instances, retention incentives may be required to achieve the receiver's staffing objectives. Retention incentives may include one or more of the following:

- Maintenance or adjustment of existing benefits, including severance.
- Performance and salary review process.
- Retention bonuses.
- Educational or tuition reimbursement.
- Providing outplacement services.

E. Other Personnel Issues

The receiver should identify any personnel-related litigation and other disputes, including equal employment opportunity complaints, workers' compensation claims, wage, and hour complaints, etc. These matters should be managed by the receiver's personnel consultants and/or legal counsel.

X. CLOSURE OF THE ESTATE

Please refer to Chapter 10—Closing Estates when reviewing this section.

The best time to start planning for closure is at the start of the receivership. Since the receivership process may take several years, the receiver may wish to prepare a closure task list or checklist. A partial list can usually be developed through a review of the receivership statute of the domiciliary state. The following are some of the general tasks that should be accomplished before a liquidation estate can be closed:

- All assets have been marshaled.
- Litigation has been resolved.
- Ancillary proceedings have been closed or resolved to a point that will not impede closure of the domiciliary receivership.
- Guaranty association claims against the estate are finalized to the extent that a final distribution can be made to the associations.
- All claims have been allowed or disallowed by the supervising court.
- Appropriate distributions have been made to creditors.
- Where appropriate, the dissolution of the corporate entity has been resolved.
- Final tax returns have been prepared and filed with the federal government and financial settlements prepared as required.

A. Guaranty Associations

The claims of guaranty associations may not be completely certain at the time non-guaranty-association-covered claims (including contested claims) are adjudicated by the liquidator. The covered claims that the guaranty associations handle are subject to a number of variables. Prior to making a final distribution, the liquidator may, where appropriate, consider policy reserve

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calculations as a basis for valuing guaranty association policy level claims (e.g., through the use of present value method). If early access payments were excessive, overages will have to be returned prior to processing the final distribution.

For a discussion of guaranty associations, see Chapter 6—Guaranty Associations.

B. Ancillary Receiverships

Closure of an ancillary receivership is generally less complicated than closing a domiciliary proceeding. Ancillary receiverships should be closed before the domiciliary receivership begins closure proceedings. Some state statutes provide that special deposits are established for the benefit of the policyholders in that state, who will either be paid in full or will share *pro rata* in the special deposit. If excess special deposit assets exist, the excess should be returned to the domiciliary receiver for distribution to the creditors.

Distributions to ancillary special deposit claimants are subject to the rule that all claims at that priority level share at the same percentage to the extent possible. If distributions in the ancillary proceeding will be made beyond the policyholder claimant level, the domiciliary liquidator should arrange for the excess unpaid portion of the ancillary special deposit funds to be returned to the domiciliary estate.

C. Tax Returns

When the receivership is required to file tax returns, scheduling the filing of the final return may be difficult. The filing of the final return will follow the application and order for closure. Counsel and tax advisors should be consulted to determine the best method for handling the filing of a final return for a particular receivership. The timing of the dissolution of the entity should be carefully considered because valuable tax attributes may be lost.

See Chapter 3, Section VIII for further discussion.

D. Final Accounting Matters

1. Adjusting and Closing Entries

Timing adjusting and closing entries with regard to the final report can be difficult. Generally, the liquidator will want to have the accounting books closed prior to the issuance of the final report and the filing of an application for closure with the supervising court. But there usually will be some accounting activity that must take place after either the final report or closure order.

During the early phases of the receivership, efforts are centered on determining what the assets and liabilities of the insurer were on the liquidation date. After the liquidator has written off any uncollectible assets, marshaled all the available assets, and distributed all the monies that can be paid, there may remain assets to be written off and unpaid claims as unsatisfied liabilities. Provision should be made for dealing with outstanding checks, escheat funds, and post-closure recoveries that do not justify reopening the estate.

2. Reserving Final Expenses

Expenses may be incurred after the closure order has been issued. Therefore, funds may need to be reserved for administrative expenses. These expenses may include final lease payments; employee withholding and taxes; storage charges; transportation charges; final tax preparation; bank charges; legal, accounting, and data processing consulting expenses; postage; court costs; and salaries. In preparation for closure, it is necessary to have all administrative expenses current.

E. Abandoned 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 the assets and liquidating them for the

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benefit of the creditors of the insolvent insurer, it is advisable for the liquidator to obtain court approval of any decisions regarding abandonment. 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, potentially reducing their claims against the state.

F. Final Reports and Applications or Motions

A final report on the liquidation must be made to the supervising court. This final report may be filed before, after, or with the application or motion for closure of the estate. (See Chapter 9—Legal Considerations.) Prior to closure, there may be a need to have the supervising court approve, to the extent it has not already done so, the following actions:

- Expenditures.
- Reserves set for final and post-closure expenses.
- Amounts to be paid in final distribution to creditors.
- Arrangements for destruction or storage of records.
- Valuation of any distributions of assets in-kind to any claimants.
- Any other significant transactions or procedures.

G. Final Claims Matters

1. Final Distribution

The final distribution percentage is calculated by dividing the assets available for distribution by the amounts allowed for claims filed and approved by the supervising court. The receiver must reserve sufficiently for administrative expenses that may be incurred after the distribution has been made.

There may have been interim distributions from the estate that will need to be considered when calculating the distribution percentage applicable to the final distribution. Also, early access payments made to guaranty associations should, by order of the supervising court, be treated as distributions and taken into account when the final distribution is made. If there is a need to have guaranty associations return any portion of the early access payments, it must be identified when the receiver starts calculating the final distribution percentages.

2. Former Insureds With Unsettled Litigation

Ongoing litigation of non-guaranty-association-covered claims may impede closure of an estate. Some states provide that the insured's claims can only be paid based on the lower of 1) the recommended and allowed amount assigned to the claim; or 2) the amount established in the underlying claim against the insured. This may require that the receiver waits for all claims against former insureds be settled or barred before making final distributions and moving the estate to closure.

3. Reducing Reserves or Recorded Allowances on Claims

After a distribution has been made, the record of allowed claims may need to be adjusted for tax purposes or to enable additional distributions to be made.

4. Unclaimed Dividends and Escheated Funds

The receiver may not be able to locate all claimants. Also, there are claimants who will refuse to accept their liquidation distribution because they are involved in litigation and believe that accepting payment would prejudice their case. State statutes may require special treatment of funds related to unclaimed distributions. Further, after a certain time period, funds held for

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unclaimed distributions will be escheated to the Treasury of the domiciliary state. (See Chapter 9—Legal Considerations, Section III.)

H. Closing the Office

After all the records have been either destroyed or sent to the appropriate archives, any separate office maintained for the liquidation will need to be closed. One of the items related to closing the office may be cancellation of any remaining lease term and insurance coverage on staff, equipment, and the office space itself. In many cases during a liquidation, the office will have been closed early in the receivership process to reduce expenses.

I. Post Closure Matters

There may be inquiries for records and information made by former agents, insureds, and other interested parties after the closure of the estate. Usually, these will be referred to the domiciliary insurance department, and basic insurer information may be posted on the domiciliary insurance department's website. If the request is for pre-insolvency financial data, the request will probably be handled by the department. Arrangements should be made to brief someone on the permanent receivership staff or in another division within the department of insurance so that post-closure questions can be answered.

J. Potential Reopening of Estate

Some statutes provide for the reopening of an estate upon the occurrence of certain events. For example, assets not previously discovered or written off may become available, making an additional distribution possible. However, a careful analysis should be made to determine whether an additional distribution would be cost-effective.

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I. INTRODUCTION

A. Information Systems—Requirements and Considerations

The management of an insurance company in receivership is, to a great extent, the management of information. To successfully perform receivership functions and fulfill all obligations and responsibilities, the receiver must effectively use system resources.

The nature of the receivership, conservation, rehabilitation, or liquidation will affect systems requirements. The type of business written by the insurer—whether life, annuity, accident, and health (A&H), property, casualty, liability, surety, title, workers' compensation, or other lines—will also affect systems requirements for the receiver. Systems needs, and the timing of those needs, will be different in a conservation or rehabilitation process than in a liquidation process.

Because of the importance of securing the data of any company subject to a receivership, immediate attention must be given to obtaining a backup of the data and consideration given to obtaining a complete backup of the systems.

In all conservation and rehabilitation efforts, the immediate focus is ongoing insurance company operations and the changes necessary to help ensure the viability of the company. A priority focus will be on analysis and management of information to support decision-makers. Realizing potential opportunities such as mergers, divestitures and loss portfolio transfers will require considerable information on all aspects of the business. Throughout the conservation or rehabilitation process, it is necessary to continually consider potential future requirements, such as release of the company to existing management, transferal to new owners (of the insurance business or the entire company), or transition to liquidation. In doing this, the receiver will need to look ahead to what systems requirements may be needed for other contingencies and make arrangements so they are in place when needed.

Liquidation processes will require a focus on timely conclusion of normal operations and an accurate final statement of assets and liabilities. Systems support will be required for estate liquidation processes, including interfaces with guaranty associations, management of claims against the estate, recovery of all receivables, pursuit of causes of action to benefit the estate, and disposition of physical assets. Compliance with all legally required processes and documentation to support compliance are crucial.

B. Overview

The chapter has been divided into the following parts:

- Taking control.
- System management and control.
- Information system deliverables.
- Implementation.

These sections are in the order that anticipated issues may arise during the receivership process. Insurers will vary in size and degree of system sophistication. Each insurer will present varied problems and issues dependent on the situation. In general, companies going into receivership have often neglected internal controls, which may have resulted in many control issues related to the company, its systems, and completeness and accuracy of its data. The guidelines, considerations, and checklists provided herein are broad in nature. Management judgment will best determine the appropriate degree of applicability or whether alternate processes are required.

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Generally, though, the receiver will first have to gain full control over the systems. Then the receiver can develop a more in-depth knowledge of processes to determine the best manner to meet the needs of the receivership.

This chapter provides suggestions and guidelines as to management of systems, issues resolution, and problem avoidance in support of receiverships. While this chapter is intended to be as comprehensive as possible, it is not all-inclusive. Other methodologies may be employed to achieve the same goals in a satisfactory manner, and issues not addressed here may arise. In every receivership, no matter the size or characteristics, the receiver must exercise judgment beyond that which can be given by texts and checklists. Still, the materials provided here should assist in the exercise of that judgment.

This chapter focuses on issues primarily related to automated information systems. When considering the scope of information systems, however, it is important to apply a holistic perspective that considers systems as being made up of processes and procedures—both automated and manual, including human judgment—in performing tasks.

Other chapters of this Handbook—specifically the accounting, claims and reinsurance chapters—address many issues related to information and manual processes. Information systems are an integral part of the operations of an insurance company and any receivership. However, not every system need must be met with a fully automated solution. Costs and benefits must be carefully analyzed.

There are detailed information systems checklists in Appendix xxx that should be consulted in advance if possible and then throughout the receivership process.

II. TAKING CONTROL

This section covers the activities necessary for a receiver to take control of an insurer's information systems in an effective manner. Generally, the checklists provided address a worst-case scenario: an information systems department that lacked control, where many key people have departed, and where documentation is incomplete, inaccurate, or nonexistent. The checklists should be completed for documentation purposes, noting those areas of the checklist that do not require action.

A. Assurance of Data Maintenance and Availability

The insurer's data will be in records and files stored within the computing infrastructure. It is important for the receiver to determine location, purpose, structure, and content of data files related to all business applications. Given the complex and detailed nature of this information within the context of a contemporary liquidation, as well as the security concerns that have increased significantly, it is desirable that the receiver have relevant background information prior to the signing of a liquidation order if possible. Ideally, this information would be shared with the affected guaranty funds in advance of liquidation. These steps will greatly enhance efficiency once liquidation is underway and result in even more dependable and timely protection of policyholders. A good starting point to gather pre-takeover information is the systems summary grid and any information technology (IT)-related workpapers from the company's most recent financial examination. Reviewing this information in advance of takeover will give the receiver a head start for what to expect. It is essential that the receiver's information systems personnel work with the other departments within the insurer to assure that all the available information has been captured and can be retrieved and reviewed at a later date. All system storage devices—including database servers, web servers, file servers, application servers, and related storage media—should be reviewed as sources of company information. End-user computing (EUC), such as spreadsheets, databases, etc., that are maintained by business departments should also be considered. EUC applications can easily fall through the cracks if there is no central repository of the EUC applications and there is turnover of personnel who maintain the EUC.

Regardless of system ownership issues, it should be the practice to immediately back up all available data on all systems. Where possible, employee workstations, including laptops, should be backed up as well. At

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a minimum, key employee workstations and laptops as determined by receivership management should be backed up.

For each major application, the receiver should obtain the following information:

- Name of application program.
- Vendor contact information, if applicable.
- Vendor contracts.
- Sources of data (automated or manual).
- References to and storage of source data.
- Complete tables of all codes used (database schema and data dictionary, when available).
- Type and frequency of processing cycles.
- Narrative descriptions, in nontechnical language, of capabilities and use.
- Administration procedures, including responsibilities of staff.
- Administrative user names and passwords for the application (also, if administration is restricted to a particular workstation or terminal).
- Systems error messages and appropriate actions.
- Distribution of output reports and samples if possible.
- Usage and control of reports.
- Links to other system modules.
- Backup procedures, including storage and retention schedules.

B. Security and Data Privacy

One of the highest priorities of the takeover phase of systems operation should be the review or initiation of system and data security procedures. The existing data may be the most reliable or only record of the assets and liabilities of an estate, and the need for securing this information is vital. In general, when the receiver takes control of the insurer's IT systems, access should be restricted until the receiver is confident that data cannot be altered by unauthorized parties. The receiver should identify the levels of access given to employees and any third parties for all applications and limit access as necessary. Remote access should be restricted to authorized users and only to users with encrypted laptops from trusted networks, such as corporate offices, virtual private networks (VPNs), etc.

In conducting a security review, the receiver is cautioned that relevant and important data records may reside on mainframe computers, servers, personal computers (PC)s, tablets, cellular phones, on the systems of contractors, or any combination of all of these. Historical information systems records in the form of backup tapes, which may be stored off-site, may be of equal or greater importance and should not be overlooked. The insurer may also maintain a website (see Section G—Internet/Intranet/Website), which should also be included in the security review.

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One of the primary purposes of the security program is to obtain and safeguard all required data records, which entails the identification and securing of this data. Such a program should include the creation and implementation of a plan to limit access to the systems and data to those with a proven need. The program should enable the receiver to identify changes made to the system and the individual responsible for these changes. The ability to track changes to systems may be limited by the existing company software applications. The information systems checklist in Appendix xxx will provide the receiver with an overview of the most important aspects of a proper system security program.

In addition to securing the data of the company for conservation, rehabilitation, or liquidation information, it is essential to ensure the secure handling of non-public personal information. Insurance companies and other financial institutions are subject to a variety of state and federal statutes and regulations regarding the protection and non-disclosure of non-public personal financial and health information. Some specific requirements are imposed by federal statutes such as the federal Gramm-Leach-Bliley Act (GLBA) and the federal Health Insurance Portability and Accountability Act (HIPAA), among others. Additional requirements may be found in state statutes, data security breach laws, and state insurance regulations, including those based upon the NAIC *Privacy of Consumer Financial and Health Information Regulation* (#672). Ongoing compliance with applicable data privacy and security laws and regulations is essential to help further the primary goal of all insurance receiverships—the protection of insurance consumers.

Accordingly, the receiver should take steps to ensure the security and confidentiality of customer records and information; protect against any anticipated threats or hazards to the security and integrity of such records; and protect against unauthorized access to or use of such records, any of which could result in substantial harm or inconvenience to insureds or claimants.

The company may have included cybersecurity self-assessment or audits/review as an integral part of its enterprise risk management (ERM) program. If so, the receiver can obtain recent IT audits/reviews, such as: e-commerce areas, self-assessment, and IT-related reviews of significant third-party vendors. These reports could be in the form of audits/reviews (e.g., internal audit, external audit, Service Organization Control [SOC] 1 and SOC 2 reports, or other contractor affiliate audit reviews. In the absence of a company policy that meets these criteria, it is essential that the receiver implement a data security policy and procedures suitable to the particular receivership. The procedures should be appropriate for the size, complexity, and structure of the company and its data. There is guidance contained in the NAIC "Receivership Data Privacy and Security Procedures for Property and Casualty Insurers in Liquidation" that should address potential security threats in three areas: 1) administrative; 2) technical; and 3) physical.

See *https://content.naic.org/cmte_e_receivership.htm* for this document and other helpful receivership tools, such as the NAIC receivership "Data Privacy and Security Procedures" policy. Because staffing is often not available to write a new data security policy specific to each receivership, the NAIC's security policy and procedures document referenced above may serve as a guideline that could be edited for purposes of individual receiverships.

1. Administrative Safeguards

   - Designate an individual who is responsible for oversight and compliance with security procedures.

   - Publish a written policy statement setting forth the company's (receiver's) intention to protect the confidentiality of sensitive customer data from anticipated threats or hazards. The receivers' policy should include two important components should an incident occur: 1) incident handling – general and specific procedures and other requirements to ensure effective handling of incidents, including prioritization, and reported vulnerabilities. Determine if there are procedures related to handling cybersecurity incidents; and 2) communications – requirements

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detailing the implementation and operation of emergency and routine communications channels amongst key members of management.

- Prepare and distribute written procedures to appropriate personnel and service providers outlining specific steps that must be followed in storage, transmission, retrieval, or disposal of sensitive customer information.
- Require all employees and other users to sign an agreement to follow the data privacy and security standards.
- Evaluate potential security threats from existing staff (e.g., disgruntled employees).
- Evaluate service providers regarding the handling of sensitive customer information.
- Train and instruct employees as to their individual responsibilities regarding data privacy and security.
- Train staff to recognize potential security threats, including intentional or inadvertent downloading of malware.
- Check references and an appropriate background screening prior to retaining new staff.
- Periodically test and monitor the effectiveness of the security procedures.
- Evaluate and adjust the security procedures considering changing circumstances.
- Use appropriate oversight or audit procedures to detect improper disclosure or theft of customer information.
- Implement procedures for notifying appropriate authorities and affected individuals if non-public personal information was subject to unauthorized access.
- Impose disciplinary measures for breaches of privacy and security rules.
- For laptops that are used outside of the office, require a secure network connection.
- Establish a remote work policy for remote workers that includes policies for where work is to be performed with a secured network connection only and safeguards that must be in place associated with their computer and other data (paper files, etc.) used outside of the office.
- Add multifactor authentication where possible, including email, application servers, and company networks.
- Consider if appropriate disabling USB ports on all company laptops and computers, if appropriate.

2. Technical Safeguards

- Use password-activated screensavers.
- Use strong passwords that are unique and independent of any personal passwords.
- Change passwords periodically.
- Prohibit posting of passwords anywhere except for a secure password manager.

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- Sensitive information must be encrypted both in transit and at rest.
- Limit or do not allow storage of sensitive information on portable devices such as laptop computers or removable drives or other storage media. If sensitive information is stored on mobile devices, it must be encrypted.
- Limit access to customer information to employees who have a business reason for seeing it.
- Store electronic customer information on a secure server that is accessible only with a password.
- Avoid storage of sensitive information on a machine with an internet connection.
- Transmit data electronically only through secure, encrypted connections.
- Implement procedures for the prevention, detection, and response to attacks, intrusions, or other system failures.
- Regularly check with software or systems vendors to update security patches.
- Maintain up-to-date firewalls.
- Back up all customer information regularly.
- Ensure that former employees do not have access to any information systems.
- Ensure that remote access to all information systems is limited to authorized users.

3. Physical Safeguards

- Lock rooms and cabinets where sensitive data or data storage equipment is kept.
- Ensure the area where data storage equipment is kept is well ventilated, is capable of maintaining an appropriate temperature for the equipment, is free from water hazards, and is not visible through a window to the outside the office.
- Allow access to information storage areas only to those individuals with a need for access.
- Require employees to secure sensitive information in their work areas whenever they are not present.
- Dispose of sensitive information in a secure manner.
    - Hire or designate a records retention manager to supervise the disposal of records containing non-public personal information.
    - Shred sensitive information recorded on paper.
    - Destroy or effectively erase all data when disposing of computers, diskettes, magnetic tapes, hard drives, copy machines, fax machines, flash drives, or other storage media containing sensitive information.
- Ensure that storage areas are protected against physical hazards such as fire, flood, or physical intrusion.

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- Maintain a current inventory of all computer equipment.
- Collect keys, computer equipment, and other storage devices from employees and disable employee access to company systems prior to termination.
- Develop a computer disposal policy/procedure that includes a strategy for the maintenance and tracking of hard drives.

C. Systems Processes for Conservation, Rehabilitation, and Liquidation

Systems emphasis for a conservation or rehabilitation effort typically focuses on timely and accurate processing, resolution of issues, and providing information for management. The additional considerations regarding liquidations outlined below may apply in some conservations or rehabilitations.

In a liquidation action, beyond timely processing and termination of operations, there are additional considerations related to accurate identification and valuation of all assets and liabilities of the insurer:

- Liquidation notices and proof of claim processes.
- Policy cancellation and/or nonrenewal notices.
- Unearned or return premium calculation.
- Agents' balances calculation and collection.
- Unearned commission calculation and collection.
- Policyholder contract assessment calculations, where applicable.
- Reinsurance recoverable tracking and collection.
- Transmission of claims data between guaranty associations and receivers See Section IV.M. in this chapter for unique standards such as Uniform Data Standards (UDS) and others that apply to the different types of insurers.
- Salvage and subrogation accounting and collections.
- Inventory and liquidation of physical assets.
- Transmission of policyholder records and data to assuming insurer for life and health insurer receiverships.

Some systems will have built-in capabilities for creation of the above items. Others may not, and an extract from the system may need to be taken and manipulated to achieve desired results. Also, when using company data to create reports, it is important to discuss the completeness and accuracy of the data with company staff since often companies in receivership may have issues where systems are not working properly or other reasons why it is known that the data on the system may not be complete and accurate.

D. Staff

Assuming control of the insurer's information systems is critical to a successful receivership. Gaining control of the information systems usually will be most cost-effectively accomplished through use of the existing staff. Since it is important to gain control of these areas at the onset of the takeover process, it is best to assess the staff at the inception of the receivership to determine how they can assist in the receivership process. In some cases, a plan may need to be devised to provide information systems

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personnel with incentives to continue their employment as the receiver requires. Even so, it is often difficult to retain IT personnel, so it is important to perform as much knowledge transfer as possible at the onset of a receivership.

After assessing the experience, potential contribution, commitment, and cost of the staff in the context of the goals of the receivership, the receiver may choose to reduce staff. The allegiance of the systems staff, as with other functional areas, may be questionable, and the possibility of sabotage exists. Sabotage of information systems is hard to detect and may be extremely expensive to repair. Because of the potential exposure to loss of critical data, the systems staffing decisions should be made quickly and decisively. Where possible, restrict full access to any systems, equipment, or work areas until staffing decisions have been made and implemented.

E. Hardware

In taking control of systems operations, frequently the first concern of the receiver is to inventory and secure the hardware. The hardware may be owned, leased, or shared, and arrangements should be made for continued use to the extent the receiver finds necessary to maintain continuity, especially at the onset of the receivership. The receiver will also want to identify collateral equipment located at branch operations, the homes of employees, related entities, storage facilities, other insurers, and agencies. All equipment should be inventoried, including all types of portable computers, tablets, cellular phones, and communication equipment.

Contingency plans may need to be developed in case the receiver must cease use of the systems in order to liquidate components.

Maintenance of the hardware should be done on schedule, and the environment should be maintained to prevent loss of data or system outage.

The configuration of the hardware should be specifically identified and cataloged. The computing hardware environment may be made up of a combination of mainframes, mid-size computers, client servers, and PC-networked equipment.

For mainframe or mid-size computers, the most important components of their configuration will be:

- Central processing units (CPUs).
- Data storage devices.
- Printer(s).
- Tape drives.
- Terminals.
- Data communications equipment.
- Any other peripheral devices.

Similarly, all PC-network configurations should be identified and may include:

- Network servers, firewalls, intrusion detection devices, routers, switches, etc.
- Mail servers.
- Web servers.

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- Imaging servers.
- PCs and laptops.
    - Make and model.
    - Internal storage devices.
    - RAM.
    - Clock speed.
- External storage devices.
- Printer(s).
- Keyboards and other input devices (e.g., scanners, microphones, and pointing devices such as a mouse, track ball, touch pad, or other sensor).
- Monitor(s).
- Any LAN-connected devices (high-performance cables, terminals, file servers, printers, modems, etc.).
- Data communication equipment, such as cell phones, tablets, and any other internet-connected devices.
- Uninterruptible power sources (UPS) and generators.

F. Systems Software and Application Software

Systems software includes broad and varied types of software, such as operating systems, utility systems, database management, virus protection, e-mail systems, and any other software that is not classified as business application software. These systems are typically commercially available systems that are closely related to hardware components.

Application software directly supports business functions and may be licensed, commercially available software or may be custom-developed, including legacy applications developed in-house.

Taking control of the software requires a different approach than that applied to most of the other assets of the insurer. This is especially true for custom-developed software. Control of the software initially means knowledge of the software in place, and its intended purpose to the insurer. For licensed software, it is necessary to have an accurate inventory of the software, to have proof of licenses and status of maintenance contracts to ensure authorized legal use, and to obtain updates from the software vendor. In the case of custom-developed software, it is necessary to identify the developer(s), whether contract or in-house, and any relationship with the insurer. It may be necessary to retain an intellectual property attorney to determine the company's rights to the software. The program source code must be physically located, whether on the company's servers or elsewhere, and rights to the source code must be determined. Succession planning information should be obtained for software developed by a sole proprietor contractor.

It will be necessary for the receiver to identify the applications that address the following functional requirements:

- Marketing and sales management.

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- Agency interface.
- Customer service.
- Claims management.
- Policy issuance and endorsement processing.
- Premium billing and accounting.
- Reinsurance.
- Policy receivables and payables.
- Cash receipts and disbursements.
- General financial management and reporting.
- Investment management.
- Data warehouse.
- Word processing and publishing.
- Company website.
- External interfaces and data sources.

G. Internet/Intranet/Website

Increasingly, insurers are using the web as a tool for their business and have web-based technologies implemented. The receiver should review the company's Internet content and application processes. The receiver should also ascertain what web services are being provided by the insurer and to the insurer by external vendors. Internet service providers (ISPs) should be documented, and service contracts should be obtained and reviewed. The receiver can assume the role of webmaster. Alternatively, the receiver may make arrangements with a third-party vendor. This may require that external ISPs be notified of the change and new passwords issued. Firewalls, web servers and proxy servers, routers, and other web- and network-related items should be reviewed for legal, data, ownership, confidentiality, and security issues. Integration with the receiver's own web usage and applications should be reviewed and considered.

If premiums are being collected over the internet, the receiver should ascertain the company is payment card industry (PCI)-compliant. PCI-compliant organizations will have an annual PCI assessment. If the company is not PCI-compliant, it is recommended that areas of noncompliance be mitigated or the ability to take electronic payments be removed. The receiver should also understand the process for collecting electronic payments and what, if any, action needs to be taken by company or receiver personnel to collect and record such payments.

H. Newer Technologies

As emerging technologies become more common in the field of insurance, the receiver should be aware of newer technologies that may have been implemented by the insurer.

Imaging systems and distributed processing of underwriting, claims, collections, and other operations all have special requirements that the receiver will need to address. An analysis will be needed to determine system ownership, hardware and network components used to support these implemented technologies, and

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vendor involvement in the support and maintenance of these systems. These should all be reviewed by the receiver to determine risk, cost benefit of continuation, conversion, and receivership issues.

I. New Business Strategies

The receiver should ascertain system ownership and system usage issues, such as leased systems, outsourced contractors or vendors performing work or services for the insurer, system availability, and security. The receiver should verify that there will be sufficient access to data and functions necessary to perform the receivership processing. The receiver should identify all the involved parties; what services, hardware, and software have previously been provided; what is currently being provided; and at what cost.

J. Remote Work

In 2020, the COVID-19 pandemic not only created new challenges for the administration of receiverships where activities were carried out remotely from the insurer's corporate offices, but also it brought about changes in how insurance companies operate. Specifically, more insurers have allowed staff to move to remote work or hybrid (partially remote) work environments, as well as to rely more on paperless electronic records and less on (or even eliminate) hardcopy documents. This has led to the need for use of platforms that allow for secure remote access by authorized staff and enhanced data security.

A few IT considerations for the receiver, if the insurer has staff who work remotely, or if the receiver's access to on-site IT systems is limited due to a disaster, include, but are not limited to:

- Review the insurer's disaster recovery and business continuity plan for remote access and maintenance of systems.
- Identify and understand the critical automated systems that need to continue operating to support business functions, the persons responsible for critical systems, location, and back-up systems (i.e., colocation data center).
- Review the insurer's work-from-home policy to gain an understanding of the roles and responsibilities of staff working remotely.
- Understand which employees have remote access to systems and/or may have company-owned equipment at home (i.e., laptops, monitor, printers, and office furniture).
- Understand what business systems, programs, technology, (e.g., VPN, phone/communication systems) that have been established for employees to work remotely and the internal controls over those systems.
- Understand the insurer's cybersecurity controls and data security protocols that are in place to facilitate secure remote access to the requisite systems and data by off-site staff.

III. SYSTEM MANAGEMENT AND CONTROL

The preceding section of this chapter dealt with the first task facing the receiver when taking over a distressed insurer—establishing control. This section will guide the receiver through a more detailed continuation of that process by identifying the areas of management and control.

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A. Systems Operations

The hardware, software and personnel who keep systems running make up the systems operations. In many mainframe computer operations, the users of the application software may never have seen the actual data center and its various related equipment. Systems operations are typically supported by an internal or external help desk support and network administration.

B. Input/Output Controls

Many application systems both receive and send data to and from other application systems, which can be internal, external, or both. This data may be in the form of removable tapes or disks that are visible. This date may also be in the form of files/databases that reside on non-removable disks and are created by one application system; then later, it is input or electronically transmitted to another application system or cloud storage. The input, output, and transmission of all data should be subject to controls, which may range in form from a simple notation indicating the application name/date/time to a more complex procedure (manual or automated) that balances or validates record counts and control totals. Controls may also be part of the application program and be unseen until an error or notification prompt occurs.

The receiver should verify that these internal and external controls are in place and fully documented. After the urgent control matters have been addressed, areas where these controls might be improved will be noted through the operation of the receivership.

C. Maintenance/Updates

Some licensed software is automatically maintained and upgraded by its vendor. In many instances, the end user or owner identifies the availability of, and acquires, updates. The receiver should be aware of the availability of updates to software used by the insurer. For some mainframe and mini-computer configurations, current maintenance costs may exceed the cost of converting to a PC-based system. The inventory made of the software and its licensing is important to ensure proper maintenance and may affect business decisions regarding continued use of the existing system.

D. Networks

Network systems in which an on-premises file server, cloud server, or CPU forms the hub of a network of interrelated PCs are now common. The age and adequacy of the networks should be ascertained, and the availability of maintenance and updates should be determined. Networks may include not only the insurer, but also other affiliates or holding company of the insurance company. Thus, the ability to separate the network into independent components may be problematic. See also Section III.G. regarding segregating commingled records and data.

E. System Location

The physical location and management of the computer system is also an important issue. Many computer systems are completely internal to the insurer. That is, all of the hardware and software components of the system are within the insurer's premises and control. The benefit of this is that the information systems operation is entirely dedicated to, and focused upon, the objectives of the insurer. However, this also requires that all aspects of the systems operation be managed and controlled by the receiver. To maintain and control an entirely in-house operation, it is vital that the receiver have sufficient systems staff in place. In instances where the receiver has determined that the responsibility and expense of an in-house information systems operation are not desirable, he or she may look to alternative arrangements, such as outsourced operations.

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1. Outsourced Operations/Hosted Systems

A service provider may have performed some or all of the data processing functions. The arrangements for this service may vary from hosted systems to a service provider maintaining the company's internal systems. The receiver's staff should perform an evaluation of the facilities and competency of the service provider. The receiver should verify that existing contracts will provide sufficient flexibility and accessibility to meet the receiver's needs; new contracts may need to be executed.

2. Shared System

The insurer may share data processing systems with affiliates or other companies, or have its data hosted and handled by a third party The receiver should ascertain to what extent the system will be available and whether confidentiality will be compromised. The legal issues arising with shared systems should be carefully considered. In the event that the receiver determines that a shared system is not adequate for the receivership's needs, a plan will need to be developed to migrate the insurance company data to another system or dedicated cloud under the control of the receiver or a host company that is independently contracted with the receiver. The receiver may wish to retain an independent consultant to assist with the migration. See also Section IV.G. regarding segregating commingled records and data. See Chapter 9, Section VII for discussion of legal issues relating to information systems and data processing.

3. Affiliate Functions

Some information systems functions may be performed internally, while others are performed by affiliates. Again, the receiver should verify that there will be sufficient access to data and functions necessary to the receivership proceeding. The receiver should also review the cost of any services provided by affiliates. See also Section IV.G. regarding segregating commingled records and data.

F. System Ownership

Systems may be owned outright by the insurer, leased from a third party, leased from an affiliate or provided by a vendor on a fee-for-service basis. Further, various combinations of these possessory interests can exist. However, regardless of the ownership of the systems, the records and data of the insurer held by an affiliate are and remain the property of the insurer and are subject to control of the insurer.

In most straightforward ownership situations, the insurer owns the hardware and software, and the insurer's employees maintain the systems. Possibly the most difficult situations to unravel are where: 1) a related party owns the hardware and leased it to the insurer; 2) another party developed the software and leased it to the insurer; and 3) the staff who operated the systems are on another entity's payroll.

The insurer may own, lease, or have borrowed its software from a third party. The ownership of the software should be determined, as ownership affects the receiver's rights to use the software. A contractor may be able to provide services using certain software, but the receiver may not directly use the same software. That is, software licenses may not be assignable to the receiver. Where this is the case, the receiver may have to purchase its own license or use an information systems contractor.

The receiver should identify the service providers, the services performed, hardware and software provided, and all of the applicable costs. The receiver should also arrange for temporary continuation of the information systems services that are critical to the continued operation of the insurer (in a conservation or rehabilitation) or to protect the estate. Whatever the system ownership situation, it should be a practice to immediately back up all available data on all systems, including all active PCs.

G. Conversion

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It may be desirable or necessary to relocate the insurer's systems operations or physical servers to a new facility. Therefore, the ability to relocate the existing servers or systems should be ascertained. If determined necessary but are unable to relocate, recreation, cloning, or converting data to a new system into the receiver's environment may be a possibility. The receiver should determine the cost of and ability to create a clone prior to implementing a plan to relocate an office. Sufficient planning and testing by the receiver should be undertaken prior to any decision to move, migrate, clone, and/or convert company data.

H. Common Systems Applications

The insurer or estate can put information systems to many uses. The most common are listed below. In each instance, the receiver should ascertain the adequacy of the system and the need to update or enhance it for the tasks that will be unique to the receivership.

4. General Ledger and Accounting Books

The accounting and reporting functions of the insurer or receivership are frequently handled through the information systems. The books of the insurer may not be books at all but rather entries recorded in the information systems. Chapter 3—Accounting and Financial Analysis specifically notes the types of records that may be kept electronically. The subledgers, cash receipts and disbursements records, registers, journals, claims, reinsurance, and tax records may all be computerized. The related software system may be designed so that all of these records are integrated. Common source documentation for related records may be stored once and linked to each of the related records, cutting down on unnecessary duplication. That is, data is only entered once, and each subsystem can access that data without manual intervention. The receiver should be aware of how the system is integrated and where manual intervention can occur, as well as be cognizant of linked data if attempting to bifurcate or move only a subset of the existing data.

5. Claims

The claims records will likely be kept in an information system to accommodate reporting, statistics, and control of the claims process. (See Chapter 5—Claims.) In a conservation or rehabilitation, control in this area is critical, and systems support is vital.

In a liquidation, the claims information system is usually a key component to the notice process and may be critical to the adjudication of claims. Where the insurer has an automated claims system, data will most likely need to be extracted and imported into the receiver's claims administration system to facilitate the proof of claims process, communication with the guaranty associations, and reinsurance recoveries. Where the receiver elects to use the company's existing system to process estate claims, it will need to be modified to accommodate several new data elements, including, but not limited to, proof of claim numbers, priority classifications, types of claims (third party, guaranty fund, etc.) and UDS conversion when transmitting claims data to property/casualty (P/C) guaranty associations. (See Chapter 2, Section IV(M)—Liquidation Considerations.)

6. Accounts Current

Some insurers will have systematic tracking of their agents' accounts. In a conservation or rehabilitation, prompt and efficient accounting to agents can improve cash flow. The receiver may need to evaluate blocks of business for retention or disposal. The information from the accounts current can be used to help make this determination.

Detailed electronic records of agents' balances for premium, commissions, collections, endorsements, cancellations, and remittances can be useful in a liquidation to determine the fixed rights and liabilities of the managing and producing agents. Collecting monies due the estate from agents is dependent on the availability of sound data supporting the amounts due.

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7. Premium Financing

The receiver should examine this area for the same reasons as accounts current. The receiver should look for affiliate companies that use or share the insurer's information systems for premium financing for reconciliation and UDS purposes.

8. Marketing

Marketing functions may be important in a conservation or rehabilitation, but in liquidation, there generally is no ongoing marketing function. This is not to say that the marketing database and records should be discarded. These records can be useful in determining what caused the insurer's financial distress. Further, the files and reports related to the marketing function usually are closely related to the agents' files and reports, as well as the account current systems.

9. Investments

Information regarding the insurers' investments most likely will be found on a PC or internal drive in the accounting or executive offices. The receiver's staff should check to determine if backups or subsidiary systems exist and whether subscriptions to specific services need to be continued.

10. Reinsurance

Usually, reinsurance receivables will be the largest asset of the receivership, and collection is highly dependent on reliable premium and loss information. Use of information systems in recording and tracking this information is fairly common. Depending on the level of integration of the systems, this may be part of, or at least closely connected with, the claims system or accounting system of the insurer.

Increasingly, a third-party hosted web application or system is used to track reinsurance receivables. Continued use of the application or system by maintaining or modifying existing contractual relationships with third-party vendors may be used. Alternatively, an attempt to clone or recreate the system within the receiver's environment may be viable options.

11. Email

Virtually every insurer uses an industry standard email system. Emails are important company records that must be preserved. In addition to performing a backup of the email server at the start of the receivership, it is also good practice to extract individual email boxes of key employees at that time as well. Consideration should be given to periodically backing-up these files throughout the receivership to insure preservation of communications. Email backup restoration often requires the use of outsource computer forensic experts. Extracting email boxes in readable format at the outset of a receivership will save costs down the road should email records be required for litigation purposes.

If the insurer is part of an affiliate insurance group or pool that includes employee e-mail correspondence pertaining to other insurance companies that are not entering into receivership, the receiver may need to execute a confidentiality agreement with the surviving entity(s) in order to obtain the troubled insurance company's electronic correspondence.

9. Large Deductibles

Large-deductible recoverables can be a large asset of the receivership, and, like reinsurance, collection is highly dependent on reliable policy and loss information. Use of information systems in recording and tracking this information is fairly common. As with reinsurance, this system may be a part of, or at least closely connected with, the accounting or claims systems, or information may be tracked in a separate application or system.

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12. Other

There may be other information systems, including PC-based calendar and tickler systems, time tracking and personnel systems, salvage and subrogation systems, imaging systems, and litigation support systems on either PCs or larger computers. Further, through websites and online services, computers now serve as important common communication devices. The company's website can be used to provide and gather useful information about the company in receivership.

The receiver may need to acquire utility programs to perform such functions as restoring deleted data or backing up data in a compressed format. The administration of some receiverships can be litigation-intensive. Case management or other information systems in support of legal activities should be considered for those receiverships.

Another use of information systems that is important to note is project management. Application programs for project management are widely available and understandable to the average user. This software can be put to excellent use in identifying what needs to be done to administer the receivership in the most cost-effective manner.

Finally, the use of electronic data for all documents is becoming more common. Documents may have been scanned and the originals destroyed or kept in a manner that makes them difficult to use. In the event of liquidation, the receiver may be compelled to export these electronic documents to the receiver's systems or external hard drive for safekeeping, as they serve as the only official company records.

13. End-User Computer Applications

EUC applications (spreadsheets, databases, etc.) are often used as part of reserving, reinsurance, investments, modeling, forecasting, and other areas. Critical applications may get overlooked because they often do not fall under the IT department's management and/or control structure. Rather, they are managed and updated by the business unit. Companies with good internal controls will have a centralized repository of EUC or user developed applications, but often troubled companies do not have this information. If an application is critical in producing the information needed by the receiver or guaranty association, the receiver should identify the application, ensure that change management is in place and guard against loss of institutional knowledge loss if the business unit employees are terminated (i.e., that the receiver has staff able to run the program). The receiver will need to inquire with personnel in the company's various business units to identify these applications and should create a list of the various applications. If these applications are password-protected, the receiver should also obtain the password. Before using these "applications" to make receivership decisions, the receiver should review the application to determine its accuracy (e.g., checking formulas in an Excel spreadsheet).

IV. INFORMATION SYSTEMS DELIVERABLES

The purpose of this section is to assist the receiver in determining what deliverables and services will be needed from the information systems. There will be generic requirements that are applicable to all receiverships. However, to a larger extent, the receiver's information systems requirements will reflect the characteristics of the subject insurer. The receiver will need to look at the full scope of historical operations, as well as the new requirements that are specific to the receivership proceeding, to determine the data processing tools that are essential to carry out the receiver's obligations, keeping in mind what the receiver has inherited from the insurer in terms of disposal and acquisition costs.

It may be necessary to perform a detailed study of a receiver's data processing requirements and compare this to the level of systems functionality and security provided by existing systems. If this level of functionality or security is deemed to be unacceptable, the receiver will need to modify the existing systems or replace them.

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This section provides a checklist of the functions associated with insurance, reinsurance, and receivership that should be considered when evaluating system requirements, including software, hardware, and security considerations. Software considerations will include any accounting, claims, imaging or policy applications, the management of email and/or instant messaging platforms, and any other tools that provide data capture, processing, and reporting capabilities. Hardware requirements will include computing power of application servers and data storage devices, including both on premises and cloud-hosted, as well as peripheral equipment and related items, such as network capabilities. Security considerations will include data protection, endpoint protection, user access controls, network security, and physical security.

By definition, any list of standard requirements may fail to address requirements unique to an individual estate. This checklist will serve as the basic outline of a systems requirements study that should be supplemented by the receiver and information systems staff.

A. Considerations Regarding the Insurer's Historical Business Practices

It is important for the receiver to quickly develop an understanding of the business practices of the subject insurer. This understanding will affect decisions regarding the receiver's ongoing information systems requirements and will provide the parameters for future information systems needs of the receivership.

B. Volume and Geography of Business

A preliminary task is to determine how many policies were written per year and for how many years and, in most cases, the geographic breakdown of the policies. The number of transactions (accounting, claims, reinsurance, etc.) associated with each policy should be considered along with the corresponding costs. This information is commonly requested by the receiver's staff immediately after the commencement of a receivership. The following items should be considered in determining the volume of the insurer's business:

- Policies.
- Claims.
- Claim transactions.
- Claimants.
- Premium volume.
- Reinsurance agreements.
- Reinsurance participants.
- Brokers/intermediaries/agents.
- Face value of the policies (life).
- Cash surrender value (life).
- Policy limits (P/C).
- Geographic distribution:
    - By state, whether one or many.
    - Territory, county, or ZIP code breakdowns within a state.

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- o By guaranty fund.
- o Worldwide (with foreign exchange requirements).

C. Types of Business Written

Initially, it will be necessary to identify general characteristics of the insurer's business practices and the insurance/reinsurance. If the insurer wrote only direct or primary insurance, the ability to process assumed reinsurance may not be of immediate concern to the receiver. However, if the insurer ceded reinsurance, the ability to track and control ceded placements may need to be considered in the systems requirements. Also, if brokers or intermediaries processed reinsurance (assumed, ceded, and/or retroceded), the receiver may need to determine if these arrangements are to be continued or if this function needs to be brought under the direct control of the receivership. If it is not brought under direct control of the receiver, the receiver should carefully monitor this function and work closely with the intermediary.

This analysis of the insurer's business practices and the insurance/reinsurance written will provide a general idea of systems sizing and related requirements, and it should include an analysis of:

- Lines of business—The lines of business underwritten and the characteristics of this business may have a substantial impact on information systems requirements. If it is a business in which claims will develop quickly, the requirement may be quite different from long-tail business in which claims will take a long time to develop. If the business includes large-deductible or loss-sensitive features such as retrospectively rated premiums, there will be additional system demands. This also will affect the amount of historical information that must be maintained in the systems.

D. Corporate Structure

The type of corporate structure of the insurer (single stand-alone company or one of several affiliates) and how many offices it has are factors to be considered when evaluating the information systems.

E. Sources of Production

The manner in which a company acquired its business (e.g., was it a direct writer, did it use managing general agents [MGAs], brokers, or both) will have an impact on the location and source of critical data.

F. Claims Handling

The way a company handled claims will affect information systems requirements as well. Claims can be handled exclusively in or in a combination of the following:

- In-house.
- External adjusters.
- Third-party administrators (TPAs).
- Agent/MGA.
- Other subsidiaries and related operations.

G. Affiliated Companies

Different companies with a common parent often use a single, centralized system, which can result in data security and privacy concerns. Certain data of the insurer and the affiliate may be comingled within the same systems. The receiver or the affiliate should segregate the data of the company in receivership from the affiliates' data.

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On Aug. 17, 2021, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) addressing data and records of the insurer that are held by an affiliate.[1] Specifically, the Model #440 revisions clarify the following:

- All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation,[2] at no additional cost to the insurer, from all other persons' records and data. The affiliate may charge a fair and reasonable cost associated with transferring the records and data to the insurer. However, the insurer should not pay a cost to segregate commingled records and data. Therefore, if records and data belonging to the insurer are held by an affiliate (e.g., on the affiliate's systems), upon request, the affiliate shall provide that the receiver can:
    - Obtain a complete set of all records of any type that pertain to the insurer's business.
    - Obtain access to the operating systems on which the data is maintained.
    - Obtain the software that runs those systems either through assumption of licensing agreements or otherwise.
    - Restrict the use of the data by the affiliate if it is not operating the insurer's business.
- The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement.
- The Model #440 and Model #450 revisions also describe that records and data that are otherwise the property of the insurer, in whatever form maintained, include, but are not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate.
- Model #450, Section 19 revisions update and expand on provisions that should be included in agreements for cost-sharing services and management services between the insurer and an affiliate.
    - Revisions specific to records and data clarify, similarly to that of the revisions to Model #440, that records that are data of the insurer are the property of the insurer, are subject to the control of the insurer, are identifiable, and are segregated from all other person's records and data or are readily capable of segregation at no additional cost to the insurer.
    - If the insurer is placed into receivership, a complete set of records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable.

[1] Although in 2021 the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) related to receivership matters including records and data, these revisions may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

[2] Model #440 and Model #450 address the insurance groups' responsibility to ensure that data is segregated or readily capable of segregation. The receiver should ensure that the process for segregating data does not interfere with ongoing operations.

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H. Foreign Exchange Considerations

If a significant amount of the subject insurer's business is international, it may be necessary to include foreign currency exchange considerations in a systems requirements study.

I. Existing Systems

The receiver's staff (or an independent consultant) needs to determine if the existing systems adequately process the business or if those systems must be supplemented with additional processing. If it is the latter, the receiver should then determine whether the level of supplemental processing required is acceptable, in terms of accuracy and the cost of processing. This will establish whether the existing system(s) are adequate to provide the receiver with the amount and types of information required.

The receiver may require various types of information in the administration of an estate. Especially with systems that do not permit online inquiry, it is imperative that reports that are adequate for the receiver's purposes be produced. At a minimum, the existing systems should have the capability of generating a wide variety of reports. The receiver's staff should carefully examine the available reports to determine whether they are adequate or if custom reports need to be developed, assuming the data stored in the systems can support custom reports. Reports are normally required for the following types of information:

- Policies and contracts.
- Accounting.
- Claims.
- Accounts receivable/payable.
- Cash.
- Reinsurance.
- Guaranty fund claims counts and reserves by state.
- Earned and unearned premium.
- Large-deductible collections and collateral.

The following types of documentation should exist for all of the company's systems:

1. Systems Documentation

Systems documentation shows how the system operates from a technical perspective. Documentation should include file structures, record layouts, data model, and related data dictionary and systems administration information pertinent to running the system and producing reports.

2. Process Documentation

Process documentation consists of narratives and diagrams of the processes involved in the major functions of the systems—imaging, policy administration, claims administration, reinsurance reporting, accounting, and billing, etc. Documentation should include the interaction of various systems and feeds to and from outside entities.

3. User Documentation

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User documentation shows users how to operate the system to perform their jobs. Documentation should include sections that are specific to particular functions (e.g., claims, accounting, etc.). Note that in many off-the-shelf systems, the only user documentation that exists is the online help.

J. Data Validation

The systems should perform basic data verification functions, such as ensuring that the date of loss falls within the coverage period. The system should also provide some form of validation to ensure that data entered conforms to predetermined values and formats (e.g., all dates or dollar values are numeric, etc.). This helps ensure the accuracy of the data and allows the receiver to predetermine acceptable data standards.

K. System Requirements

The performance characteristics of the information systems as they relate to the processing requirements of the receivership need to be analyzed. If the system does not have sufficient resources to process the volume of data required, it may be necessary to enhance or replace the related computer hardware with higher capacity hardware. Conversely, if the computer system exceeds requirements, the receiver may wish to consider the cost benefit of system sharing or, provided company data is appropriately segregated, downsizing.

1. Application Servers

Company systems run on local or cloud-based application servers, which must be analyzed to ensure sufficient computing performance. Further, because servers are prime targets for malware, technical staff should analyze company servers to make certain patching is current, malware protection is implemented, the local firewall only permits the minimum necessary services, and all servers are being backed up out-of-band.[3] On-premises servers should be physically secured with least privilege[4] access applied.

2. Networks

Company switches, routers, and firewalls will need to be analyzed to ensure sufficient performance when systems and users access web-related services, such as a cloud-based hosted email service. Network tools are an essential layer of defense for the security of company systems. Technical staff should review network protocols to verify that entries onto the company network is properly authenticated (two-factor authentication strongly preferred) and that data is being backed up out-of-band.
14.

3. Data Storage Requirements and Sizing

Modern storage devices can be managed on premises or in public/private cloud-hosted environments. Technical staff needs to consider the volume of historical, current, and anticipated future records that will need to be stored on the computer system. Note that imaged records like PDF and JPEG files are significantly larger than other document types, which can increase storage requirements as a company reduces its reliance on paper processes. Technical staff must ensure company data repositories are secure and encrypted, and that access is administered on a least privilege basis. Backups of company data should follow similar protocols and should be tested by technical staff to ensure viability in the event of a data loss.

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[3] Communication between parties using a means or method that differs from the current method of communication (e.g., one party uses U.S. Postal Service mail to communicate with another party where current communication is occurring online). Sources: NIST SP 800-32 under Out-of-Band.
[4] The principle that a security architecture should be designed so that each entity is granted the minimum system resources and authorizations that the entity needs to perform its function. Source: NIST SP 800-12 Rev. 1 under Least Privilege.

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L. Additional Considerations

Other systems considerations to address in assessing systems requirements include:

1. PCs, Laptops, and Terminals

To operate the system, an adequate number of PCs, laptops, or terminals need to be available. The determination of that number will be affected by the type of system, as well as the number and functions of staff members required to process the volume of business. Technical staff should determine whether endpoints are encrypted, properly patched, and limited by the company firewall, and that malware protection is applied.

2. Environmental Considerations (Climate Control)

Computers—whether mainframe, mini, or PC-based servers—generally require a stable temperature and humidity-controlled environment in which to operate. Failure to provide adequate air conditioning and/or heating can cause catastrophic systems failure. Incorrect humidity can cause excessive static, which is especially dangerous due to static discharge. It is, therefore, necessary to balance the computers' thermal output with a temperature control system capable of maintaining the operating temperatures and humidity specified by the computer manufacturer(s). A water alarm is also a good investment, especially if raised floors are used. Physical access to the computer room should also be restricted and carefully monitored.

3. Environmental Considerations (Power Consumption)

Data processing and networking equipment is sensitive to the quality of the electrical power supplied to it. Surges, spikes and brownouts of any kind can damage equipment, cause systems to crash, or, in some cases, corrupt data. Most data centers and their attendant equipment are equipped with power conditioning of some type. PCs usually have surge suppressors for this reason. Power conditioning can take various forms, but data centers usually have as a minimum an UPS that filters the power before distributing it to the equipment. A UPS may also have a backup battery that will power the equipment for a short interval while waiting for power to stabilize or allow a graceful shutdown. Emergency lighting should be provided with enough battery time to allow a safe shutdown and evacuation of the area, if necessary. Emergency shutdown procedures should be available to personnel. Finally, a UPS may be coupled with an auxiliary generator, which will supply electricity during a power outage.

In addition to special power and heating, ventilation, and air conditioning, many dedicated data centers have fire suppression systems. These systems may be stand-alone or tied into a building fire detection panel. The receiver should become familiar with how the fire suppression system operates and how it should be tested. Failure to keep these systems in good working order and to follow procedures could be deadly. It is important that testing and training be carried out regularly and that procedures be posted and read by data center personnel. Additionally, the fire suppression system must, at a minimum, comply with local fire and safety codes.

M. Liquidation Considerations

In liquidation, there are several special considerations as a result of the fixing of rights and liabilities and the involvement of guaranty associations. In nearly all liquidations, guaranty associations are the initial direct handlers and payers of most policyholder claims or other policyholder contractual obligations. In certain instances, guaranty associations are required to provide some level of continuing policyholder coverage. The receiver should consider the ability of the information systems to supply information required by guaranty associations. Most of the data should already be in the company records, but the information systems will need to accommodate the unique needs of the insolvent insurer and the guaranty associations.

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1. Property/Casualty Guaranty Funds

For P/C insolvencies, this information must be in compliance with the UDS in order to allow the guaranty associations to meet their statutory obligations. Therefore, UDS expertise is needed to determine whether the systems meet all of the applicable UDS record requirements. The receiver may elect to have an analysis of the system data elements performed by a representative of one or more of the guaranty associations or outside consultants. Compliance With UDS

The UDS is a precisely defined series of data file formats and codes used by receivers and P/C guaranty associations to exchange loss and unearned/return premium data electronically. These formats were developed by a group of personnel representing both receivers and guaranty associations and submitted to the NAIC. The NAIC originally endorsed the use of UDS effective March 31, 1995. The formats were revised and updated during 2003–2004 with an implementation date of Jan. 1, 2005. Since this time, several additional updates have occurred. UDS and the UDS manuals are managed by the UDS Technical Support Group (UDS-TSG).

The National Conference of Insurance Guaranty Funds (NCIGF) developed a secure process for transferring UDS data from the P/C insurance guaranty associations to insurance receivers. The concept proposed by the California Conservation and Liquidation Office (CLO) in 2005 and the process advanced by the NCIGF in 2007 is known as Secure Uniform Data Standards (SUDS), which uses Secure File Transfer Protocol (SFTP). SUDS provides cost savings by creating greater uniformity and efficiency in how UDS data is transferred from guaranty associations to insurance receivers. SUDS also provides privacy protection through the use of a secure server. In 2012, the NCIGF developed a web-based application that allows receivers to quickly and easily create UDS records for distribution to the guaranty associations through SUDS. The application is known as the UDS Data Mapper.[5] The NCIGF, through its subsidiary, Guaranty Support Inc. (GSI), maintains both SUDS and the Data Mapper and makes them available to insurance receivers or the guaranty associations at no charge.

The NCIGF maintains and provides updated copies of the UDS manuals. For further details about UDS as it applies to claim records or the implementation of UDS, please refer to the UDS Operations Manual.[6] Information and formats relating to UDS financial reports from the guaranty associations are contained in the UDS Financial Manual.[7] The site also includes a helpdesk request form, which emails questions to members of the UDS-TSG.[8]

a. Insolvency Data Transfers

Guaranty associations become statutorily obligated to pay covered claims when the court enters an order of liquidation with a finding of insolvency. The goal of every insolvency is to transmit relevant company claims and policy data to the guaranty associations on the date of liquidation. The guaranty associations and their coordinating body, the NCIGF, have established experts and tools to assist receivers with the transmission of insolvent company data.

ii. Evaluation

Company data will be spread across multiple information systems (claims, policy, accounting, imaging, etc.) oftentimes managed by TPAs. Each information system is a unique source of data requiring independent attention to extract, process, and convert to UDS. On average, each source takes roughly two weeks to process. Getting access to company data managed by third parties can be complicated when it is commingled with noncompany data. Working with information system administrators to segregate company data pre-insolvency can save precious

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[5] The UDS Data Mapper is available at *https://udsdatamapper.com*.
[6] https://www.ncigf.org/resources/uds/uds-claims-manual/
[7] https://www.ncigf.org/resources/uds/uds-financial-menu/
[8] https://www.ncigf.org/resources/uds/

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time when an insolvency is imminent. In the event policy and claims data cannot be transmitted to the guaranty associations on the day of liquidation, providing remote access to those systems can help them address hardship claims and other urgent matters.

iii. Extraction

Beyond the generation of reports, most information systems are not designed to export significant portions of data. This is especially true of imaging applications, which are used in "paperless" offices. Extracting the relevant data from these systems requires specific technical training and oftentimes server access. Data extraction by competent IT professionals can take days or even weeks to complete though various factors can increase the extraction time. If the system is administered by a third party, several factors can add additional delay, such as the administrator not having been paid, company data being commingled with third-party data, or the administrator has insufficient staff to extract company data in a timely manner. Obtaining regular backups of all company data from the administrator can help ameliorate some of these concerns. Technical staff should examine the backup data to determine if it is sufficient to create usable UDS records upon liquidation. Further, if company data is segregated pre-insolvency, technical staff or third-party vendors can extract the relevant data without inadvertently accessing or disclosing non-company data.

iv. Processing

Once extracts of company claims and policy data are obtained, technical staff will need to process the files before they can be loaded into the UDS Data Mapper. Data must be formatted into comma-separated values (CSV). Date and currency values must be normalized to a single format per file. The CSV files must use Latin 1 encoding and have characters outside the scope of this encoding removed or replaced. The receiver will then create a map that coordinates fields from the source data with their corresponding field in the UDS standard. The UDS Data Mapper will report errors encountered while ingesting data to guide other necessary cleaning steps.

v. UDS Production

After the data is ingested by the UDS Data Mapper, it may then be reviewed and edited within the application and then sent to the relevant guaranty associations. This process creates the UDS files and notifies the guaranty associations that they may pick up their files, which are provided via SUDS. For the receiver's own purposes, CSV files of the produced UDS records are also provided via SUDS.

b. Priority of UDS Records

All UDS records serve a valuable purpose and are important. However, the timing of some of the UDS records is more critical than others because guaranty associations need them to perform their statutory responsibilities of covered claims. Below is a general guide regarding the level of criticality of the various UDS records.

Highest Priority

A Record (Claim File)—Confirms the existence of policy with insolvent insurer; necessary to confirm coverage.

F Record (File Notes)—Adjuster's claims notes; needed to quickly grasp essential nature of claim and current issues.

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G Record (Transactions)—Necessary to understand what has already been paid to timely continue any future payments owed and avoid duplication.

I Record (Images)—Contains the contents of the insurer's claim file including report of incident, claim history, investigation notes, treatment history, photos, medical records, and other essential information.

Very High Priority

C Records (Guaranty Fund Loss Claims)—Guaranty association monthly reporting; typically commences within 30 days of the association's receipt of critical claim information.

High Priority

B Records (Unearned Premium)—The importance of unearned premium reimbursement may vary depending upon the nature of the insolvency; in a liquidation with substandard auto insurer, timely refund of unearned premiums is often critical because many insureds cannot afford to purchase replacement coverage. In such instances, the production of the B Record should be assigned a higher priority.

Medium Priority

D Records (Guaranty Fund Expenses)—Important for the reimbursement of the guaranty association's administrative expense claims but secondary to the records that are essential to the timely payment of covered claims.

Low Priority

E Records (Closed Claims)—Important to enable guaranty associations to reopen claims; can be managed on a case-by-case basis until higher priority records are delivered.

M Records (Medicare Secondary Payer [MSP] Reporting)—Allows parties to verify that pre-liquidation MSP reporting was made by company; assists guaranty associations in identifying open or reopened files where guaranty associations will become responsible for future MSP reporting.

2. Life and Health Insurance Guaranty Associations

The life and health insurance guaranty associations (GAs) do not use the UDS reporting system because the data needs of the life and health GAs are much different from those of the P/C funds, both in terms of timing and the types of data needed. This is due both to the types of contracts covered and the particular nature of the statutory obligations of the life and health GAs. Because the life and health GAs continue coverage, they need the data and the lead time necessary for putting in place the agreements and infrastructure required to either transfer or continue administration of the insolvent company's business. In either event, NOLHGA and its member GAs need data files at the earliest possible opportunity, and well in advance of liquidation, in order to evaluate options and develop a plan for meeting GA statutory obligations while minimizing disruption to policyholders. Policyholders are best served if the GAs can be ready to implement a plan for assumption transfer or for seamless administration of the business immediately upon entry of a liquidation order.

If preliminary data suggests that an assumption transfer may be feasible, a NOLHGA task force will develop a request for proposal (RFP), which will be sent to prospective carriers, subject to their execution of a confidentiality agreement. The RFP will include a description of the business to be assumed, along with summary policy, claims, and financial information. Policy-level detail is not typically required at this stage.

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If assumption transfer is not feasible, the GAs must prepare for runoff administration. This typically requires contracting with a TPA and, in the case of health business, retention of the company's health care provider networks, pharmacy benefits providers, and all related service providers. Policy-level data is essential for policy and claims administration for all lines (e.g., life, health, annuity, disability, and long-term care [LTC]).

Getting this information can be particularly challenging if the insolvent company has been using one or more outside TPAs. Data may reside on different platforms and systems and can take longer to gather. Other challenges arise when a company has been using one or more legacy systems with outdated software or hardware, making data extraction and transfer more difficult. In those cases, some consideration may need to be given to keeping the legacy systems in place if short-term data conversion is impractical. It may be necessary to contract for access to the existing administration platform, at least on an interim basis. In many cases, this will involve the receiver as successor to the insolvent company's operations, but it may also include affiliates of the insolvent company or the company's outside TPAs.

a. Specific Data Needs

Specific data needs will depend on the facts and circumstances of each case, as well as the types of business involved. Initial, critical data needs typically include all relevant summary policy and reserve information. Typically, if the policy master/eligibility records can be provided, that file may contain sufficient information for preliminary coverage determinations and to consider the potential feasibility of an assumption transfer.

Other data needed for runoff administration, depending on the lines of business involved, typically includes the following:

- In-force files/counts (by state and by line of business).
- Policy values (face amounts, cash surrender values, policy loans, interest crediting rates, rate crediting history, etc.).
- Policy forms.
- Claim files/claims history (including plan of care and related information for LTC lines).
- Premium files (and status indicators such as reduced paid up or waiver status for LTC).
- Rate files/history.
- Reserves, by line.
- Provider/vendor agreements.

b. Timing Considerations

Initial data files (policy master records) are needed at the earliest possible opportunity, but preferably at least six months in advance of liquidation, so that the GAs can evaluate the business and any coverage issues, assess the feasibility of one or more assumption deals, initiate an RFP process for assumption of the business, and negotiate and prepare to implement related agreements.

The lead time needed for policy-level data will vary depending on the size and complexity of the business, as well as the lines of business involved. Typically, a four- to six-month minimum lead time is needed in order to evaluate the business, negotiate TPA agreements, and get claims reporting and funding arrangements made for runoff administration. In the case of health lines, additional time is needed to evaluate, retain, or replicate health care provider networks and related services. If an RFP process is needed to find a replacement TPA, additional lead time may be required for that as well.

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c. Secure Data Transfer

To ensure secure data transfer, receivers or insurance department personnel typically establish a secure website portal or FTP site to provide NOLHGA and its member associations secure access to the data needed. Otherwise, NOLHGA (or a designated TPA or consultant) will establish a secure file portal where designated users can securely upload records.

V. IMPLEMENTATION

This section describes various courses of action to meet the receiver's needs once it has taken control of the insurer's information systems. The course of action selected will vary according to many factors, including the size and needs of the insurer and whether the insurer has its own information systems staff.

The receiver will be faced with several options as to how to meet the needs of the receivership. These may include: extraction or bifurcation of comingled system data; retaining the present system; enhancing the present system; replacing the system with either a new system or the receiver's system; or relying on a third-party vendor. The receiver must be prepared to justify a cost-benefit basis expending limited estate assets in pursuing any option other than retaining the present system. The following should be of assistance to the receiver in the formulation of a plan to select and implement the most effective option.

A. Retention

The current system's ability to meet the receiver's needs should be carefully evaluated prior to making a decision to retain it. If the system hardware is to be sold, a plan should be developed and executed to move the necessary data to a system that can be accessed by the receiver. The plan to sell existing system hardware should also include safeguards to ensure that any data on the system is erased before the sale. No sale of system hardware should take place without first determining ownership and consulting with the receiver's legal counsel. The retention policy and decisions should be consistent with the liquidation order.

1. Verify Capabilities

Through examination of available reports and interviews with systems staff, management, and operational staff or other sources, the current capabilities of the system should be identified, listed, and documented. The system's capabilities, thus identified, should be compared to the previously identified needs of the receiver. Identified needs will be considered from the information systems checklist in Appendix xxx. This will identify information needs that cannot be met by the existing systems and steps that should be taken to satisfy those needs. If system capabilities exceed the receiver's needs, consideration should be given as to whether the configuration and size of the system should be altered to increase efficiency and control costs.

2. Verify Condition of Hardware and Adequacy/Integrity of Software

The condition of the hardware should be carefully examined to determine both its reliability and its capacity to handle anticipated growth. Suspect components should be repaired or replaced. In like manner, the existing software should be carefully reviewed to confirm adequacy, appropriate licensing, and integrity. Software that is inadequate, outdated, corrupted, or no longer supported by the vendor should undergo review to determine the best strategy for replacement.

3. Assure Adequate Security and Disaster Recovery

Given the likelihood of litigation and other legal proceedings that will depend upon data gathered and processed by the system, as well as the threat of a cyberattack, immediate steps should be taken to ensure its continued security. Access should be limited to those with an absolute need and in whom the receiver has utmost confidence. Consideration should be given to purchasing cyber insurance for the liquidation estate if the company does not already have an applicable policy. A review should also be

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made of the current system as it pertains to the documentation and quality of data, and as to a disaster recovery plan. Many data processing centers do not have a disaster recovery plan other than having the system backup information in an off-site location. A true disaster recovery plan provides for installation of system backup information in an off-site location so that in the event of a disaster, the system can be running within a specified time frame. That time frame may vary from a few hours to a few days.

4. Devise Assessment Methodology

Methodology should be devised for assessing the adequacy of the staff, the system, the software, security procedures and disaster recovery procedures. Weaknesses identified through this assessment should be remedied. If necessary, a third-party contractor may be brought in to make this assessment.

B. Enhancement

If the receiver has control over the system, and it is determined that the existing system can be retained but should be enhanced in order to meet the receiver's needs, a plan should be devised for the implementation of those enhancements. After careful consideration, a list should be made of the hardware, software, and applications that require enhancement. These may consist merely of the addition of hardware components, or they may require restructuring of the operating system or supplementation of available software. In like manner, available staff may be inadequate for the anticipated needs.

Once the required enhancements are identified, availability should also be ascertained, and the availability of qualified personnel should be similarly confirmed. Once the needed enhancements have been identified and their availability confirmed, a schedule should be prepared for implementation in a manner that will not interfere with other aspects of the receivership proceeding and which will be consistent with the anticipated needs of the receiver. This may require the operation of shadow systems on a parallel track with the implementation of the enhancements. Testing methodology should be implemented to confirm that the enhancements were successful and sufficient

C. System Replacement

If the receiver determines that the existing system, even if enhanced, is inadequate and decides to replace it, a plan should be devised for system implementation. The first step is to select the replacement system, considering the future needs of the receiver, including how long the estate may have to remain open, and the available assets of the estate. A plan for migration from the existing system to the replacement system should be implemented. In many circumstances, the replacement or enhancement is handled by a third-party vendor.

To make use of a third-party vendor as a replacement for in-house systems, it is essential to prepare a comprehensive list of the receiver's anticipated needs. Because the receiver will have relatively little control of the actual operation of the system and, therefore, little flexibility in adjusting the ability of the system to meet its needs, it is essential that the initial list of needs provided to the third-party vendor be as comprehensive as possible.

Once the needs have been identified, a list of potential vendors should be compiled for evaluation. Each eligible vendor should be carefully evaluated with full consideration being given to at least the following factors:

- Cybersecurity expertise and data safety requirements.
- Short-term and long-term availability.
- Expertise and demonstrated ability.
- Price and method of charging.

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- Support and maintenance resources.
- Available warranties.
- Capability to respond to emergencies.
- Ability to preserve confidentiality and comply with security procedures.
- Existence of potential conflicts of interest.
- Ability to respond to changing needs.
- Familiarity with the type of business involved.

5. Contract With Vendor

Once the appropriate vendor has been selected, a contract that will meet the anticipated needs of the receiver should be negotiated in accordance with the receiver's contracting policy. It should be clear that liability under the contract will be limited to estate assets and will not involve personal liability on the part of the receiver or the state. Once an agreement in principle has been reached with the vendor, protocols should be established for the operational relationship. A plan should be devised for assessing whether a third-party vendor satisfies the requirements of the contract.Document and Back Up Old System

As a result of the decision to use a third-party vendor, the existing system will become unnecessary. Before it is shut down and disposed of, however, it should be fully backed up, including both the software and data, and documented for future reference.

6. Shut Down and Disposal of Old System

Once the old system has been completely backed up and documented, it should be taken out of operation and prepared for disposition. Disposal of any system, data, or information related to the liquidation must meet the requirements set in the liquidation order and be preapproved by the court before any action is taken. Before the system is shut down, any data must be erased. Once the existing system is shut down, it should be disposed of at maximum gain to the estate. Proprietary software developed solely by the insurer may also be marketable.

D. General Concerns

Be careful not to dispose of the system too soon. If the information is to be migrated either to the receiver's computer system or to a third-party vendor's system, steps should be taken to ensure that the integrity of the data from the insurer's old system is preserved and accessible. Controls should be in place to ensure that the same number of records leaving one system is received by the other system. This should be confirmed by the comparison of record counts and the cross-checking of financial data.

If any enhancements have been planned, then consideration should be given to whether the enhancements should be done by in-house staff or an outside consultant. Once again, it is usually best to get competitive bids as required by the receiver's purchasing policy.

E. Implementation of UDS

A plan to secure the information required for UDS should be developed as early as possible in the receivership proceedings when there is an indication that liquidation is a possibility. Data availability from company to company varies significantly. In some cases, all data for UDS is located on the system; in other

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situations, manual coding is necessary to capture the required data. The goal is to make the information available to the guaranty associations as soon after entry of the liquidation order as possible.

The guaranty associations must be notified as soon as possible when liquidation preparations have begun. The notice should include a copy of the company's Schedule T from its annual statement and the receiver's plans to supply UDS data. Data transfer preparations should begin immediately after the notice, to be put in place immediately following receipt of the liquidation order. This step is important, as it places the guaranty associations in a better position to respond to the inquiries that typically occur soon after the company is placed in liquidation.

It is likely that the initial UDS plan will be modified as the receiver completes its review of the company's systems. (See Section IV. M., which expounds on UDS production and record priority.)

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I. INTRODUCTION: OBJECTIVES OF THE ACCOUNTING FUNCTION

The purpose of this chapter is to identify and explain the various objectives of the accounting function for an insurer in receivership and provide guidelines for the preparation of reports summarizing the financial position of the receivership.

It is important to highlight the context or perspective from which this chapter was prepared. Any accountant serving a receiver is, by necessity, an integral part of a team of regulatory, legal, actuarial, and other professionals working together to achieve common goals. The nature of these goals is described at length in Chapter 1—Commencement of the Proceeding. In most receivership situations, the duties of the receiver's accountants, investigators, and attorneys will overlap when information about a common topic such as a reinsurance treaty is needed by staff members. While these other individuals have a legitimate interest in accounting and financial information, this chapter has been prepared from the perspective of the accountant serving the receiver.

This chapter will deal with the following issues:

- The objectives of the receiver and how they may vary from the traditional accounting objectives of a going concern.
- The need to gain an understanding and control of the impaired or insolvent company's bank accounts and assets.
- The importance of evaluating the impaired or insolvent company's accounting staffing and consulting needs early on in the receivership, as well as the need for assistance from certified public accountant (CPA) or actuarial firms to do projections, forensic accounting, and tax reporting.
- The need to inventory and safeguard documents, ledgers, contracts, and other financial items that will shed light on the financial position of the insolvent insurer and provide support to the receiver in collecting assets, settlement of balances, litigation, and other matters.
- The need to focus on the corporate structure of the enterprise, the importance of analyzing related-party transactions and intercompany accounts, and consideration of restructuring certain transactions.
- The need to identify and scrutinize tax issues, including necessary informational filings with the IRS (such as 1099s), various areas of tax exposure, premium and payroll tax consequences, and other taxes.
- Considerations related to the nature of the insolvent insurer's investments and safeguarding and valuing the investment portfolio.
- Considerations relating to direct and assumed reinsurance premium receivables, including the need to identify and control treaties, to determine if in-force treaties should be maintained or cancelled, and to quantify setoffs and other issues. Consideration should also be given to ceded reinsurance receivables and the identity of the various lines of business and policies ceded to other insurers. Insurers often have excess of loss or stop-loss reinsurance where recoveries of amounts due the health maintenance organization (HMO) should be investigated.
- The need to prepare financial statements and related information in a format that will support the receiver directly in managing the affairs of the estate and in responding to the needs of various third parties, such as state insurance departments, the courts, guaranty funds, policyholders and other creditors, attorneys, and other parties.
- The need to review and understand the various cost centers and associated expenses and contracted services.

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The overall objective of the accounting function in receivership can be expressed as follows:

To assist the receiver in securing control of the insurer's assets and to provide timely, relevant, and accurate financial information as to the assets, liabilities, surplus (deficit), and cash flow of the insolvent insurer to support the duties of the receiver, and to assist in making economic decisions.

The sections that follow will discuss the points above in more detail as they relate to the overall objective of the accounting function in a receivership.

II. OBJECTIVES DIFFERENT THAN GOING CONCERN

In many respects, the overall accounting function objective discussed above is equally fitting for the accounting function of a going concern. However, the important phrase that distinguishes this objective for receivership is "to support the duties of the receiver."

For solvent insurers, the accounting function is generally designed to support management and to fulfill the insurer's responsibility to report information to shareholders, creditors, taxing authorities such as the IRS, regulatory authorities such as state insurance departments, and others. The purpose of this information is to allow these parties to monitor the insurer's financial operations and protect their interests (e.g., investment, loan, or tax obligations). The accounting system may be designed to support reporting on the basis of both U.S. generally accepted accounting principles (GAAP) and statutory accounting principles (SAP) prescribed or permitted by the insurer's state of domicile.

For an insurer in receivership, the situation is different. The state insurance regulator has already determined that the insurer is in an impaired or insolvent financial position. A receiver has been appointed. For an insurer in rehabilitation, the objective may be to identify the causes of the impairment, eliminate them, and work to return the insurer to a solvent position. Alternatively, it may be determined that a successful rehabilitation is not achievable, in which case an order of liquidation will be sought. For the insurer in liquidation, the objectives are to identify and marshal the assets of the insurer; identify and evaluate liabilities and determine the appropriate class of each creditor in accordance with the domiciliary state's priority of distribution statute; and liquidate the insurer in a manner that minimizes the cost to policyholders, state guaranty funds, and other creditors.

Thus, the new and important user of the financial information is the receiver. In rehabilitation, pro forma reporting is often used to help the receiver assess the feasibility of potential transactions that have been proposed to mitigate the surplus deficit. Additionally, liquidation-basis accounting becomes an important form of reporting to help the receiver assess the realizable value of the assets of the insurer and the extent such assets will be available and sufficient to cover approved claims of policyholders and other creditors.

It is important to understand the difference between the responsibilities of the receiver and those of former management. In a going concern, management has the responsibility to develop internal controls and procedures covering a variety of items such as payroll, transfers to affiliates, reinsurance balances, etc. However, the receiver will review and perhaps revise these internal control procedures. The receiver will approve disbursements; revise wage and salary schedules (especially for excessive amounts payable to officers); streamline the organizational structure if needed; and place a moratorium on payments to reinsurers, related parties such as the insurer's affiliates and others, pending a complete analysis of the insurer's financial position.

In some instances, the duties of the receiver and that of management will differ in subtle ways. For example, consider an insurer that has been placed in rehabilitation: The insurer is a wholly owned subsidiary of a publicly held insurance holding corporation. The receiver, by statute and court order, has responsibility and authority only for the affairs of the insolvent insurer/company subsidiary. Thus, the accountant working with the receiver may assist in or direct the preparation of financial information relating to the insurer/subsidiary that may ultimately be provided to and used by management of the holding company/parent to prepare its filings with the U.S. Securities and Exchange Commission (SEC) or consolidated tax returns for the IRS. However, it is generally not the

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responsibility of the receiver or his or her accountant to prepare or file such documents that relate to the holding company.

It is not uncommon for the receiver to maintain certain of the insurer's key management personnel on staff because of their knowledge of the insurer and their familiarity with its business, reinsurance treaties, data processing systems, and various other matters. The receiver should ensure that such staff be sensitive to the new responsibilities created by the order of rehabilitation or liquidation. It is unlikely that these individuals have ever been through a receivership before and may unknowingly perform their duties as if it were business as usual, not realizing that the receiver now must be informed of, and approve, procedures and disbursements. Additionally, the receiver should identify those individuals who may conceivably have an interest in concealing or altering information because of their concern about their role in the events that may have precipitated or contributed to the insolvency.

The principal responsibility of the accountant is to the receiver. However, the accountant should be aware that the receiver must provide certain financial information to other parties, including (in no particular order of importance):

- Domiciliary state insurance department.
- Other insurance departments in states where the insurer is licensed.
- The receivership court, other state courts, or federal courts.
- Creditors, including banks, premium finance companies, providers of health care (if an HMO), and reinsurers.
- Shareholders.
- Federal, state, and local taxing authorities.
- State guaranty funds, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), or the National Conference of Insurance Guaranty Funds (NCIGF)
- Policyholders.
- Prospective investors.
- Other regulatory agencies, such as the SEC.
- Legislatures (state and federal).
- State and federal agencies responsible for Medicaid/Medicare (if an HMO).
- Reinsurers.
- Agents.

Financial information for a receivership is similar to that of an ongoing enterprise with some important differences. These include the following:

- The need to identify and provide for various classes of creditors pursuant to the domiciliary state's receivership priority statute. The receiver's accounting system should be capable of capturing information provided by creditors on proofs of claim in order to review and adjust those claims and to aggregate them by creditor class.
- Reinsurance recoverables must be viewed from a different perspective, particularly ceded unearned premium for property and liability companies. In a going concern, a ceding insurer would not expect to

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receive ceded unearned premium. However, when reinsurance is not renewed, the ceded unearned premium recoverable can be quite substantial if the termination clause of the contract is written on a cut-off basis. In a runoff situation, the insurer would have reinsurance until the ceded premium ran off.

- Setoffs are another reinsurance issue that should be identified and reviewed to determine if they are acceptable under the applicable state receivership statutes. Setoffs (often referred to as "net accounting" in going-concern accounting) frequently occur in reinsurance transactions and may involve setoff of amounts within a contract. These may include premiums due to the reinsurer from the ceding insurer set off against recoverables for paid losses owed by the reinsurer to the insurer, setoff of balances under two or more contracts with the same two entities, or setoff of amounts owed to or from different ceding insurers and/or reinsurers that have been set off by a reinsurance intermediary or broker, usually on a monthly or quarterly net reporting basis to the insurer. If necessary, setoff transactions will need to be recast or set aside. (Note: Identification of setoffs is an accounting function. The receiver's counsel should address the legality of identified transactions. See Chapter 9—Legal Considerations for discussion of setoffs.)

- The need to separate any commingled assets and liabilities of the insurer from entities affiliated with the insurer, such as the parent corporation, other subsidiaries or affiliates, and employee benefit plans.

- The need to identify transactions that are significant to the receiver because of the potential for recovery from third parties, as well as the possible institution of criminal proceedings. Generally, these may include transactions with affiliates or officers and directors, for example, and preferential payments made within statutorily prescribed periods. (See Chapter 9—Legal Considerations.)

- The need for a clear cutoff date in the accounting records to establish a beginning balance sheet that represents the point at which the receiver has become accountable for the financial affairs of the insurer.

- Payments for pre-receivership transactions may be suspended pending review by the receiver. It is also important to immediately change company procedures and implement controls to assure that the insurer's assets are not disbursed unless approved by the receiver or his representative. The receiver may wish to consider placing a stop order on outstanding checks, both claims-related and administrative.

- The need to recognize differences between liquidation accounting and statutory accounting practices followed by the insurer as a going concern. For example, certain assets of the insurer—such as furniture, equipment, and overdue agent balances—may not be admitted for statutory accounting. An HMO's membership may also have potential value that is not admitted for statutory accounting purposes. Nonetheless, in a receivership, they should be considered for possible collection or sale, even if they are not considered in evaluating the solvency of the insurer.

- The need for preliminary assessment of the causes of the impairment or insolvency, with an analysis of whether any parties have potential civil or criminal liability for their role in causing the insolvency. (See Chapter 4—Investigation and Asset Recovery.)

- The need to challenge, with an appropriate degree of professional skepticism, the adequacy of the insurer's personnel who may be retained by the receiver, and assess skills, loyalties, and potential conflicts of interest that they may have because of their roles in, or knowledge of, events that precipitated or contributed to the receivership.

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III CASH AND LIQUID INVESTMENTS

Cash

The receiver must determine the existence, location, and amount of all cash, cash equivalents, and short-term investments through direct confirmation with financial institutions, investment managers, and other parties thought to be holding cash, cash equivalent, or short-term investments. The insolvent company's financial management should be able to provide a listing of financial institutions and contacts.

The receiver should immediately determine who has access to the cash and investments and should consider changing or restricting this access. In this era of electronic banking, Internet banking access should be closely scrutinized. Administrative controls of Internet banking should be evaluated by the receiver as soon as possible and modified as necessary. If the company holds cryptocurrencies, access to the cryptocurrency wallet and any associated hardware should be restricted. Large amounts of cash can be removed from an estate via wire transfer. Procedures should be established with the financial institutions to curtail or limit access regarding wire transfers. Wire transfer capabilities must be limited to receivership staff immediately upon receipt of a receivership order. Operations of the insurer may be affected temporarily, but that situation pales in comparison to allowing large amounts of money to be wired out of an estate.

All financial institutions should be notified immediately of the receivership order. A receivership order should be faxed or emailed to the contact person at each financial institution, and a proof of service should be signed by an appropriate financial institution representative as corroboration that the financial institution received the order. Some receivers, especially in liquidation, advocate immediately closing all existing bank accounts to ensure complete control of cash. The receiver should also consider whether to continue relationships with the banks used by the insurer or to establish new accounts with only the receiver or their designated representatives having signatory authority to disburse funds. The receiver must decide whether to allow certain checks to clear, as a disruption in payments to claimants may cause hardship, lead to complaints, and would be viewed negatively by regulators. Another consideration associated with account closure is the magnitude of penalties and interest that would accompany any substantial delay in payments.

A letter should be sent that gives the bank or other financial institution instructions with regard to allowing or not allowing checks to clear the account. As soon as possible, signatories on bank accounts should be changed to the receiver's designated personnel.

All check stock should be inventoried and bank accounts reviewed to determine which accounts are related to the insurer's business and which accounts, if any, are still needed. If bank accounts are closed, the related check stock should be voided and destroyed. If the accounts are required, an appropriate protocol needs to be established between the banking institution and the receiver. The normal practice would be to freeze all accounts or, at a minimum, the signatories should be changed to individuals on the receiver's staff.

The receiver may consider moving out-of-state assets into the domiciliary state to improve control and lessen the chance they may be subject to attachment by creditors. This step should be completed as soon as possible after the liquidation order is filed with the court. If an ancillary receivership is established, the receiver should work in conjunction with the ancillary receiver when moving assets out of the ancillary state.

Special care should be applied to the identification of accounts not held in the insurer's name but to its benefit. Bank statements, investment statements, cash ledgers, and cash-flow statements should be reviewed. This process should also include any funds held as collateral, letters of credit (LOCs), or other restricted cash.

Credit or debit cards in the company name should be gathered and secured in the same manner as cash. Determine if there are recurring charges on the card and if those recurring charges need to be continued or can be canceled. If the cards are no longer needed, consider canceling the cards. Credit or debit cards are often kept in the accounting or human resources department but could exist in other areas of the company.

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A company may also have recurring charges set up as Automated Clearing House (ACH) transactions. Review all accounts for recurring charges so they can be canceled as appropriate.

Some companies will have gift cards or prepaid debit cards (for example Visa- or American Express-branded prepaid cards) that have been purchased for agent/broker incentives, employee incentives, or wellness incentives. These cards may not be accounted for in the company's general ledger and could potentially be kept by many different departments of the company. They should be gathered and treated in the same manner as cash.

Liquid Investments

Determine the existence, location, amount, and type of liquid securities (bonds, stocks, mortgage loans, etc.) through direct confirmation with financial institutions, investment managers, and other parties thought to be holding securities. Investment statements from financial institutions, portfolio statements from investment managers, and other similar reports should be secured and used to establish a balance as of the receivership date.

As with cash, company personnel should provide a list of brokerage houses, financial institutions that have custody of investments, and related contact names. All institutions having custody of the insurer's investments should be sent a copy of the receivership order. The brokerage house or financial institution should be given instructions by cover letter that only receivership staff is authorized to buy or sell investments. The receiver should be aware of who has access to the investments and who had the authority to direct the investment managers/brokers. Once again, the investment managers/brokers should only take direction from the receiver.

The receiver should determine whether any of the liquid investments are hedged and who the counterparties are, as well get a description of the entity's hedging program.

Sometimes it is easier for the receiver to transfer securities to a financial institution with which they are familiar. Doing so facilitates transactions, as sales can be efficiently executed to maximize the value to the estate, after obtaining the appropriate advice about the most advantageous time to liquidate a security.

IV. INITIAL REVIEW OF FINANCIAL STATEMENTS AND PROJECTIONS

It is imperative that the receiver's accountants perform an initial review of the financial statements that had been produced by the company as soon as possible. Obviously, these financial statements should be viewed with a heavy dose of professional skepticism. However, the receiver's accountants can usually garner a lot of information from company accounting personnel. The receiver's accountants must use professional judgment in determining the accuracy of the information provided by the company or whether further investigation/confirmation is required. In either case, it is critical that the receiver's accounting staff perform an evaluation of the company's surplus and cash position in the first few months (or sometimes weeks) of a receivership. The receiver's accountants must provide this information to the receiver so that objective decisions regarding the company's rehabilitation or liquidation may be made.

The receiver's accountants should obtain the last published statutory quarterly or annual statement that the company filed. If the company is an unauthorized entity or it did not file financial statements, internal financial statements will have to suffice (preferably financial statements that were audited or reviewed by an outside CPA firm). The receiver's accounting staff can use these statements as a starting point for surplus and cash projections. Another source for financial statements is those prepared by insurance department examiners. If the entity is publicly traded, get copies of the latest 10-K and 10-Q at *https://www.sec.gov/edgar.shtml*.

Admittedly, the analysis of a company's cash or surplus position in the early stages of a receivership is not an exact science. In addition to calculating anticipated receiver administrative expenses, the following measures should be incorporated to make projections and analysis more meaningful:

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- Confirm that bank reconciliations are brought up to date.
- Review anticipated premium income. Look at recent premium written reports, and review the timing of any anticipated policy cancellations or non-renewals.
- Review any capitation arrangements, contracts with hospitals and doctors, and the federal Centers & Medicare and Medicaid Services (CMS) for all approved plans.
- Review recent claims and loss adjustment expense (LAE) payment history to use as an estimate for the future claims liability of insurers in receivership.
- Claims payments should begin to decrease after policies are cancelled (if applicable).
- Review all active reinsurance treaties, especially for the current treaty year. Ceded reinsurance is especially important for property and liability companies.
- Review recent large expense payments such as rent, commissions, legal expenses, etc.
- Review potential voidable preferences.
- Review monthly investment income and sources generating the income.

V. INVENTORY AND DESCRIPTION OF ACCOUNTING RECORDS

This section summarizes and describes the preexisting accounting records that are typically maintained at various locations of the insurer and/or at affiliated and nonaffiliated entities. This chapter should be read in conjunction with Chapter 1—Commencement of the Proceeding, Chapter 2—Information Systems, and Chapter 4—Investigation and Asset Recovery, which may identify additional records and functions that may be useful to the receiver.

A. Inventory of Accounting Records

As soon after the takeover of an insurer as is practicable, the receiver should identify and secure the books, records, systems, and documents that are necessary to maintain and review the accounting functions of the insurer. Familiarity with the preexisting accounting processes and related accounting records and their location will help the receiver prepare for the many other tasks that will follow. The receiver may find that accounting processes should be consolidated, streamlined, or simplified, particularly for insurers in liquidation. A thorough knowledge of the preexisting accounting systems is an integral step in identifying those systems that can be eliminated or simplified. Furthermore, such knowledge will greatly assist in the investigation and asset recovery processes, which are discussed in the next chapter.

Types of documentation vary, but one thing is certain: The records of an insurer that has been placed into receivership will be, or at least may seem to be, incomplete, confusing, and, in many cases, inaccurate. To the extent systems and account balances are undocumented, some documentation may have to be recreated. Work papers of state insurance examiners, outside auditors, and actuaries may be useful in reconstructing records. In addition, existing personnel may be retained by the receiver to assist in this process because of their knowledge of the insurer's operations and systems.

B. Records at the Administrative Office of the Insurer

The administrative or "home" office of the company will, most likely, be the location from which the domiciliary receiver will direct the receivership. The bulk of the insurer's financial and accounting records usually are located and maintained at the home office. However, the domiciliary receiver should be aware

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that the company records may also be located at third-party administrator (TPA), managing general agent (MGA) and branch offices.

The following is an overview and brief description of accounting records that the receiver should attempt to locate and secure. If documentation of this nature does not exist or cannot be located, special effort may be required to understand how the financial data was compiled.

1. Organizational Chart of the Accounting Department, Flowchart of Accounting Process, Procedure Manuals, and Chart of Accounts

An organizational chart may give the receiver an overview of the organization, including the accounting department. It may identify the various functions (e.g., cash accounting, underwriting accounting, reinsurance accounting, etc.) of the accounting department and the individuals responsible for those functions. It can also indicate the reporting hierarchy and help assess the adequacy of segregation of duties consistent with sound internal control practices.

A flowchart of the accounting process might describe what action is taken for the significant functions or accounting processes. The flowchart may summarize the route of the original accounting documentation. Most importantly, the flowchart may well identify the key records relied upon to record financial information; when, how, and by whom it is entered into the accounting records; and how and by whom the resulting balance is verified by reconciliation or other procedures. The flowchart may also identify the responsibilities of each significant function in the accounting department. The flowchart may identify controls. The public CPA firm will normally have a process flowchart for the accounting function of the insurer and the controls within that process if not available directly from the insurer. If a flowchart is not available, the receiver may wish to request that one be created to assist in assessing the adequacy of internal controls over the significant accounting processes.

Procedure manuals may exist that describe the duties and functions to be performed by the accounting department. If the accounting system is computerized, the procedure manual of the computer system may describe the process and controls for specific job functions. Procedure manuals may be detailed by job function or by department function. If available, these manuals will assist the receiver in understanding the accounting process. Care should be taken by the receiver, however, because procedure manuals possibly will be incomplete or out-of-date, and they may be unintentionally misleading as to the actual processes currently in place. A walk-through documentation from CPAs/ exams/internal audit of the key systems and/or inquiry of the insurer's personnel will help to confirm the accuracy of such documentation. The degree of the walk-through depends on judgment and internal controls of the insurer.

The chart of accounts should detail the description and purpose of all general ledger accounts. The chart (a manual) of accounts may be a useful tool, especially to an external auditor. Again, care should be taken because account titles and descriptions may not reflect their true nature or use in practice by management. Typically, accounts are numbered in sequential order using the following convention:

- Assets.
- Liabilities.
- Surplus accounts.
- Income accounts.
- Expense accounts.

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2. Accounting Records, Including the General Ledgers, and Supporting Schedules

The receiver should find a complete set of records at the home office. The general ledger provides a listing of the dollar amounts in each of the accounts in the chart of accounts. The amounts in the general ledger may be posted on a monthly or quarterly basis. Automated and interfaced systems may post to the general ledger on a daily basis.

Depending on the size of the company and the type of reporting system, the general ledger listing may include:

- A transactional listing that reflects, by account, the items posted to that account by period entered. The period entered and supporting schedule may allow the receiver to locate the "support" or underlying documentation for the entry. This information will be valuable in the audit procedures.

- A journal entry listing that specifies, by period, the accounts and amounts affected by the entry. When a transaction from one particular account has been identified for investigation, this listing will allow the receiver to determine the other accounts affected and the amount.

The accounting records will provide details of balances that are summarized and posted in the general ledger. Some of specific detailed schedules that may be found at the insurer are:

- Investments.
- Agents and/or insured balances.
- Funds held.
- Premiums written.
- Reinsurance recoverables.
- Fixed assets (e.g., furniture and equipment).
- Claims paid.
- Claims outstanding (case reserves).
- Contingent commissions.
- Amounts retained for accounts of others.

Accounting records detail the daily accounting activity of the company. The daily cash activity of the insurer is maintained in the accounting records.

3. Accounting Files

Generally, accounting files are maintained by an insurer based on the various accounting functions. Accounting files usually contain original accounting source documentation (check remittance advices, invoices, and purchase orders) or images files of the documentation. The records are all important. The more crucial accounting records are:

- Certificate of deposit files and investment.
- Cash.

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- Agents' and producers'.
- Contingent commission.
- Claim.
- Reinsurance.
- Federal, state, and local tax.
- Accounts payable.

The insurer may have several years of accounting files on the premises and keep the older accounting files/backups at a warehouse location. A records retention policy for the insurer may be available from the chief accounting officer. It is important to suspend any document destruction.

The investment accounting should support the investment transactions of the insurer. Included in the files should be broker slips, bank advices, and custodian statements. If the investment accounting is held by a custodian or asset management firm, the receiver should notify them of the receiver and request records. Monthly reconciliations of the custodian statements/files to the related general ledger account balances may also be found here. For more information on investment files, see Section IX in this chapter .

Cash contains records often from bank lock boxes of cash receipt and disbursement that support the cash entries made on a daily basis. Deposit records, checks or checks images, wire transfer information, and records of disbursements may also be found in these files. In addition, banking records—such as authorized signatory lists, wire transfer instructions, sweep account information (bank orders to transfer daily receipts from depository accounts to investment accountings), and agreements with banks regarding custodial and other matters—may also be found here.

Agents' and producers' records should contain copies/images of the statements and billings to those entities for premiums written. Statements may be gross or net of commissions. Advance commissions statements and copies of agreements with the agents or producers that detail the rate of commission, and the authority of the agent may also be found in these files.

Contingent commission records should contain the computations for any contingent commission or profit-sharing commission paid to agents and producers and the associated agent/producer agreements.

The accounting records for reinsurance ceded by the insolvent insurer prior to receivership should contain the details for any of the insurer's reinsurance transactions. The supporting schedules should contain summaries of reinsurance premiums and loss calculations for each treaty or reinsurer. The records should include account statements, the reinsurance treaty, and endorsements thereto, including the interest and liability (the percentage participation) endorsement that each reinsurer has signed or a digest or summary thereof.

The documentation that an insurer maintains with respect to reinsurance assumed by the insolvent insurer prior to receivership depends on whether it was acquired directly from the cedent or through a reinsurance intermediary.

The direct method of acquiring assumed reinsurance may generate more documentation on the insolvent's end because the direct method generally requires an internal function to solicit or accept business from cedents. On the other hand, the broker market method may not require maintenance of an in-house reinsurance underwriting function because this role is assumed by the intermediaries. Therefore, only bordereaux or other summary information may be found at the reinsurer's offices.

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Nonetheless, the receiver may want to determine that the documentary information maintained by the ceding company or intermediary supports the bordereau.

Tax records (e.g., federal, state, local, and payroll) should contain the tax returns that have been filed with each jurisdiction. The records may contain references to the original source information. Section VIII of this chapter has more information on taxes. Copies of filed returns may also be found in the general corporate records, with independent accountants or legal counsel, or can be obtained from the IRS.

Accounts payable records should contain vendor invoices, identification, invoice date, date approved, and date paid.

4. Contracts and Agreements

The accounting, underwriting, or corporate legal department may be the custodian of agreements or copies of contracts into which the insurer has entered for insurance and general business operations. The agreements frequently may be referred to by the accounting department to assure that related transactions are authorized, recorded correctly, reported between the parties, and reconciled.

The contracts and agreements may include: real estate leases, furniture and equipment leases and maintenance agreements, information technology (IT) equipment leases, software licensing agreements, bank custodial agreements, hedging agreements, real estate management agreements, mortgage loan servicing agreements, trust funds, investment service, payroll service, management service, and allocation of federal income tax and expenses with affiliates. Other contracts related more to the insurance business may include agency contracts (general or managing), claims administration services, producer contracts, reinsurance contracts, interest and liability endorsements, and LOC agreements. For HMOs, it is important that the receiver have a complete inventory of all provider agreements, as well as a listing of all commercial groups with renewal dates and coverages.

Chapter 1—Commencement of the Proceeding has more information on contracts, and Chapter 7—Reinsurance has more information on reinsurance treaties and LOCs.

5. Financial Reports, Filings, and Other Records

The accounting department is the originating department and custodian of financial reports, both for internal use and external compliance. The department may also be the originating department for many analytical reports that are used by management, although such reports may also originate from other departments, such as claims or underwriting. Filings for compliance with governing jurisdictions may also be the responsibility of the accounting department.

A list of reports that are produced periodically and a schedule of required filings may be available from the controller. Otherwise, the receiver should discuss what reports and filings are produced and available with the chief financial officer (CFO).

The financial reports that the insurer should have readily available include the NAIC annual statements, NAIC quarterly statements (if required), and all supplemental exhibits that are part of these documents. The last page of the annual statement under “Supplemental Exhibits and Schedules Interrogatories,” if properly completed, reports the exhibits that should be filed. In addition to the reports, the accounting department maintains records and the supporting schedules that identify sources of data and reconcile the reports to the source.

Other external financial reports that may be found in the accounting department include insurance department financial examination reports, actuarial reports and opinions, and CPAs’ audit reports. Along with these reports, the receiver should request related correspondence files (CPA management letters and management responses to the reports). If the insurer’s stock is publicly traded on a stock

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exchange, the insurer is required to file an annual report and various interim documents with the SEC; i.e., 10K and 10Q for U.S. markets, which are available at: *https://www.sec.gov/edgar.shtml*. These are complex filings that may require involvement of outside counsel and/or external auditors.

The accounting department may also be involved in periodic rate filings made with insurance departments. Folders may be available that support the rate change requested. Responsibility for rate filings and approvals may rest with the legal or underwriting department.

Some insolvent or financially troubled insurers have internal audit departments. The receiver should request a listing of all internal audit reports issued and any internal control procedure documents.

C. Accounting Records at Other Locations

1. Branch Offices

Branch offices of an insurer may operate independently of the home or main administrative office. However, the branch offices usually use the same computer system, or they upload data daily to the main office. Branch authority, method of operation, and procedure manuals should be in place both at the home office and with the branch manager.

The branch may have limited authority to carry out only certain insurance functions, i.e., either underwriting, claims adjusting, or both. In such instances, the accounting records at the branch will be limited. The branch office may have claims folders and underwriting folders with original documents.

2. Claims Offices

The claims offices facilitate the adjustment and settlement of claims. As such, each claims office should maintain open claim files for losses in its respective region. The receiver should collect any checkbooks that the claims office has on-site. Closed claim files may have been returned to the administrative office.

3. Off-Site Storage

Many insurance departments and/or insurers themselves require that copies or duplicates of essential records be maintained at an off-site location for the purpose of reconstruction in the event the records are lost or destroyed at the primary location. If this procedure is followed by the insurer, duplicates of records that cannot be located at the primary location might be found at the off-site storage. The off-site storage may also be the location of periodically stored computer backups for the same purpose. Old files (e.g., accounting, claims, underwriting, etc.) and other records may also be in storage. The off-site storage may be a branch office of the insurer or a contracted warehouse. An inventory list of records at the off-site storage location may be available from the controller or CFO. Review the inventory and compare with any retention policies.

D. Records at Offices of Other Parties

1. Managing General Agent

The types of records to be found at the offices of the MGA will depend on the authority of the MGA. If the MGA has the full powers of the insurer—including accounting, underwriting, rate filings and reinsurance—then all related accounting records, as previously described, may be at the MGA's office. If the MGA has limited authority, then only records that pertain to the specific function will be in the MGA's office. The insurer may have duplicate copies of some of the records at its main administrative office, although these frequently include only summarized reports or bordereaux.

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2. Third-Party Administrators

TPAs should maintain sufficient records to perform their assigned function. Authority from the insurer may be necessary before any action is taken by the TPA. Alternatively, certain limited discretionary authority may be granted in the agreement with the TPA. Copies of written authority granted should be available from the insurer and/or the TPA.

3. Reinsurance Intermediaries

The intermediary should have in its office copies of reinsurance treaties, interest and liability agreements, endorsements, lists of reinsurer participations, files on LOCs, and historical records on premiums paid to and losses collected from the reinsurers. Reinsurance intermediaries should also have details to support the balances due, including details of amounts set off.

4. Agents and Brokers

Both agents and brokers will have files for policies that have been issued to insureds. Agents and brokers periodically (monthly) submit to the insurer a list of policies that have been issued. The agents and brokers may be responsible for the collection of premiums. In such instances, the insurer will bill them for the premiums due. Otherwise, the insurer bills the insured directly.

Producers are compensated by a commission on the premiums written. If the insurer uses the direct billing method, the agent or broker may have been paid an advance commission until the premium is collected from the insured. Otherwise, the insurer may bill the agent or broker on a basis net of the commission due. The insurer may also require the producers to pay the full amount of the premium. In turn, the insurer will pay the commission. Producers will have records of all business placed with the insurer.

5. Department of Insurance

Insurers are required to file numerous documents with the insurance department of the state of domicile and/or other states where the insurer is authorized to transact business. The receiver may consult legal counsel, state statutes, or the department's staff for specific state requirements. In addition to the annual, and possibly quarterly, statements and financial and market conduct examination reports, the following documents may be on file with the insurance department: contracts (reinsurance, agents, management, investments, etc.), dividends payment approvals, holding company and related party transaction approvals, rate filings, minutes of meetings, and biographical affidavits of officers and directors.

The insurance department examiners, as part of the documentation for support of their findings, may have photocopied certain documents, flowcharts, procedure manuals, or other materials that may be of interest to the receiver. The copies would be found in the examination workpapers that are kept by the insurance department.

6. Certified Public Accounting and Actuarial Firms

The CPA firm that performed the last financial audit may be a valuable source for copies of many of the insurer's documents. As part of their workpapers, the auditors may have copied pertinent documentation from the various accounting files. The auditors may also have documented and flow-charted the various significant functions of the accounting department and their related controls. Similarly, independent actuarial firms may have copies of insurer documents and/or working papers that document the calculation or evaluation of the carried reserves or pricing of business.

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7. Banks

Banks may be able to furnish images of canceled checks, check number sequence issued, bank statements, loan files, collateral files, safe deposit box records, and correspondence (signatories and requirements).

8. Internal Revenue Service

The IRS may be a source for the insurer's income tax returns and filed payroll tax forms.

9. Securities and Exchange Commission

If the insurer is regulated by the SEC (publicly traded company or public debt offering), then copies of any documents (10K, 10Q, etc.) filed with that agency may be obtained at SEC.gov | Filings & Forms.

E. Internal Controls

In an increasingly complex business, receivers manage insolvent insurers' investments, accounting systems, and other operations, all of which require close scrutiny and professional care in the safekeeping of the company's resources. If the company under receivership had an internal audit/control department, the receiver should request and review any internal control procedure documents and reports available.

There is currently no requirement that receivers of insolvent insurers prepare a report acknowledging responsibility for establishing and maintaining an adequate internal control structure. Even so, efforts should be made to ensure and promote effective controls. Further, the receiver should determine if, and to what extent, internal controls and other requirements of federal Sarbanes-Oxley Act-type documentation were created and maintained. All such documentation should be reviewed and matched to the processes and procedures observed and analyzed for identification of obvious control weaknesses.[1]

The receiver should consider establishing internal control policies and procedures and then periodically audit to determine compliance with established directives. Documentation of the receiver's accounting staff's evaluation or internal audit will be useful in identifying controls that should be maintained or strengthened, in providing a baseline for ongoing evaluations, and in demonstrating to other interested parties the rationale used in making the assessment.

This section addresses internal controls by identifying the broad functions typically found in a failed insurer.

The evaluation of controls over particular applications depends on the sources of information that flow into the applications and the nature of the processes to which the data are subject. These processes can be viewed as:

Accounting estimation processes: Processes that reflect the numerous judgments, decisions, and choices made in preparing financial statements. Examples of this include the actuarial reserve estimates or tax projections.

Routine data processes: Accounting applications/systems that process routine financial data (the detailed information about transactions) recorded in the records (e.g., the processing of receipts and disbursement transactions, other transaction processing, and payroll).

[1] The federal Sarbanes-Oxley Act of 2002 was in many respects a response to high-profile corporate scandals, but the Act contains corporate governance and accounting regulation concepts that had been proposed even before these scandals became public. Although, in most respects, the Act is directly applicable only to publicly held companies, many Sarbanes-Oxley concepts may eventually be brought to bear on mutual or privately held insurance companies through state regulation, changes in delivery of accounting and auditing services, adaptation of bank lending covenants, insurance and/or reinsurance requirements, and court decisions in state law fiduciary duty litigation.

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Non-routine data processes: Other less-frequently applied processes used in conjunction with the preparation of financial statements (e.g., financial statement consolidation procedures, gathering of financial information for special reports, actuarial estimates of reserves, etc.).

In evaluating controls over an application/system, it is important to note that routine data processes generally are subject to a more formalized system of controls because of the objectivity of data and volume of information processed. Conversely, because accounting estimation processes and non-routine data processes typically are more subjective (involving estimates), or because they are performed less often, these processes typically do not have controls at the same level of formality. Consequently, the risk of errors occurring may be greater, and therefore additional scrutiny of the controls may be required.

It is suggested that the approach for evaluating internal controls consider five broad control objectives that affect the reliability of information in the accounts, records and financial statements of the insolvent insurer:

Segregation of duties: Are procedures in place to ensure that employees with the responsibility for recording or reporting transactions do not have custody of the assets on which they are reporting?

Authorization: Are controls in place to ensure that transactions are executed in accordance with the receiver's general or specific authorization?

Access to assets: Are controls in place to ensure that access to assets (including data) is permitted only in accordance with the receiver's authorization?

Asset accountability: Are controls in place to ensure that amounts recorded for assets are compared with the existing assets at reasonable intervals, and that appropriate action is taken regarding any differences?

Recording: Are controls in place to ensure that all transactions are recorded and that all recorded transactions are real, properly valued, recorded on a timely basis, properly classified, and correctly summarized and posted?

VI. AUDIT/INVESTIGATION OF FINANCIAL STATEMENTS

The first step in performing an audit/investigation of an insurer's financial statements is to secure the insurer's cash and investment assets (as discussed above), and then obtain the most recently published financial statement. This may be the most recent annual, quarterly, or monthly financial statement submitted to the domiciliary state insurance department. As discussed later in this chapter, control should be obtained over all automated and manual records of the company, including financial, underwriting and claims records.

Computer systems should be secured at the date of takeover, which includes creating a backup to preserve data at the time of takeover, limiting physical access, changing locks and passwords, and obtaining and taking inventory of all computer disks and related backups. (See Chapter 2—Information Systems.)

All manual records of the insurer, including those at off-site locations, should be inventoried. A central location for all records should be established, and all records should be transported to this location. An electronic inventory system should be created to track the location of records/files.

A review of internal controls should identify the nature and extent of significant problems within the insurer and the segregation of duties. This review should ideally be performed by independent auditors at the beginning of the receivership and on a periodic basis thereafter.

An examination of all accounts as of takeover date and a balance sheet as of the date of receivership may be required for reporting purposes or to support litigation. The balance sheet can be prepared using GAAP-basis, statutory-basis, or cash-basis accounting. The accounting department, insurance department personnel, or independent

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accountants may perform this function. The balance sheet should be prepared using the accounts and the general ledger, as well as current bank statements, investment statements, cash reports, and other supporting documents.

The receiver's accountants should obtain workpapers from the last completed audit and/or from the preliminary audit done by an independent accounting firm. These workpapers and any documents or correspondence related to the audit should be reviewed, focusing on restricted assets, related-party transactions, commitments and contingencies, disclosure items, and any other support documentation or unusual items noted. The accountant may be asked to comment on the adequacy of the financial statements opined upon by the insurer's former accountants.

The accountants should also obtain the most recent audited annual statements, SEC reports, 10Ks, 10Qs, filed statutory blanks, and internal audit files and reports, again focusing on restricted asset documentation, related-party transactions, unusual items noted, and internal control studies.

The principal types of assets and liabilities that an insurer could have and the recommended procedures for establishing the balance sheet at the date of receivership and for securing assets on a prospective basis are discussed below.

A. Cash

As addressed in Section III, the existence, location, and amount of all cash, cash equivalent, short-term investments, and cryptocurrencies should be verified through direct confirmation with financial institutions, investment managers and other parties thought to be holding cash or investments. Special care should be applied to the identification of accounts not held in the insurer's name but to its benefit. Bank statements, investment statements, cash ledgers and cash-flow statements should be reviewed. This process should also include any funds held as collateral, LOCs, or other restricted cash. The initial procedures established with the financial institutions regarding wire transfers, as well as the identity of all who have access to the cash and investments, should be reevaluated and further consideration given to changing, restricting, or curtailing this access.

B. Investments

As with cash, the existence, location, amount, and type of liquid securities (i.e., bonds, stocks, mortgage loans, etc.) should be confirmed directly with financial institutions, any joint venture managing partners, investment and real estate managers, and other third parties thought to be holding securities. Investment statements from financial institutions, portfolio statements from investment managers, and other similar reports should be secured and used to establish a balance at the receivership date. Purchases, sales, and transfers of any kind, especially recent transactions, should be reviewed, with special attention to related gains/losses. A focus on related-party or affiliate transactions is important, as it could be helpful to the receiver and attorneys. The receiver should be aware of who has access to the investments and the authority to direct the investment managers/brokers. The receiver should consider changing and restricting this authority.

A review of the investment policies should be made and guidelines and procedures established regarding the future investing of securities. State law(s) should be researched to determine if there are any applicable restrictions. Receivers should take into account how they act in a fiduciary capacity, and any investment decisions and guidelines should reflect that. If an investment management firm is controlling allocations according to the investment policy, the receiver should inform them of any difference in the allocations. Allocation of this function between in-house personnel and independent investment services should take into consideration the current dollar amount of investments, projection of future investments, capability of the company personnel, and the complexity of transactions. The receiver should investigate company ownership of derivative and options instruments (see the Notes to the Financials, and Schedule DB of the annual statement) and obtain a description of the company's hedging strategy.

The market value of investments as of the date of receivership should be ascertained to determine the realizable value of the assets.

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Examples of the various types of investments that may be recorded on the insurer's books include:

- Stock
- Bonds.
- Mortgage or asset-backed securities (ABS).
- Short-term investments (e.g., money markets, overnight deposits). (See cash above.)
- Government securities.
- High-yield, high-risk bonds.
- Mortgage loans.
- Joint ventures.
- Partnerships.
- Investments in subsidiary, controlled, or affiliated (SCA) entities.
- Real estate.
- Company-owned automobiles.
- Other assets, including health care-related receivables (for health-related receiverships).

The receiver should also be aware of the risks associated with the various investments recorded on the books of the insurer and should consider liquidating high-risk investments in favor of more conservative investments. Certain risks can be defined as:

- Credit risk
  - The risk that default may occur on an obligation.
- Market risk
  - The risk that values are affected adversely by changes in interest rates or similar type price changes.
- Liquidity risk
  - The risk that the ability to sell investments readily has diminished, resulting in an inability to generate cash to pay off obligations.
- Off-balance-sheet risk
  - The risk that a potential loss may occur in excess of the amount recorded on the financial statements. This loss may be related to guarantees or commitments entered into by the insurer with respect to a particular investment.

The insurer may have entered into hedge transactions or other sophisticated investment contracts; the receiver should have an understanding of these arrangements before undertaking any transactions relating to them.

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C. Real Estate

Determine the existence, the location, and the amount of related mortgage/debt and/or income from properties. Obtain any real estate-related management contracts. Consider obtaining current valuation of the properties through an appraiser or based on current market conditions. Transactions should be identified and quantified with related parties or affiliates on recent transactions within the voidable preference period. Management of existing properties should be reviewed by the receiver. The bank/lender holding related mortgage/debt should be notified of the receivership. If any of the real estate is held in a joint venture/partnership, obtain and review the joint venture/partnership agreements.

D. Reinsurance Recoverables

A present-day evaluation of the collectibility of reinsurance recoverables should be performed by the receiver based on current balances, aging of recoverables, and valuation of allowance for doubtful accounts by reinsurer. The processing of claims by the guaranty funds and the reporting of paid losses should be monitored by the receiver for adherence to protocols regarding completeness and timeliness and the effect of delays on its ability to collect reinsurance recoverables. (See Chapter 2—Information Systems and Chapter 6—Guaranty Funds.) Further, consideration should be given to whether ceded reinsurance premiums should be paid and the legal effect of refusal to pay. In the context of a life and health receivership, the receiver should be mindful of the guaranty associations' right to elect to continue reinsurance in accordance with Section 612 of the *Insurer Receivership Model Act* (#555) and Section 8(N) of the *Life and Health Insurance Guaranty Association Model Act* (#520), as adopted in the states.

A receiver should, as part of their evaluation of all reinsurance contracts, determine if there is a contingent commission component and if so, find out whether the estate qualified and received any present or future contingent commission.

Most reinsurance contracts reward contingent commission by way of the ceding commission, i.e., if the loss ratios are within the contract terms that trigger the contingent commission, it typically would be reflected in an increase in the percentage on the ceding commission.

E. Prepaids

Identify prepaid assets, which could include insurance coverage, taxes, pension benefits, etc. If a prepaid asset relates to property insurance coverage, cross reference the insured property to the real estate section, making sure that the property has been identified and recorded under the real estate section. Focus on any prepaids for services from related parties and affiliates.

F. Agents' Balances

Review agents' balances, focusing on additional information that should be recorded on the books of the insurer versus the agents' books. Examine agreements and commissions, and check for unlawful setoffs, evidence of broker funding, and other netting activities. Investigate any advance commissions, or bonus or delayed payment arrangements with agents. Consideration should be given to lags in the reporting of premium (and thus exposures), particularly when MGAs, TPAs, or multiple agents/brokers are involved. Particular attention should be paid to determine if there are any unearned commissions due to the cancellation of policies caused by the liquidation. Often the agency agreement makes the agent responsible for collection of premium. Under those agreements, if the agent is carrying an account receivable for uncollected premium and the amount of the uncollected premium has not already been paid to the insurance company, the receiver can demand that the agent make payment for the premium even though it has not been collected by the agent. Agent agreements also vary as to the terms for collection of audit premium. Some make the agent responsible for collection of audit premium, while some leave audit premium collection to the insurer. If the audit or audit collection responsibility lies with the agent, the receiver will want to enforce that, at least to the extent that the agent actually collects audit premium. Whether premiums

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are to be remitted to the receiver in gross or net of commissions is an issue of state law that should be resolved by the receiver in consultation with counsel.

G. Loans or Advances to Affiliates or Agents

Determine whether any receivables have been written off without an effort to collect.

H. Personal Property

Obtain a complete inventory of all personal property, such as furniture, fixtures, and equipment, including any depreciation schedule. Care should be taken to verify that the insurer is the owner of these assets as opposed to an affiliate or another entity. For example, some assets may be leased as a form of financing. If the company is a staff model HMO, the receiver should also obtain an inventory of medical equipment and a pharmacy or medical supplies inventory.

I. Other Assets

Review other assets, determining existence, location, and amount. Verify expiration dates and adequacy of trust accounts and LOCs posted as collateral by reinsurers, policyholders, and others. Ascertain whether any assets have been sold or transferred for less-than-adequate consideration. Review sales contracts and independent appraisals, and focus on any transactions with related parties and affiliates.

For health care-related receiverships, health care receivables can include items like provider risk sharing receivables, coordination of benefits, provider overpayments, and/or subrogation recoverables among other items.

J. Accounts Payable and Accrued Expenses; Debt

Identify and quantify liabilities outstanding for all general and secured creditors and employee-related expenses. Employee-related expenses include payroll and bonus, severance, vacation, and personal time. Obtain pension and deferred compensation program documentation where applicable. These items can be determined by using the payroll register, personnel policies and procedures, and personnel records. Confirm that all personnel receiving monies are currently employed by the insurer, and review all related-party transactions.

Notify any bank/lender of the receivership, and confirm outstanding balances as of the date of receivership. Review debt agreements, loan files, and collateral files to determine that liabilities are properly recorded on the financial statements as to type of debt and classification, i.e., short-term versus long-term.

K. Claim Reserves and Incurred but Not Reported (IBNR) Claims

Obtain an understanding of the insurer's policy on booking reserves, and determine whether the policy has been consistently followed. Make any necessary adjustments to the financial statements. Continue to monitor claims for ongoing evaluations and reporting of case reserves.

The receiver must consider the use of in-house actuaries or independent actuaries to determine the adequacy of reserves. Consider commissioning a new actuarial study, as of the liquidation date, to establish ultimate losses in a property/casualty (P/C) receivership or to evaluate blocks of business in life, accident, and health carriers. The additional cost of the study may be justified by the receiver's enhanced ability to finally commute reinsurance or to adjust account balances that involve retrospectively rated policies. (See Chapter 5—Claims.)

Determining the adequacy of claims reserves and incurred but not reported (IBNR) claims is especially critical for HMOs. It is also important to identify the inventory and associated liability for claims that are in-house but have not been processed through the HMO's claims system. The receiver may consider hiring

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a TPA or other outside claims processing service to process the claims and determine the ultimate liability. The receiver may also consider hiring an actuary to establish the medical loss ratio (MLR) for each of the HMO's product lines in order to determine whether a line of business is profitable.

L. Income and Expense

Examine any unusual income and expense items, including sales to or purchases from related parties or affiliates, significant gains/losses, and unusually high expenses in relation to the size of the insurer and type of business.

M. Equity

Review surplus accounts, and investigate any unusual changes in surplus, statutory to GAAP adjustments, recent capital contributions, recent capital issues, and other activity that appears unusual.

VII. RELATED PARTY TRANSACTIONS

Insurers often enter into many different types of transactions with various related-party entities. Each of these transactions should be scrutinized carefully because of the potential that they were not the result of arm's-length bargaining. Further, even fairly negotiated transactions may not have been carried out according to the terms of the agreement. Finally, the transaction may not be exactly as it appears. For example, a sale of an asset at a huge loss may in fact amount to a fraudulent transfer. Related parties may include a parent company, affiliates or subsidiaries, shareholders, directors, officers, and employees. Transactions with affiliates are required to be disclosed in Schedule Y, Part 2 of the annual statement. Related parties may also include entities or individuals that are not as easily identified, as they may be owned by individuals associated with the insurer (such as directors, shareholders, officers, or employees), or they may be entities that have entered into significant transactions with the insurer. These transactions may be significant as to the number of transactions or as to the amount of money involved. Alternatively, the transactions may be immaterial from the standpoint of assets changing hands, but they may be significant because of the nature of the transaction (guarantees, debt forgiveness, etc.).

It is important to identify related parties and transactions between the insurer and any related party as quickly as possible for many reasons, including to preserve the assets. Often, related-party transactions are not appropriately reflected on the insurer's books; sometimes the transactions may not be reflected at all, therefore misstating the insurer's assets or liabilities. The transactions may be accounted for (if at all) on the incorrect entity's books, and funds or entries may be commingled by management, thinking that all the companies are part of a consolidated group or owned by the same parent. However, the legal corporate entities are important, especially when one or more of them become insolvent. Insurers are subject to the jurisdiction of the insurance commissioner. Other entities are governed by bankruptcy law and are generally not subject to the jurisdiction of the commissioner; however, they may be subject to the jurisdiction of the receivership court in certain circumstances. On Aug. 17, 2021, the NAIC adopted a new provision, Section 5A(6), of the *Insurance Holding Company System Regulatory Act* (#440), which provides that the affiliated entity whose sole business purpose is to provide services to the insurance company is subject to the jurisdiction of the receivership court. This applies to affiliates performing services for the insurers that are an integral part of the insurer's operations or are essential to the insurer's ability to fulfil its obligations.[2]

Further, with regard to commingled data and records, the 2021 revisions to Model #440 and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) specify that records and data of the insurer held by an affiliate are identifiable and are segregated or readily capable of segregation at no additional cost to the insurer. The models' reference to "at no additional cost to the insurer" is not intended to prohibit recovery

[2] The full text of Section 5A(6) of the *Insurance Holding Company System Model Act* (#440) is available at *https://content.naic.org/sites/default/files/MO440_0.pdf*. The 2021 NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

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of the fair and reasonable cost associated with transferring records and data to the insurer. Because records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate

Related-party transactions may give rise to culpability on the part of the interested entities or individuals. Preferential transfers, fraudulent transfers, and other bases for liability are discussed further in this chapter and in Chapter 9—Legal Considerations.

Organization charts showing a parent, affiliates, or subsidiaries may be obtained from a schedule within the annual statement Schedule Y, Part 1, board minutes, or SEC filings. Additionally, relationships with insurance groups and entities that share common ownership can be found on Schedule Y, Part 3. Additionally, an electronic column of the various investment schedules of the annual statement identifies "Investments Involving Related Parties." It is more difficult to identify individuals who might have been involved with related-party transactions, and often that list of individuals is much longer. However, the receiver should start with the list of officers and directors of the insolvent insurer; its parent, subsidiaries or affiliates, again listed in the annual statement or SEC documents; and board minutes. Stockholders' names should be listed in shareholder records maintained, possibly, by legal counsel or trustees. Lists of employees may be obtained from payroll registers. When these transactions are reviewed, it may be determined that a significant number or dollar volume of transactions have occurred with one individual or entity. This may indicate that the involved entity or individual is also a related party.

Once an initial list of related parties is established, the types of transactions that may have occurred between these entities can be determined. The types of transactions that may be identified relate to various types of business transactions. An understanding of the related entities and how they are affiliated will help the receiver to identify and formulate the types of transactions that may have occurred between them. Many insurer company groups have established affiliates to act as investment vehicles or managers, brokers, reinsurers, MGAs, TPAs, premium finance companies, and computer service companies, or to accept select types of risks. A parent holding company may have been established. It is important to ascertain the related parties and their affiliation because the insolvent insurer may have claims against affiliates.

The receiver should review the notes to financial statements in the annual statement, the independent auditor's report and the state insurance examiner's report. These reports typically identify and summarize some of the significant related-party transactions. Also, board minutes will frequently contain discussions or resolutions pertaining to specific significant transactions involving related parties.

Brokerage, agency, or management agreements may exist between the insurer and its affiliates. There may also be reinsurance, both assumed and ceded, or pooling arrangements among affiliates. Expense-sharing arrangements may exist. An affiliate may provide data processing services. The receiver needs to determine immediately if they can continue to obtain these services and how to secure the data. Leasing arrangements for offices, data processing equipment, and furniture and fixtures may also exist. With respect to all agreements with affiliates, the receiver should be alert to possible differences between the apparent transaction and its real substance.

Holding companies may also provide management expertise for which there is a management agreement and/or expense allocation agreements. Tax-sharing agreements may also exist between all the affiliates and parent.

Insurers may have management agreements with unaffiliated parties, or control may be maintained through interlocking directors of the management company and the insurer. For example, an HMO may be controlled by a provider group such as hospitals. Therefore, these agreements or contracts need to be reviewed to determine if they are arm's-length transactions.

It is important to identify these transactions as quickly as possible, not only for the identification of assets and liabilities that may be recovered by the insurer, but also to determine if alternative data processing, management, facilities, etc., should be obtained, as these services may no longer be available from the affiliate. Alternatively, such services may be available on more favorable terms from nonaffiliated providers.

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The types of transactions that may have occurred between the insurer and its directors, officers, employees, and stockholders may be the same as some of the above, but they may also include items such as travel and expense advances, unsecured loans, or loans secured by personal or real property. Companies owned by any of these individuals may also be responsible for providing services discussed above, including leases, data processing, brokerage, reinsurance, etc.

To determine the existence of these types of transactions, their validity, and the appropriate accounting for the transactions (both in the books and records of the insurer and in cash flow), the tasks described below should be performed.

A. Identify Related Parties

The receiver should obtain or develop organizational charts to identify any and all affiliates and related parties. These affiliates should be identified as: 1) parent companies; 2) subsidiaries; or 3) affiliates (which would be organizations owned or controlled by the same parent company, but not owned by the insolvent insurer). Schedule Y, Part 1 of the annual statements provides an organization chart of the insurance holding company system; Schedule Y, Part 2 includes transactions with affiliates; and Schedule Y, Part 3 includes further information on insurance groups and entities that share common control. The various investment schedules of the annual statement include an electronic only column that identifies "Investments Involving Related Parties."

After preliminary identification of these related entities, the receiver should determine the status of these related entities:

- If the related parties are financially troubled, are the parties under the jurisdiction of the insurance regulator of their state of domicile, or are the parties under the jurisdiction of corporate bankruptcy laws?
- Does the insolvent insurer need to file a proof of claim against the related entity to preserve its claim? (The receiver should consult with counsel about the risks of submitting to a foreign court's jurisdiction on issues other than those set forth in the proof of claim.)
- Are the entities affiliated, in which case the insolvent insurer may have access to the assets of the related entities?
- Is cash commingled among the companies?
- Are the entities operating as alter egos?

The receiver should also obtain lists of individuals, as well as their related entities who might also be related parties, beginning with the directors and officers of the insurer listed in its annual statement and the officers and directors of the insurer's subsidiaries and affiliates. The receiver should also obtain a list of all shareholders and employees of the insolvent entity. Each of these individuals may be categorized in a manner similar to that described above for companies that are related entities. Each can be evaluated for the types of transactions that may have occurred between them and the insurer. It should be kept in mind that these individuals may have been involved with other entities that appear not to be related but, in fact, may have had sufficient transactions with the insolvent entity that they, too, become related entities.

B. Find Supporting Legal Documents for Transactions

The receiver should obtain all key documents and agreements entered into between the insurer and its various related entities. As discussed above, these agreements may have been collected through the inventory of documents in the takeover period. If these documents have not been located, a search may be made to locate any agreement or documents that indicate arrangements between the insolvent insurer and the various related entities.

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As the receiver completes the procedures described below and in Chapter 4—Investigation and Asset Recovery, identified transactions may indicate the advisability of searching for additional documents.

C. Identify Amounts Associated with the Related Party Transactions

Next, the receiver should review the various accounting records of the insurer, including the chart of accounts, general ledger, journal entry listing, and transaction listings. It must be noted that when dealing with related-party transactions, the receiver should attempt to obtain the corresponding records of related entities to cross-reference transactions and amounts as described in the procedures below.

The chart of accounts may be obtained and reviewed for any accounts that appear to be intercompany receivables, intercompany payables or loans to affiliates, related parties, directors, officers, shareholders, employees, etc. This may be an easier task for some companies than others. Often separate accounts will be established for all related-party transactions. On the other hand, the transactions may be difficult to identify if they were charged to accounts with innocuous titles such as "other assets" or "miscellaneous expense," or if they were netted with other transactions. Some transactions, particularly insurance-related transactions, may be buried in the normal transactions of the insurer. However, if the receiver reviews the chart of accounts to identify preliminarily the accounts that may be with related entities and individuals, subsequent procedures will help identify buried transactions.

After particular accounts have been identified as possibly containing related-party transactions, the general ledger should be reviewed to ascertain the dollar amount in the identified accounts. The receiver may want to prioritize the items reviewed by the dollar magnitude of the balances. However, caution should be taken at this point, as the dollar magnitude alone may not be indicative of the significance of the transaction. Understanding the types of transactions recorded in the particular account is helpful, especially if there is a high volume of transactions that have been netted. A small balance in an account with a significant volume of transactions may have other implications. No cash may have changed hands in the case of guarantees or debt forgiveness.

The next step is to obtain the transaction register by month to see the actual transactions that have been posted to the account. This will be the beginning of the investigation, or audit phase of the review. As mentioned above, depending on the size and type of systems the insurer used, it is possible that the general ledger listing also will provide the listing of transactions posted to the various accounts, meaning that a separate transaction listing is not necessary or available.

It may be beneficial to obtain a listing of disbursements sorted by payee. This can help identify related-party transactions that, as mentioned above, may not appear significant standing alone and that may be buried in other transactions of the insurer.

The above steps are easily accomplished if the insurer had an efficient, effective accounting system. Unfortunately, this is often not the case with many insurers that become insolvent. Frequently, the accounting system may not have been operational as originally designed due to budgetary concerns, cutbacks of manpower, and other problems during the period immediately preceding the insolvency, or there may have been intentional distortion of the system to hide improper transactions. In any case, it may be necessary to reconstruct information.

D. Cross-Reference to Affiliates' Books

If the receiver has access to the related entities' books, they should be obtained from those entities. A receiver who does not have ready access should attempt to obtain access promptly. The reciprocal accounts for those entities may then be reviewed and cross-referenced to see that the amounts recorded on the related entities' books are in fact the reciprocal of the amounts on the insolvent insurer's books. Differences should be investigated. In addition to the cross-referencing, the receiver may also perform all the analytical procedures discussed above for the related entities' identified accounts. Through this process, the receiver

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may find other transactions that need to be evaluated and analyzed. In the absence of a court order, the receiver will usually be unsuccessful in his/her attempt to obtain the books and records of related entities.

E. Analyze All Transactions

Once related-party transactions have been identified, detailed analyses of most of the transactions can be completed to determine whether they were business transactions entered into at arm's length and for valid business reasons with appropriate support. The arm's-length aspect of some transactions may be difficult to determine (or refute); however, all such transactions should be reviewed with an appropriate degree of skepticism. The analysis of the identified transactions may be completed by the accounting department or by the audit/investigation team.

The receiver may attempt to segregate transactions into types for analysis. Otherwise, the task may seem too large to accomplish. The transaction types may be determined by the accounts that have been identified as including related-party transactions and the relationships of the related parties. For example, if the related-party accounts include advances to or from, or accounts receivable or payable, then one of the transaction types might be cash advances or loans to related parties. The following are some of the transaction types that may be identified for analysis:

- Advances/loans to related parties.
- Reinsurance receivable/payable.
- Premiums due to/from.
- Commissions due to/from.
- Operating expenses receivable/payable (leases, management, computer services, etc.).
- Payment of dividends.
- Purchase or sale of assets from or to related parties.

The receiver should then systematically review the transaction types in each of the identified accounts. This would include noting the description of the transaction in the transaction listing.

It may be necessary for the receiver to search for the underlying documentation for all entries. The journal entry listing and other documents obtained in the document search may be helpful in this effort. Also, the various schedules in the annual statement should be reviewed. In any event, the receiver will have to seek any underlying information that may indicate the substance of the recorded transaction. The receiver may also have access to current or former employees who can shed light on the nature and intent of these transactions, locate documentation, and otherwise interpret such documents. Once the transaction entry has been obtained and the underlying documentation has been obtained and reviewed, the receiver can determine whether the information was recorded appropriately on the insurer's books. At that time, the receiver should add the correct dollar amount of this item to the schedule of items for ultimate determination of action. This schedule should be prepared on a gross basis, without netting of balances, to enable the receiver to see the full impact of the transactions.

The receiver should systematically analyze all significant transactions in all identified accounts, as demonstrated above, until all transactions have been reviewed and scheduled for ultimate disposition.

As each of these transactions is being reviewed and scheduled, it is always necessary to cross-reference to other related parties' books and records, if available.

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F. Evaluate All Identified and Analyzed Transactions

After all transactions have been reviewed, analyzed, and scheduled, the receiver will have to evaluate the propriety of the transactions and any action necessary. Some of the transactions might not stand depending on the type of transaction and when it occurred relative to the date the insurer was declared insolvent. If the related-party transactions result in receivables to the insolvent entity, it may be necessary for the receiver to file a proof of claim in another proceeding if the other party is in some form of receivership. If the related-party transaction resulted in payables from the insurer, the receiver may have creditors that need to be notified of the insolvency.

G. Potential Reconstruction of Records

If the insurer does not have the types of records listed above, it may be necessary to use available records to reconstruct the needed information. In such cases, the receiver should begin with the insurer's annual statement. From this, the receiver may find supporting documents for the numbers entered and filed in this statement. If the underlying information does not agree with the annual statement, the discrepancies should be identified and the reason for the discrepancies determined. The receiver may be able to obtain information from the insurance department or outside auditors, which can be of great benefit when reconstructing records.

If a total reconstruction is required, the receiver should start with all the bank statements for the past year (at a minimum). The receiver should review the receipts and disbursements from the most recent year to determine if there are additional types of transactions that were not previously disclosed in the last filed annual statement. This detailed analysis should include a schedule that categorizes disbursements by type and segregates those related to the payment of claims or reinsurance and other underwriting expenses from those that were pure operating expenses. Disbursements that may have been to related entities should also be segregated and identified. The same type of schedule should also be prepared for all cash receipts.

If available, any financial information regarding affiliates, subsidiaries, or the parent company would be useful in this reconstruction.

H. Data and Records of the Insurer Held by an Affiliate

The *Insurance Holding Company System Model Act* (Model #440 and Model *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450 contain provisions that address data and records of the insurer that are held by an affiliate. While the models have contained provisions since 2010, on Aug. 17, 2021, the NAIC adopted revisions to further clarify owner of data and records.[3]

Specifically, the Model #440 specifies the following:

- The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

- All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. The affiliate may charge a fair and reasonable cost associated with transferring the records and data to the insurer. However, the insurer should not pay a cost to segregate commingled records and data.

[3] Although in 2021 the NAIC adopted revisions to Model #440 and *Model* #450 related to receivership matters including records and data, these revisions may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

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Therefore, if records and data belonging to the insurer is held by an affiliate (e.g., on the affiliate's systems), upon request, the affiliate shall provide that the receiver can:

- Obtain a complete set of all records of any type that pertain to the insurer's business.
- Obtain access to the operating systems on which the data is maintained.
- Obtain the software that runs those systems either through assumption of licensing agreements or otherwise.
- Restrict the use of the data by the affiliate if it is not operating the insurer's business.

- The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement.

- The revisions to Model #440 and Model #450 also describe that records and data that are otherwise the property of the insurer, in whatever form maintained, include, but are not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate.

- Section 19 of Model #450 lists provisions that should be included in agreements for cost-sharing services and management services between the insurer and an affiliate, which includes certain provisions specific to the insurer being placed in supervision, seizure, conservatorship, or receivership.

    - All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by state law.
    - Records and data of the insurer are the property of the insurer, are subject to the control of the insurer, are identifiable, and are segregated from all other person's records and data or are readily capable of segregation at no additional cost to the insurer.
    - If the insurer is placed into receivership, a complete set of records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable.
    - Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship, or receivership.
    - Specify that the affiliate will provide the essential services for a minimum period of time (specified in the agreement) after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship, or receivership.
    - Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure, notwithstanding supervision, seizure, conservatorship, or receivership.
    - Specify that if the insurer is placed into supervision, seizure, conservatorship, or receivership, and portions of the insurer's policies or contracts are eligible for coverage by

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one or more guaranty associations, the affiliate's commitments under certain provisions of Section 19 of Model #450 will extend to such guaranty association(s).[4]

VIII. TAX ISSUES

In virtually every receivership, federal tax issues must be considered. The insurer cannot be discharged or liquidated without the filing of federal income tax returns. In addition, consideration should be given to the payment of federal corporate income and other taxes. The receiver can be held personally liable for the payment of certain unpaid taxes if specific procedures are not followed.

Because of the complexity of federal income taxation issues, the potential personal liability of the receiver and the additional complexities associated with receiverships—and the significant impact on the estate from items such as forgiveness of debt, consolidation rules, and other matters—the receiver should hire individuals with expertise in these areas. Such experts could include independent CPAs or counsel with experience in such matters. Furthermore, because of the continuously evolving nature of federal income taxation issues, many of the issues addressed in this chapter may have changed. This is a reason that the receiver should hire individuals that will be as up to date as possible in these areas and why receivers should seek updated guidance on tax matters (both federal income and state premium tax issues) in reference to the issues addressed in this Handbook.

The receiver should ascertain the insurer's tax status as part of the takeover procedure, in addition to securing copies of tax returns and company tax payment records. Foremost, the receiver should learn whether all tax returns due have been filed and any amounts owing have been paid. In addition, the receiver should learn whether the insurer was part of a consolidated group filing or party to any tax sharing or similar contractual agreements. The receiver should also obtain and carefully review and understand the provisions of any tax-sharing agreements between the insurer and any related parties. In almost all receiverships, the receiver takes over the insurer but not necessarily its holding company or other affiliated group with which the insurer may be consolidated for tax purposes. In addition, the insurer may own nonregulated subsidiaries that are taxed differently from the insurer.

Prior years' returns and any correspondence with the IRS also should be reviewed. Discussion may be held with any outside CPAs or counsel who may have been involved in filing the returns or in handling any disputes with the IRS. The receiver should be alert to any contingencies that may exist for payment of taxes, penalties, and interest resulting from failure to file on time, failure to pay tax due on the return, inappropriate treatment of income or deductions on the return, etc. Contingency reserves recorded on the balance sheet of the insurer or its parent should be reviewed and analyzed for purposes of determining tax positions taken by the company that are not "more likely than not." The receiver should consider these contingencies when allocating distributable assets of the estate in light of the priority generally alleged by the federal government and accorded by the applicable priority statute. (See Chapter 9—Legal Considerations.)

The receiver may request an account transcript from the IRS for the receivership entity. The transcript, available by type of tax (Form 1120, Form 941, etc.) and year, may be obtained by filing form 4506-T, Request for Transcript of Tax Return. An account transcript typically contains information on tax payments (amounts and dates) and filing of returns (dates).

Income taxation of insurers is somewhat different from conventional corporations, with additional provisions that are applicable to life insurers contained in Part I of Subchapter L of the Internal Revenue Code (IRC) and specific provisions applicable to other insurance companies contained in Part II of Subchapter L of the IRC.

Even though an insurer may have substantial statutory losses, it is possible that based on its taxable income, federal income taxes may be due. See discussion in this chapter of deferred income that may be taxed when a company loses its status as a life insurance company for federal tax purposes. There also exists the possibility that the insurer

[4] The full text of Section 19 of Model #450 is available on the NAIC website at: *https://content.naic.org/sites/default/files/MO450_0.pdf*.

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is entitled to recover prior years' taxes because of the existence of capital losses, operating losses, or tax credits. Operating losses can be carried back two years and carried forward 20 years by P/C insurers. Prior to 2018, life insurers were allowed to carry back ordinary losses for three years and carry forward losses for 15 years. No carryback is allowed for operating losses of insurers other than P/C insurers for taxable years after Dec. 31, 2017, but these insurers are allowed indefinite carryforwards, which are limited to 80% of taxable income in each year to which the operating loss is carried. All insurers are allowed to carry back capital losses three years and carry forward up to five years to offset capital gains. Tax credit carrybacks vary depending upon the type of credit, so you should always check with a tax advisor. The insurer may also have made estimated tax payments that can be recovered. Additionally, an insurer may be entitled to a tax recovery because of its inclusion in a consolidated tax filing where its losses were used to set off taxable income from affiliated entities. Tax recovery due to tax sharing agreements will not be recoverable from the IRS but must be recovered from affiliated entities. Therefore, income tax recoverable may not be collectible and, as such, should not be booked. In addition, under Section 848 of the IRC, an insurer must capitalize its estimated acquisition expenses, which are then amortizable (deductible) over the ensuing 10-year period for amounts capitalized prior to through Dec. 31, 2017, and over a 15-year period for amounts capitalized after Dec. 31, 2017 (five years for smaller companies).

The receiver should be aware that IRC Section 6511(a) places a deadline by which claims for credit or refund of taxes must be made. In many instances, this deadline will be three years from the due date of the return for which the claim for refund is being made. However, if the claim for refund results from the carryback of losses to preceding tax years, the deadline will be three years from the due date of the return that generated the loss. Due to the critical nature of properly determining these deadlines, the receiver should consider consulting independent CPAs or counsel with experience with these matters.

In addition to federal corporate income taxes, the receiver also has to be concerned about foreign taxes, state corporate income taxes, federal and state payroll taxes, premium taxes, real estate taxes, federal excise taxes, state franchise and excise taxes, sales taxes, and personal property taxes, along with myriad reporting and filing requirements. The receiver will also need to file final tax returns upon the closing of the receivership estate.

A. Notice

Within 10 days from the date a receiver is appointed, Form 56 (Notice Concerning Fiduciary Relationship) must be filed with the IRS. A certified copy of the court appointment should be attached. This form should be filed for all forms of receivership. The receiver should specify that they are to receive notice concerning income, excise, sales and property, and payroll tax matters. The list of tax forms should include Form 1120L (for life companies) or Form 1120PC (for P/C companies), Form 941 (quarterly payroll tax returns), Form 940 (Federal Unemployment Compensation Tax), and Form 720 (Federal Quarterly Excise Tax Return). If the insurer owns subsidiaries, the receiver should also file a Form 56 notice for each subsidiary.

In addition to the federal filing, many states have similar notice requirements. Even without a specific requirement, sending similar notice to the taxing authorities of those states and foreign countries where the insurer did business or had employees should be considered.

Form 56 is not to be used to update the last known address of the receivership entity. The receiver should file form 8822, Change of Address, with the IRS.

B. Income Taxes

Under Section 1.6012-3(b)(4) of the federal income tax regulations, a receiver or trustee who, by order of a court of competent jurisdiction, by operation of law or otherwise, has possession of or holds title to all, or substantially all, the property or business of a corporation, must file a return in the same manner and form as the corporation.

The due date for filing federal corporate income tax returns for insurance companies is the 15th day of the fourth month (generally April 15) of the year following the year end of the company. (For years beginning prior to 2016, the due date was the 15th day of the third month [generally March 15] of the year following

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the year end of the company.) A six-month extension to Oct. 15 can be obtained for the filing of the return if the extension form is sent to the IRS prior to the April 15 deadline. This extension, however, is only for the filing of the return and not for the payment of tax liabilities. The April 15 deadline is applicable to calendar-year companies only. There may be certain non-insurance companies under the receiver's authority that have fiscal year-ends.

Once an affiliated group of corporations files a consolidated return, it must continue to do so as long as the group remains in existence. Therefore, consolidated returns must continue to be filed with the insurer's subsidiaries. In addition, the IRS has ruled under PLR 9246031 that an insurer in liquidation under state law generally is required to be included in its common parent's consolidated federal income tax return. The receiver may request approval from the IRS to file separate returns. This permission may be granted on a case-by-case basis for good cause shown. Pursuant to the consolidated return regulations (1.1502-75), the parent of the affiliated group must request deconsolidation for good cause. A deconsolidation may weaken the IRS' position; as such, the granting of a deconsolidation is not guaranteed.

Following is a list of various insurance or insurance-related entities and the federal income tax form that should be filed:

Type of Insurer (Based on Business Written)	**Federal Income Tax Form**
P/C	1120-PC
Life	1120-L
HMO	1120-PC
Staff Model HMO	1120
501(c)(15)(A) - Tax Exempt	990
Title	1120-PC
Blue Cross Blue Shield Association	1120-PC
Health	1120-PC
Health w/Noncancellable and/or Guaranteed Renewable Contracts	1120-L

For a company to be considered an "insurance company," at least half of its business during the taxable year must be the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies.

For a company to be considered a "life insurance company," it must be engaged in the business of issuing life insurance and annuity contracts (either separately or combined with accident and health [A&H] insurance), or noncancellable and/or guaranteed renewable contracts of health and accident insurance. Also, its life insurance reserves plus unearned premiums—and unpaid premiums on unpaid losses and on noncancellable life, accident, or health policies not included in life reserves—must make up 50% or more of its total reserves.

In certain special situations, managed care organizations may qualify for tax exempt status; if so, they would file Form 990.

1. Life Insurance Companies

Life insurers (whether stock, mutual, or mutual benefit) that meet certain reserve requirements file Form 1120-L. If a life insurer does not meet the reserve requirements, then it must file Form 1120-PC. If a stock life insurer loses its life insurance tax status because its life insurance reserves fall below the minimum requirement, then taxes that were deferred in earlier years may now become due. In Revenue Procedure 2018-31, Section 26.03 provides for an automatic accounting method change when there is

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a change in qualification as a life insurance company as defined in Internal Revenue Code (IRC) Section 816(a).

For taxable years ending before Jan. 1, 2018, life insurers with less than $500 million in assets are entitled to a small life insurer deduction of 60% of their "life insurance company taxable income." This deduction is available for income up to $3 million and then is gradually phased out on income from $3 million to $15 million. For taxable years after Dec. 31, 2017, the small life insurer company deduction is repealed, and the alternative minimum tax for corporations is repealed as well.

2. Non-Life Insurance Companies

Non-life insurers (stock and mutual) file Form 1120-PC. Non-life companies generally are taxed on their statutory income with certain modifications, including the discounting of loss reserves and the non-deductibility of 20% of the increase of the unearned premium reserves. The non-deductible 20% of the unearned premium reserve (UPR) gives the taxpayer a tax benefit when the UPR is reduced, but the effect of the reversal of the 80% deductible portion has a greater impact and may create taxable income. As previously stated, the receiver should consult their tax consultant regarding the ramifications of these issues.

Non-life insurers whose written premiums for the year do not exceed $2.2 million (an amount that is inflation-adjusted for each taxable year beginning after 2015) may elect to be taxed only on investment income under Code Section 831(b). The premium limits are based upon the premiums of a "controlled group" of corporations as defined by Code Section 1563(a), with the exception that more than 50% is the definition of control. The fact that an insurer is in receivership does not remove it from a "controlled group." The company also must meet certain diversification requirements with regard to premiums and owners as prescribed in IRC Section (831(b)(2)(B)). Taxation on investment income may not be advantageous to companies that are currently generating or using net operating losses, as the company may lose the benefit of those losses. IRC Section 831(b)(3) prescribes limitations on the use of net operating losses for insurance companies taxed only on investment income.

Prior to Jan. 1, 2005, small non-life insurers with less than $350,000 of premium income could qualify to be exempt from income tax under Code Section 501(c)(15). Many receivers took advantage of this provision to exempt liquidation estates from federal income taxation. In 2004, IRC Section 501(c)(15) was amended to provide tax exempt status only to those non-life insurers with gross receipts less than $600,000, and then only if more than 50% of the gross receipts were from premiums. Because most companies in liquidation have virtually zero premium income after the first couple of years of the liquidation, and because most have annual income exceeding the $600,000 cap, this amendment to Code Section 501(c)(15) generally eliminated its applicability to insurance receiverships.

The impact upon insurance companies in receivership was considered as Code Section 501(c)(15) was being amended in 2004, and the applicability of the exemption to insurance companies in receivership was specifically extended through calendar year 2007. However, as of Jan. 1, 2008, any insurers in liquidation that may have previously been qualified for exemption under the pre-2005 provisions of Code Section 501(c)(15) became ineligible for such exemption and are subject to federal income tax from that time forward unless they met the new requirements.

3. Special Relief

Under Revenue Procedure 84-59, the receiver may apply to the district director of internal revenue for relief from the filing requirements under limited circumstances. In order to request this relief, the insurer has to have ceased operations and no longer have assets or income.

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4. Prompt Audit

The receiver may request that a prompt determination be made under Revenue Procedure 2006-24 whether the income tax return is being selected for examination by the IRS or is accepted as filed. The receiver will be discharged from any liability upon payment of the tax shown on the return if the IRS does not notify the receiver within 60 days after the request that the return has been selected for examination, or if the IRS does not complete the examination and notify the receiver of any tax due within 180 days after the request. This procedure enables the receiver to proceed with the receivership, or enhances the possible sale of the insurer, by resolving contingencies relating to taxes due for prior periods. The prompt audit provisions specifically apply to bankruptcy proceedings, not state liquidations. Certain IRS offices have approved applying the provisions to state liquidations. However, the approval is not automatic. When this is the case, a request for prompt assessment should be made under IRC §6501(d). This will reduce the statute of limitations for assessment to 18 months. The request contemplates a corporate dissolution in 18 months and requires the submission of Form 4810 to the IRS.

5. Carrybacks

An insurer often becomes financially troubled because it incurred operating and/or other losses. Such losses may be deductible for income tax purposes. A review may be made of the deductibility of such losses to determine if the losses were deducted in the correct fiscal year and may be carried back to recover previously paid income taxes. If the losses were not deducted in the correct years, prior years' income tax returns may have to be amended. Under the federal Tax Cuts and Jobs Act of 2017 (TCJA), net operating losses of non-life insurance companies can still be carried back two years and carried forward 20 years (IRC Section 172(b)(1)(C)). However, there is no carryback for life insurance company net operating losses arising in 2018 and later years and an unlimited carry forward period (IRC Section 172(b)(1)(A)). Operational losses of life insurers arising in 2017 and earlier are carried back three years and forward 15 years. A non-life insurance company can use the full amount of its net operating losses to offset taxable income (IRC Section 172(f)). A life insurance company is limited to an 80% net operating loss deduction against taxable income (IRC Section 172(a)(2)).

An example of a restructuring technique used in the liquidation of Reliance Insurance Company to address significant net operating loss carryovers is available in Exhibit 3-4.

6. Carryovers

To the extent that there is a discharge of indebtedness, any net operating loss carryover may be reduced by the amount of the discharge. If guaranty funds or other creditors are entitled to future funds, there may not have been a complete discharge.

Net operating losses are allowed an indefinite carryover period in taxable years beginning after Dec. 31, 2017. The net operating loss deduction is limited to 80% of taxable income (without regard to the deduction) for losses arising in taxable years beginning after Dec. 31, 2017. Therefore, even when there are net operating loss carryovers available, discharge of indebtedness could still result in income tax liabilities due because of the carryover taxable income limitations.

7. Deferred Taxes

The deferred taxes for both deferred tax assets and liabilities should be reassessed. For example, the deferred tax assets that rely on further taxes payable to be realized may no longer be realizable.

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C. Premium Taxes

If the insurer is in rehabilitation, the receiver may be required to continue paying state and municipal premium taxes. Insurers are usually required to pay premium taxes that are calculated as a percent of direct premiums written. Many state and local tax authorities require insurers to pay estimated premium taxes. In many cases, a financially troubled insurer may experience a decrease in premium volume, or policies in force may be canceled. This may result in a reduction in premiums written and the related premium taxes. A review may be made to determine whether the insurer is entitled to premium tax refunds. It may then be necessary to refile the most recent returns to reflect the reduction in premium income. In addition, the receiver may attempt recovery of any prepaid or estimated premium taxes. If premium taxes are owed in a liquidation, many states may relegate premium tax claims to a lower or general creditor status.

D. Payroll Taxes

Insurers are required to withhold federal income tax and Social Security tax (as well as state and local income taxes) from the wages and salaries of their employees. All of these taxes are considered trust fund taxes and must be remitted periodically to the various taxing authorities. The receiver should promptly ascertain that all payroll tax payments have been remitted by the insurer. If the receiver finds that taxes have not been paid, the Special Procedures Office of the IRS should be notified. In this way, the taxes or 100% penalty can be assessed against the former officers or persons with the responsibility for paying the taxes. The receiver may be asked to complete Form 4180 or Form 4181, which are questionnaires relating to the payment of trust fund taxes.

If the receiver fails to follow these procedures and funds that could have been used to pay trust fund liabilities are used for other purposes, the receiver may be held personally liable. The receiver should make certain that any plan filed with the court for the distribution of assets provides for the payment of these outstanding federal tax liabilities.

Many states have similar laws relating to withheld payroll taxes, and the receiver should be aware of the responsibilities imposed by these laws. The receiver should continue to file Form W-2, as well as Form 940 and Form 941, for employees of the insolvent insurer.

E. Other Taxes and Assessments

1. Real Estate and Corporate Personal Property Taxes

The receiver should ascertain whether all real estate tax payments have been made, including those that the insurer has been collecting on mortgages it holds or services. The tax collector should be notified of the receivership proceeding and instructed to send any notices to the receiver.

2. Guaranty Fund Assessments

State guaranty funds assess insurers to cover their administrative and claim costs. If the insurer is operating under supervision or rehabilitation, it remains liable for guaranty fund assessments, though a guaranty fund may defer or abate an assessment, in whole or in part, under certain circumstances. In liquidation, guaranty fund assessments are paid in accordance with the domiciliary state's liquidation priority statute.

3. Excise Taxes

Some insurers are required to remit excise taxes to the IRS because of foreign reinsurance premiums. These taxes are also considered trust fund taxes, and the same care should be afforded these taxes as is given to withheld payroll taxes.

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4. Commissions and Other Payments

At year-end, insurers are required to file Form W-2 and/or Form 1099 for all commissions and other payments to an individual or partnership in excess of $600 during the year. In addition, the receiver is required to prepare 1099 forms and send them to policyholders of life companies while business is still being serviced by the insolvent insurer. In addition, if the insurer has received interest from mortgages, the receiver is required to prepare and provide Form 1098 to the payer. If more than 250 1099 forms are to be issued, the filing is required to be done electronically. However, relief from this electronic filing may be secured upon request to the IRS. The receiver should be able to demonstrate that an electronic filing would place an undue hardship on the insolvent insurer. The IRS can assess penalties for both the failure to issue the forms to agents and the failure to file the forms with the IRS. If the receiver has not already sought relief and the estate is assessed, the IRS may waive the assessment upon request. Additionally, most states and some localities have filing requirements.

5. Franchise Taxes

Several states have franchise taxes. The tax basis can be the net worth of the insurer, the assets of the insurer, the number of shares of authorized stock, or the amount of paid-in capital. The failure to file and pay these taxes may result in the cancellation of the insurer's corporate certificate of authority.

6. Other State Taxes and Licenses

Insurers are subject to numerous state taxes and assessments, including: workers' compensation; second injury funds; firemen's and policemen's pension funds; medical disaster funds; major medical insurance funds; arson, fire, and fraud prevention funds; fire marshal tax; insurance department administrative assessments; federal Fair Access to Insurance Requirements (FAIR) Plan assessments; and motor vehicle insurance funds. In addition, many localities have licenses and taxes unique to insurers. Comprehensive summaries are published by several insurers groups, including the American Property Casualty Insurance Association (APCIA) and the American Council of Life Insurers (ACLI). The receiver should also ascertain if the insurer has any responsibility for filing informational returns and/or paying other state or local taxes such as sales and use taxes, water and sewer taxes, business and occupational privilege licenses, and taxes for employment training funds. Before paying these taxes, consideration should be given to the importance or lack of importance of maintaining state corporate certificates of authority and/or licenses.

All taxes should be reviewed to determine how any liability should be included in the priority scheme. The receiver should consider whether the certificate of authority or licenses have value before they are allowed to expire or be cancelled.

IX. INVESTMENTS

Investments may represent the largest group of assets on the balance sheet of an insurer. The purpose of the investments is to provide the company with resources and a steady flow of investment income to meet obligations as the obligations become due. A priority of the receiver is to take over full responsibility for all investments. This section will attempt to guide the receiver and identify any hidden elements in the following steps: seizure and control, inventory/identification, balancing, valuation, and other considerations.

The investment management function may be delegated to a bank or other professional manager. Depending on the receiver's evaluation of the company's investment manager, that person or entity may be retained with or without additional restrictions on their discretionary authority. Further, the receiver should consider that prior company investment objectives of high-yield, equity-related gains, and acceptance of reasonable risk may no longer be appropriate. Concerns of safety and liquidity may be foremost.

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A. Seizure and Control of Investments

To seize investments, the receiver should identify the various custodian institutions, investment brokers or managers, and the pertinent account numbers for the insurer. Most of the essential information may be obtained by review of the annual statement and the workpapers of the last full statutory examination or CPA audit. The examination workpapers will most likely include year-end statements and confirmations from the various institutions that are holding the investments. A review of the last filed annual statement will disclose the brokers that are most frequently used for the purchase and sale of investments.

The receiver may also corroborate all the pertinent information with the chief investment officer of the insurer.

If the investment managing function has been contracted to an outside institution, the receiver should promptly notify the institution of the receivership action. The external manager may be allowed to continue with their duties at the direction of the receiver, but transfers to other non-managed accounts should be restricted. The manager's discretionary authority should be reviewed to determine if additional restrictions should be placed on the manager to maintain investment balances in safe, liquid, and/or insured securities. The receiver should consider the difference between investment goals related to rehabilitation versus liquidation

The receiver should notify all banks, custodians, depositories, brokers, and managers of the takeover as soon as possible and by the most expeditious method practicable under the circumstances. Time may be of the essence in preventing insiders from absconding with company funds. The notification should be specific as to account numbers but not limited to those account numbers. (Include any other accounts that bear the name of the insurer.) The notification should be accompanied by a copy of the court order of receivership. The institutions should be instructed as to their continuing duties and what is expected of them.

As part of the notification, the receiver should instruct the institutions to add the receiver's name as a signatory, deleting all others.

A matter that may need priority attention is the immediate suspension of wire transfers. Today, many insurers are electronically connected to financial institutions. Funds can be transferred by use of a personal computer (PC) or by telephone instructions (wire transfers) in a matter of minutes. Until the receiver has had an opportunity to review the process and change access codes and requirements, wire transfers should be suspended.

To avoid the exchange of good quality investments for lower quality investments, the receiver should review the authority for purchases, sales, and reinvestment of securities. The receiver might choose to impose a temporary restriction that only maturing securities may be liquidated to issuing institutions. This will provide the receiver an opportunity to review the quality of the investment portfolio. The receiver may desire the opinion of an outside service company in the evaluation of the portfolio. If the investment function is internally managed, the receiver may want to consider the economies and expertise of an outside investment management company. The receiver may also consider moving out-of-state assets into the domiciliary state to improve control and lessen the chance the assets may be attached by creditors.

B. Identification and Inventory of Investments

An inventory will help establish control of the investments. A good initial control list may be the investment schedules of the last annual statement, including Schedule A—Real Estate; Schedule B—Mortgage Loans; Schedule BA—Other Long-Term Invested Assets; Schedule D, Part 1—All Long-Term Bonds; Schedule D, Part 2, Section 1—Preferred Stock; Schedule D, Part 2, Section 2—Common Stock Schedule DA, Part 1—Short-Term Investments; Schedule DB—Financial Options, Caps, Floors, Collars, Swaps, Forward, and Futures; Schedule DL—Securities Lending Collateral Assets; and, Schedule E—Cash and Cash Equivalents. Also, the General and Special Deposit Schedules (Schedule E, Part 3) found in the annual statement will identify investments on deposit with various regulatory jurisdictions.

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The receiver should confirm investment holdings with the appropriate institutions. The insurer should have detailed listings of investments held, transaction statements, bank notices and advices, and broker slips and statements. These documents will assist the receiver in the identification and inventory of investments.

The insurer's financial statements may not disclose all investments in which the insurer has an interest. Subsidiaries of the insurer accounted for on the equity method will have separate listings of investments owned. The equity method (as opposed to the consolidation method) permits the parent company to report the net value of (or the equity in) the subsidiary as an investment. Therefore, the assets and liabilities of the subsidiary are not evident in the books of the parent company. In the case of a pension plan, the assets are owned by the pension plan and will not be listed on the insurer's statutory annual statement. Even though pension funds may come under the receiver's control, these funds should be maintained in a separate account. The receiver should also be aware of significant restrictions that may exist on the investment and use of the funds. Generally, pension funds are subject to the federal Employee Retirement Income Security Act (ERISA), which imposes severe penalties for mishandling funds and governs the dissolution of the pension plan.

Many states require that purchases and sales of investments be approved by the insurer's board of directors. The board minutes may reflect all purchases and sales. A review of the minutes may assist in the identification of investments.

Insurers from time to time may purchase debt obligations directly from the issuing company, without the assistance or the evaluation of a broker. Private placements indicate that the underwriting of the investment was solely the responsibility of the insurer. The insurer should have an underwriting file containing documentation of matters taken into consideration and copies of correspondence regarding the decision to purchase the instrument. The document of indebtedness may be located on the premises of the insurer, rather than with a financial depository or custodian. If securities that are not publicly traded are to be listed in the annual statement as admitted assets, all insurers must submit to the Securities Valuation Office (SVO) of the NAIC documentation to support the market value of the securities. The SVO will evaluate the documentation and assign a market value and a quality grade to the securities. The receiver should check with that agency to determine if management sought such valuations, possibly indicating the existence of additional assets not otherwise apparent from the accounting records.

An insurer should identify those securities with a high risk as to the potential of a loss of principal. While derivative instruments are reported in Schedule DB, the receiver should also be aware of other securities, such as structured securities, included in Schedule D that maintain significant risk. See the section on audit/investigation of financial statements in this chapter for a listing of risks inherent to certain investments. The receiver should determine whether such securities are consistent with the current investment strategy of the insolvent insurer and conclude whether the insolvent insurer should hold or sell the security and the timing of such action. Often, insurers use derivative instruments as a hedge to reduce exposure to other risks incurred by the insurer. With respect to hedge transactions, the receiver should consider whether the hedge transaction effectively reduces the insolvent insurer's exposure to losses arising from other aspects of the insurer's operations or investment portfolio. A common hedge used by insurers is an interest rate swap. The NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) describes an interest rate swap as "a contractual arrangement between two parties to exchange interest rate payments (usually fixed for variable) based on a specific amount of underlying assets or liabilities (known as the notional amount) for a specified period." Insurers have used swaps for various reasons, including matching returns on assets to contractual obligations. The AP&P Manual provides additional examples, for both life and P/C companies, of complex investment arrangements entered into by insurers. The receiver should consider engaging an investment/derivative expert to review the insurer's hedging program and make recommendations.

State insurance laws differentiate between real estate owned and occupied, and real estate owned for investment purposes. Some state laws require that real estate owned for investment purposes be income producing. If no income is generated within a set period of time, the property must be timely and properly

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disposed of (sold). Non-income-producing real estate should be investigated for possible alternative, non-investment objectives or accommodations. The receiver should review the pertinent statutes and consult with legal counsel regarding possible improprieties.

The insurer may own property in varied capacities. The insurer should have in its possession documentation for each property owned, including the deed (registered with county clerk), appraisal, survey, title policy, lease agreement (if rented), mortgage agreement (if any), schedule of future payments, hazard insurance policy, evidence of real estate tax payments, correspondence, related real estate management agreements, and other pertinent information.

The insurer may own a share of an investment property or may be part sponsor of a capital venture through a limited partnership, and it should have adequate documentation to support the investment. The documentation should include the partnership agreement, contracts with project managers, projections of cost and time to complete, projections of future income, expert evaluations and opinions, plans of operation and financing, description of any guarantees or financing commitments, and current status reports from project managers.

The insurer should have an individual file for each mortgage loan that contains the signed mortgage note, trust deed, recorded lien, appraisal report, amortization schedule, documentation of hazard insurance, and evidence of real estate tax payments. The insurer may have mortgage servicing agreements, and the receiver should obtain those servicing agreement documents.

Collateral loans are investments that are covered by other assets of the borrower. For each collateral loan, the insurer should have an instrument securitizing the insurer, a description of the borrower (possibly financial statements of the borrower), description and value of property pledged as collateral, and the repayment schedule.

C. Balancing and Reconciliation

The control list of investments that the receiver has developed can be reconciled to certified listings of brokers, custodians, and other depositories. The insurer should have in its investment files the supporting broker slips and bank advices for all investment transactions. A detailed statement of account activity can be obtained from brokers and custodians. The control list should also be reconciled to the general ledger and investment subledger. All discrepancies should be noted and resolved.

Investment transactions should be audited for possible unauthorized transfers. Reference is made to Chapter xxx on investigation and asset recovery in this Handbook.

D. Location of Investments

Usually, the bulk of an insurer's investments will be on deposit for safekeeping with a custodian (a financial institution) to facilitate the transfer of securities for purchases and sales. The safekeeping also minimizes and transfers the risk of theft or misplacement to the custodian. Securities in the custodian's possession may include bonds and publicly traded stocks, option and future contracts, and, on occasion, stocks of subsidiaries.

Many states require securities to be deposited with the insurance department or the state treasurer's office as a prerequisite for the insurer to write business in that state. Alien insurers may be required to place various assets in a trust for the protection of U.S. policyholders. Deposits may be held by non-U.S. jurisdictions. The receiver should notify all jurisdictions and, where possible, obtain the return of all deposits to avoid costly jurisdictional battles with creditors.

Investment brokers may also be holding securities that the insurer has purchased and not yet settled or that have been pledged as collateral for options.

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Other investments—such as real estate, mortgage loans, collateral loans, private placements, common shares of subsidiaries, etc.—may be held in an in-house safe or vault for safekeeping. The receiver should make a complete detailed list of documents in the in-house safe. If any items are marketable, the receiver should take appropriate steps for the safekeeping of the items. Since the receiver may not be able to ascertain who has access to keys or codes for such safes, consideration should be given to changing locks or setting up a new safe deposit box under sole control of the receiver.

The insurer may have rented a safe deposit box at a financial institution. An inventory of the box will be necessary and appropriate safeguards taken against access by others. The receiver should obtain the access log for the safe deposit boxes. If the boxes have been accessed just prior to the receivership order, the receiver should investigate the reasons for entry.

E. Valuation of Investments

The determination of value for securities that are publicly and actively traded should not be a problem because prices are published on a daily basis through various data feeds. The receiver should consider the published market value rather than the NAIC value in the evaluation of the liquidation value of assets. Often, a receiver is compelled to sell investments prior to maturity to generate cash flow. The NAIC value, which generally shows stocks and preferred stock at fair value while bonds are usually at amortized cost, will not necessarily reflect the amount the receiver will receive from the sale of investments.

The market value should approximate the amount of cash that may be generated from the sale of investments. The market valuation reflects an adjustment for current market rates as compared to the fixed interest rate on the investment and for the credit worthiness of the debtor.

Private placements will be the most difficult to value, and the opinion of outside experts may be necessary. The receiver may wish to employ an investment specialist to determine the values and liquidity of below-investment-grade private placements or non-publicly traded stocks. The financial statements of the borrower may be sought. A review of the financial statements may tell whether the company is in sound financial condition and whether it is able to repay the obligation. Prepayment at a discount may be an alternative for both parties.

Several values may be placed on real estate that is occupied by the insurer. The value may be the cost paid less depreciation, construction cost less depreciation, appraisal value, or market value. The receiver may consider the latest appraisal of the property and determine the possible market value. Economies may warrant the sale of the property and rental of other quarters.

Real estate that is held for investment ordinarily should be income-producing. A large negative cash flow may warrant disposal of the property. An appraisal may be necessary to assess the marketability, which will disclose the sale price of similar properties in the area. If comparable sales are not available to estimate market value, the receiver may consider using a discounted cash-flow approach to valuing the real estate. The receiver may wish to obtain outside professional support in determining proper values, methods of valuing, investments in real estate, mortgage loans, and real estate joint ventures or limited partnerships.

The book value of mortgage and collateral loans is usually the unpaid principal balance. The receiver may also assess the value of the property that has been pledged as collateral. Many states' insurance laws require that mortgage loans be first-lien mortgages. A second-lien mortgage is of greater risk and subordinate to the first-lien mortgage. Insurance laws require the amount of the mortgage, at inception, not to exceed a specified percentage of the appraised value of the property. The receiver should research compliance with the statutes. Possible accommodations given to affiliated parties should be investigated.

F. Other Considerations

The insurer may be the owner of various tangible and intangible assets that may not be apparent on its statutory balance sheet. The receiver should try to identify and value all possible assets of the insurer,

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including insurance licenses, the value of the shell of the company, assets that have been previously written off, and any assets that are listed in Schedule X of the annual statement.

1. Pension and Deferred Compensation Plans

The insurer's employee benefits may include participation in either a defined-benefit or defined-contribution pension plan. The plan may require or allow that a percentage of the assets of the plan be invested in shares of the insurer. It is not uncommon for the trustees of the plan to be officers of the insurer. Also, the plan administrator may be the insurer itself or an outside financial institution. The regulatory action will create several uncertainties in relation to the plan. The receiver should be familiar with the provisions of the plan and whether a complete liquidation and distribution is required. The provisions of the pension plan agreement and the Employee Retirement Income Security Act of 1974 (ERISA) may clarify some of these issues. It is recommended that the receiver retain the services of a consultant CPA firm to audit and provide independent opinion regarding compliance with IRS and ERISA requisites.

If the insurer is insolvent and the plan is heavily invested in shares of the insurer, then the plan may be insolvent also. The administrator, therefore, may need to liquidate the plan. If the pension plan is solvent, the administrator must continue with its duties. If the insurer is the plan administrator, the receiver may become the plan administrator by succession. If the plan administrator is a third party, the receiver may wish to evaluate the propriety of changing administrators.

The insurer may have hidden equity in other employee benefit plans. A saving plan that requires the insurer to partially match amounts contributed by the employees may be such a plan. The plan agreement will detail the operation of the plan and when the insurer's contributions vest to the employees. The plan should have provisions for possible employee termination on a voluntary or involuntary basis. Depending upon the terms of the plan, the receiver may recover contributions that have not vested to the employees, or the receiver may amend terms, for example, to eliminate employer matching of contributions.

Pension considerations may be further complicated if an employee benefit plan is established to cover the employees of a parent holding company and its many subsidiaries, of which the receiver has authority only for one or more insurer subsidiaries. The desire of the receiver to terminate the plan and attach excess assets (or reduce additional exposure to underfunding) may be mitigated by excise tax issues on termination, ERISA, and other considerations.

It should be noted that under some state liquidation priority statutes, amounts, and priorities due employees may be limited. Compensation and benefits due officers and directors may also be excluded in their entirety.

2. International Considerations

As insurers become part of a global economy, the receiver may be confronted with the issues of investments and other assets held in other countries. The receiver should try to gain control of the investments or assets and bring their value back to the estate. An ancillary receiver may be appointed by a foreign country, which may make that difficult, since the ancillary receiver may need the assets to settle claims in the ancillary jurisdiction. The ancillary receivers will need to cooperate with the domiciliary receiver. The value of the foreign assets will fluctuate with the exchange rate of the foreign currency, and the receiver should try to match in foreign denomination the assets and liabilities (claims) by the foreign country. This should indicate whether any excess assets are held in the foreign country. The receiver should ascertain if the company's Schedule DB contains derivative instruments covering foreign currency exchange risks. Because foreign countries may have currency restrictions for repatriation of assets, the receiver should consult with legal counsel.

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Special deposits and general deposits with insurance regulators in other jurisdictions in the U.S. and outside the U.S. may also present problems to the receiver. Many U.S. courts have ruled that the state of domicile has the duty to liquidate the insurer and, therefore, all deposits should be returned to the domiciliary receiver. In the case of a non-U.S. jurisdiction, the foreign receiver may claim the right to the deposits for purpose of distribution in his jurisdiction. In this situation, the receiver should consult legal counsel. The receiver should consider whether they can divest themself of the responsibility for foreign claims.

3. Structured Settlements

In the insolvency of an annuity insurer, special consideration should be given to any single premium immediate annuities that were issued to form the basis of funding periodic or lump sum payments in personal injury settlements, commonly known as “structured settlement annuities.”

These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS tax codes (primarily 104 (a)(2)) and various revenue rulings in order to preserve the tax benefit to the beneficiary or payee. However, some older annuities (prior to 1986), although not issued to a QA company, may nonetheless enjoy the same tax benefits. Generally, periodic payments are excludable from the recipient’s gross income only if the payee is not the legal or constructive owner of the annuity and does not have the current economic benefit of the sum required to purchase the periodic payments.

When these blocks of business are resolved in the insolvency context (typically through assumption reinsurance), extreme care must be taken to ensure that the resolution does not compromise the tax benefits to the payees. It is strongly recommended that competent and experienced tax counsel be retained to guide the receiver through this potentially complicated process.

X. RECEIVABLES

A. Uncollected Premiums

The amount of uncollected premiums may vary from company to company, but may be a significant asset.

1. Methods of Billing

The billing and recording of insurance premiums differ, depending upon the insurer (e.g., direct billing of policyholders versus billing of agents) and type of insurance (e.g., primary versus reinsurance). Following are four of the more common types of billing methods:

a. Direct Billing

Some insurers bill the policyholder directly for the full amount of the premium. A separate liability is established for any commissions allowed to brokers or producers.

b. Agency Billing

Insurers that use agency billing send monthly statements to their agents, listing premiums written during the month, including any adjustments and endorsements of previously issued policies. Commissions allowed to the agent are deducted on the statement to arrive at the net amount due to the insurer.

c. Account Current Billing

This method is used when the agent submits a statement to the insurer. The account current sets forth premiums written by the producer during the month, less the commissions. This method

requires the insurer to maintain a premium difference register to account for differences between the premiums reported by the agent and insurer's records. Differences are usually resolved by communicating with the agent. (Use of the agency billing method will transfer the premium difference reconciliation to the agent.)

d. Item Basis

The item basis of billing is generally used when each item is remitted when collected by the producer, as is the case when business is submitted by many independent brokers. The amount of the bill is usually net of the broker's commission.

2. Different Types of Premiums

a. Property/Casualty Insurance Premiums

Most property and liability policies provide for the payment of a single premium for the entire term of the policy (usually one year). Different types of property and liability premiums include:

- Installment premiums—Some insurers issue policies that are payable on an installment basis. Even though the premiums may be payable on an installment basis, the insurer must record the full annual premium when the policy is issued, except for those policies that are recorded or billed monthly because of changing exposures. Premiums that are due currently are billed using any of the foregoing methods. The billing of future installments is deferred until the due date of the installments.

- Retrospectively rated premiums—Retrospectively rated policies are used when the ultimate premium is based on the individual policyholder's claim experience. The ultimate claim experience may not be known until several years after the policy has expired. Usually a deposit (estimated) premium is billed using any one of the above methods when the policy is issued. However, the ultimate premium will be developed by applying the retrospective factor set forth in the policy to the policyholder's claim experience. The ultimate premium will not be less than the minimum nor more than the maximum premium set forth in the policy.

- Audit premiums—Some premiums are based on the amount of the policyholder's payroll or sales (reporting values). For these policies, the insurer will bill an estimated or deposit premium at the inception of the policy and, upon determining the reporting values, the final premium will be billed. Sometimes insurers send auditors to determine and/or verify the reported values. These premium adjustments are called audit premiums. The billing of the deposit and audit premiums may be done by using any combination of the aforementioned methods.

- An insurer should maintain an inventory of policies with adjustable premium features such as retrospectively rated premiums and audit premiums. Typically, retrospectively rated premiums are popular features of workers' compensation policies and reinsurance treaties. The receiver should be aware of adjustable features included in contracts of the insolvent insurer and ensure that all contracts with such provisions are summarized. In the preparation of financial statements, appropriate accruals should be recognized for these contractual features based on the related claim experience and premiums paid under the agreement as of the date of the financial statements. The receiver should further ensure that appropriate action is taken to collect monies owed the insolvent insurer under these contractual provisions and that proper recognition of liabilities arising from these contractual provisions is provided in the financial statements. If the accrual is significant, a receiver may consider performing a systematic review of the related accounting support,

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focusing the review on policies with premiums that are substantial to the overall population.

b. Life and Accident and Health Premiums

Unlike property and liability insurance policies, life and A&H insurance policies can be guaranteed renewable contracts and are generally accounted for as long-term contracts. Premium payment plans for life, annuities, and A&H insurance vary. Some polices may be payable monthly, as is frequently the case with group insurance. Others may be payable quarterly, semiannually, and/or annually. Some may be fully paid up when issued. For HMOs and health insurers, it is important for employer groups and government plans like Medicaid that premiums are reconciled monthly to enrollment tapes to ensure that additions and deletion of members are updated promptly.

c. Assumed Reinsurance Premiums

Assumed reinsurance premium billing, recording, and collection methods and procedures primarily depend on the reinsurance treaties, which specify the relationship between the parties.

- Facultative premiums—Facultative reinsurance may be billed and recorded using any combination of the methods described above for direct insurance. It is usually billed and recorded on a direct basis or account current basis.

- Treaty premiums—Premiums due on assumed treaty business are usually reported to the reinsurer either directly by the cedent or by the reinsurance intermediary.

3. Policy Control

An insurer normally prenumbers its policies when printed. A control procedure should be in place routinely to identify and follow up on skipped and missing policy numbers. The receiver should ascertain the insurer's policy control procedures and ensure that missing and skipped policy numbers are properly accounted for because a skipped or missing policy number may represent an unbilled, in-force policy. In the case of multiple offices and multiple agents with policy-issuing authority, there may be several sets of policy numbers.

4. Setoff Against Uncollected Premiums

State insolvency statutes may restrict setoffs that previously were allowed against uncollected premiums due the insurer when it was solvent. In many cases, no setoffs may be allowed, even if:

a. Agents were previously permitted to: (i) deduct commissions from premium remittances; and (ii) return premium owed to one policyholder from an amount owed to the insurer on another unrelated policy.

b. Cedents were permitted to: (i) set off ceding commissions and loss payments from premium remittances; and (ii) settle balances for a variety of assumed and ceded contracts on a net basis.

The propriety of recognizing setoffs should always be reviewed with the receiver's legal counsel.

5. Commission Recoverable on Cancellation of Policies In Force

Agents and brokers are usually prepaid their full commission when the premiums are collected, even though the premiums are earned over the life of the policy. They frequently deduct their commissions from their remittances to the insurer.

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Upon cancellation of the policies in force by the receiver, the policyholders are entitled to a return of the premiums applicable to the unexpired term of the policy (unearned premium). Such return may be fully or partially paid by a state guaranty fund. The policyholder may file a proof of claim with the receiver for any amounts not paid by the guaranty funds. In any event, the receiver should look to the agents and brokers for the return of prepaid commissions applicable to the refundable unearned premiums.

6. Summary

A variety of methods and procedures are used by insurers to bill, record, and collect premiums. A combination of methods may be used. Since uncollected premiums are usually a significant asset, it is important that the receiver become familiar with the insurer's premium billing and recording procedures in order to most effectively marshal these assets. If necessary, new systems and procedures may be required to collect these assets subsequent to liquidation.

Finally, the applicability of federal and state debt collection statutes should be considered by counsel. Receiverships may be entitled to governmental exemption from certain statutes.

B. Bills Receivable Taken for Premium

Insurers sometimes accept a promissory note from the policyholder for a portion of the premium due. The promissory note includes a payment schedule and is subject to interest on the unpaid balance. Some companies record the principal amount of the note, plus the total interest to scheduled maturity, as a receivable and set up a contra account for the unearned portion of the interest. Others record only the principal amount of the note as an asset and separately accrue the interest as it is earned. Statutory accounting treats bills receivable differently than agents' balances and notes receivable. (See *Statement of Statutory Accounting Principles (SSAP) No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers*.) The realizable value of these receivables should be ascertained.

C. Life Insurance Policy Loans

Policy loans usually are a significant asset to a life insurer that writes permanent plan life insurance. Unlike term insurance, permanent plan life policies build cash surrender values that may be borrowed by the policyholder either as a:

- Conventional loan where the policyholder makes an application to borrow all or part of the policy's available cash surrender value.
- Automatic premium loan (APL) where the policy provides, or the insured has elected in the application for insurance, that the policy shall not terminate (lapse) because of the nonpayment of premiums as long as there is adequate cash value to cover the unpaid premiums and any other amounts owed under the policy.

If the policyholder dies before the policy loan is repaid or the policy is surrendered, the proceeds payable by the insurer should be reduced by any outstanding policy loan.

D. Salvage and Subrogation (Property/Casualty and Health)

1. Salvage

Salvage is an amount received by an insurer from the sale of damaged property or recovered stolen property for which the insured was indemnified by the insurer. In the claim settlement process, the insurer will obtain title to the property and sell it for its remaining value. This asset needs to be addressed quickly because property often is stored, and storage fees are being incurred. Salvage on

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surety bonds (e.g., construction performance bonds) may be of considerable amount. Due to the intricacies of the surety line of business, consideration should be given to the hiring of external experts to manage the salvage of uncompleted projects.

2. Subrogation

Subrogation is the legal right of an insurer to recover from a third party who was wholly or partially responsible for a loss paid by the insurer under the terms of the policy. In the case of a property accident, where there is a dispute between the parties, an insurer will often pay its policyholder's claim and assume the policyholder's right to pursue the negligent third party.

3. Accounting Practices

Until 1992, under statutory accounting practices, an insurer was not allowed to recognize salvage and subrogation recoverables until they were collected. In 1992, the AP&P Manual began allowing accrual of salvage and subrogation recoverables. However, certain states may still disallow the asset. GAAP requires that an insurer recognize an asset or reduce its liability for unpaid claims for the amount of salvage recoverable on paid and unpaid claims. Therefore, an insurer should have records, systems, and procedures to identify and follow up salvage and subrogation recoverables on both paid and unpaid claims.

4. Summary

A receiver should ascertain how an insurer identifies and follows up on its salvage and subrogation recoverables. This becomes more difficult when claim files are turned over to a guaranty fund. Salvage and subrogation practices may vary among the guaranty funds. Salvage and subrogation collected by a receiver or guaranty funds may have to be held in trust for certain beneficiaries (e.g., where the policyholder's claim is subject to a deductible, or the loss is a reinsured loss and the reinsurer previously reimbursed the insurer for the full amount of the claim). The right to the salvage and subrogation proceeds should be discussed with legal counsel.

5. Salvage and Subrogation (Property/Casualty – Deductible Recoveries – Only)

   a. Deductible Recoveries

   Large-deductible recoveries are amounts received by an insurer from an insured covered under a policy having an endorsement providing that the insured is responsible to indemnify the insurer for losses and certain LAE incurred that are for amounts below the high deductible. The high-deductible definition varies, but it is often for deductibles up to $100,000. While these policies share some characteristics with retrospectively rated policies, the accounting treatment of recoveries under the two types of policies is different. If the policy form requires the reporting entity to fund all claims including those under the deductible limit, the reporting entity is subject to credit risk, not underwriting risk.

   b. Accounting Practices

   Under statutory accounting practices, reserves for claims arising under high-deductible plans are established net of the deductible. However, no reserve credit shall be permitted for any claim where any amount due from the insured has been determined to be uncollectible. Reimbursement of the deductible is accrued and recorded as a reduction of paid losses simultaneously with the recording of the paid loss by the reporting entity. Therefore, these amounts are not easily identified on the balance sheet. It is important that the receiver examine the records, systems, and procedures to identify and follow up large-deductible recoveries on both paid and unpaid claims. It is also important to understand the insurer's process for

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obtaining collateral to mitigate credit risk on high-deductible policies. The receiver should examine the scope of the large-deductible business written, as well as the collection and collateral procedures employed by the company. The High Deductible Disclosures, Note 31 in the Annual Statement Disclosure and the related guidance in *SSAP No. 65—Property and Casualty Contracts* should aid the state insurance regulator in this review.

E. Reinsurance

For additional information on reinsurance, see Chapter 7—Reinsurance.

1. Reinsurance Recoverables

For P/C insurers, reinsurance recoverables on unpaid losses are not reported in the cedent's financial statement as receivables, but they are accounted for as a reduction of its gross liabilities for unpaid losses and LAEs. Reinsurance recoverables on loss payments and LAEs are, however, recorded as an asset in an insurer's financial statement. However, GAAP reporting now requires reporting reinsurance recoverables on paid as well as unpaid losses as an asset (FASB No. 113). All insurers—both P/C and life—use a variety of internal accounting procedures to bill and record paid loss reinsurance recoverables. Unfortunately, financially troubled insurers do not always have adequate internal controls and procedures in place to properly quantify and identify their recoverables by individual reinsurer. Consequently, a substantial amount of record reconstruction may be necessary by the receiver's staff, not only to identify all present recoverables, but also to install appropriate systems and procedures to bill and monitor future paid recoverables.

2. Funds Held By or Deposited With Reinsured Companies

The reinsurance treaty between the reinsurer and its cedent may require the cedent to withhold a portion of the premiums owed to the reinsurer and/or the reinsurer to deposit funds with the cedent. The purpose of such an arrangement is to collateralize the reinsurer's obligations for unpaid losses owed to the cedent. Care should be taken by the receiver to ensure that proper credit is taken against invoices submitted by the cedent for any such deposits.

F. Health Care-Related Receivables

Insurers and HMOs may have receivables for provider claims overpayments, pharmacy rebates, provider risk sharing recoveries, capitation arrangements, and loans/advances to providers.

XI. ACCOUNTING AND FINANCIAL REPORTS TO THE RECEIVERSHIP COURT AND THE NAIC

Accounting and financial reports will be required by the receivership court at the date of the receivership and subsequently to monitor the progress and status of the receivership. To prepare these reports, the receiver will need to continue processing and recording transactions and producing related reports. The results of the accounting transactions described in the preceding sections of this chapter should be incorporated into the company's financial information and subsequently produced financial reports. Exhibit 3-1 is a representative summary of the format required to be input into the NAIC's GRID Global Receivership Information Database (GRID) system.

Additional information is often critical to the daily management of the receivership. Perhaps the most needed additional reports are: 1) daily cash reports (Exhibit 3-2); and 2) a budget to monitor costs (Exhibit 3-3).

A. Timing of Preparation

Within 180 days after the entry of an order of receivership by the receivership court, and at least quarterly or annually thereafter, the receiver shall comply with all requirements for receivership financial reporting

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as specified by existing state receivership laws. The financial reports should include: a statement of the assets and liabilities of the insurer; the changes in those assets and liabilities; and all funds received or disbursed by the receiver during that reporting period. (See Exhibit 3-1.) These reports are also to be filed with the receivership court. Receivers in those states without Model #555 may be required to file some or all of these reports with the receivership court. The receiver may qualify any financial report or provide notes to the financial statement for further explanation. The receivership court may order the receiver to provide such additional information as it deems appropriate. The reports should include claims and expenses submitted from each affected guaranty association.

For good cause shown, the receivership court may grant relief for an extension or modification of time to file the financial reports by the receiver.

In the early stages of a receivership, especially one involving an insurer with limited liquid assets, daily cash reports are critical to determine whether the insurer should be in conservation, rehabilitation, or liquidation. A budget is useful to manage the costs of the receivership and should be produced in the first year after the initial receivership court order.

B. Necessary Sources and Records

The following is a listing of information that may be used to prepare the financial reports:

1. Trial Balance and Detail Subledgers

The trial balance normally is produced on a monthly basis and details all assets and liabilities on a cumulative basis, plus income and expenses for the period. The line items on the trial balance can tie directly to the general ledger or can consist of a grouping of several general ledger accounts. The detail subledgers exist for accounts payable and contain more detailed information about an account, such as individual account information, vendor name, and due date of payment. The totals of these subledgers either tie directly to the general ledger account balances, or they are reconciled, and differences are identified. If the corporate structure consists of more than one company, then a consolidated trial balance should be produced that consolidates all individual companies.

2. General Ledger

The general ledger details the account information, showing the activity in an individual account during the period. Totals tie to the trial balance on an individual basis, and sometimes accounts and subaccounts are detailed and grouped into one line item that ties to the trial balance. The general ledger typically gives more detailed information on the transactions that were recorded during the period. An individual general ledger usually exists for each company/legal entity.

3. Bank Reconciliations

Bank reconciliations are useful in reporting on and projecting available cash for the operations of the receivership.

4. Investment Ledger

The investment ledger contains investment activity, investment income, types of securities, and realized and unrealized gains and losses. Totals should tie to the general ledger.

5. Accounts Receivable and Reinsurance Recoverable Aging

The accounts receivable and/or paid recoverable aging contain detail of accounts receivable and paid recoverable balances by account and ages the receivable based on number of days it has been

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outstanding. Reinsurance recoverable ledgers will also be kept here. Reinsurance recoverables will be included in the aging. The aging will be used in establishing allowances for uncollectible items.

6. Reserves

With respect to P/C insolvencies only, loss and LAE reserves (case, IBNR, and LAE reserves) tend to be the most significant amounts on the balance sheet, as well as the most subjective. If an outside actuary is used to evaluate the existing reserves and to project the ultimate losses, the resulting actuarial studies may be used when preparing the financial statements, and any adjustments should be reflected in the statements. With respect to life insurance insolvencies, there are substantial non-loss reserves for expected future benefit payments on various policies or contracts.

7. Paid Loss Information

Losses paid by the guaranty funds on behalf of the insurer should be recorded as liabilities in the insurer's records.

8. Cash Disbursements and Cash Receipts

A check register of all amounts paid during a given month, including payee and amount, should be maintained. Cash receipts are actual cash items received monthly and deposited into the estate's bank accounts.

9. Budget Versus Actual Report

A receivership budget for expenses and income by department should be established within 12 months of the date of receivership. On an ongoing basis, a report should be generated detailing budgeted versus actual expenditures for the reporting period. All significant variances should be investigated by the receiver.

C. Responsibility

The responsibility of preparing the financial and accounting reports can be assigned to the insurer's accounting and finance departments, the receiver's personnel CPA, or independent CPAs. The use of independent CPAs should be considered if the receiver questions whether the remaining insurer's personnel are capable of completing the report, or the receiver does not have sufficient staff.

A specific individual should be designated as the party responsible for the distribution of the reports to the receiver, attorneys, personnel, applicable state agencies, and other predetermined parties.

The filing of the completed reports with the courts should be assigned to the attorneys handling the receivership.

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I. INTRODUCTION

Insurance receivers generally have two principal duties: 1) marshalling assets; and 2) paying or otherwise disposing of claims. Typically, the marshalling of assets involves selling real and personal property, collecting reinsurance recoverables and/or commuting treaties, collecting earned premium, filing preference and fraudulent conveyance actions, and bringing lawsuits against former owners and management.

In any receivership, the receiver is responsible for maximizing and safekeeping the assets of the insolvent insurer. One of the receiver's early priorities is to examine the insurer's records to identify the insurer's assets, marshal them as necessary or appropriate, and then determine whether litigation should be pursued against any persons or entities liable for causing or contributing to the insurer's financial difficulty.

It is important for the receiver to keep in mind that the receiver's investigation and asset recovery activities may be subject to approval by the receivership court, with notice to guaranty associations and other interested parties. Furthermore, the receiver should take special care to review any applicable state or federal laws.

As a general rule, most state statutes require receivers to seek court approval before they may sell, assign, transfer, or abandon assets having an individual or aggregate value above a threshold dollar amount. Therefore, a receiver seeking to sell an asset or settle a claim of the type described below may need court approval before closing the transaction.

II. DISPOSITION OF ASSETS ALREADY IN THE ESTATE

A. Title to Assets—Legal Versus Equitable Title

The first issue to address before a receiver may dispose of an insurer's assets is whether the receiver is vested with title to those assets. The NAIC *Insurer Receivership Model Act* (#555), also known as IRMA, gives possession of all assets of the insurer to all receivers. Title to an asset may be legal or equitable or both. Legal title is ownership of the asset; equitable title is the right to the benefits or possession of the asset. Normally, both titles are held together, but in some cases, they can be divided. In a trust situation, the trustee is the legal owner of the asset, but the beneficiaries receive the benefits of the trust and so are the equitable owners of the asset. A receiver can only transfer the interest the insurer held. If an insurer had both legal and equitable title, the liquidator has the full power to dispose of the asset. If the title was bifurcated, the holders of the legal and equitable titles must join in the transfer in order to pass full ownership of the asset to the purchaser. Counsel should be consulted to assure that all equitable interests are identified prior to attempting to sell any assets.

B. Payment Terms

The principal reason for entering into a sale transaction is to generate income for the insolvent insurer, with a view to maximizing the distribution of assets to its policyholders and creditors. If creditor distributions will not occur until a later date, the receiver can entertain installment terms, possibly attracting purchasers or an increased purchase price not attainable in an immediate lump-sum sale.

C. Tax Consequences of a Disposition

All disposition of assets will result in tax implications, which will need to be reported on the company's tax returns. Appropriate professional advice should be sought.

D. Other Terms

Most assets are sold on an "as is" basis with limited representations and warranties to prevent the receiver from being exposed to liability for matters for which it has limited knowledge. If the buyer is unwilling to

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purchase the asset "as is," the receiver may consider giving limited representations and warranties, but only subject to the receiver's "knowledge" and restricted to facts concerning the asset to be sold that the receiver has learned during the conduct of the receivership proceedings.

An asset sale agreement may also contain provisions designed to maintain confidentiality of its terms. Confidentiality is particularly desirable if the receiver subsequently may enter into similar transactions with other third parties on more or less favorable terms. Venue over all disputes should remain in the receivership court. Finally, the breadth of release given by and to the receiver should be carefully considered in light of the transaction being documented and the receivership proceedings as a whole.

E. Supervising Court Approval

Court approval may be required prior to disposition of an asset.

F. Identification and Collection of Statutory/General and Special Deposits

The receiver should make every effort to identify and collect all estate assets held by other states or entities as statutory/general or special deposits. The receiver should have specific policies and procedures regarding the identification and collection of these assets. These should address:

- Location and current status/value of the deposit.
- Determination of creditors within state holding deposit.
- Discussion with the state insurance department holding the deposit about their intentions regarding:
    - Possible full ancillary receivership.
    - Holding the deposit due to open claims within their state.
    - Releasing the deposit to the receiver.
    - Releasing or assigning the deposit to the guaranty funds.
- Review and execution of release agreement.

G. Disposal of Assets

Once the receiver has identified and inventoried all assets, the focus should turn to the process of sale and disposal of assets. Assets should be sold at the most opportune time to recover their maximum value by approved sales and disposal methods that are transparent and avoid any appearance of a conflict of interest.

III. INVESTIGATION AND PURSUIT OF CLAIMS AGAINST THIRD PARTIES

A. Objectives of Investigation and Asset Recovery

The goal and the scope of the investigative examination should be tailored to fit the specific situation. In all cases, the examination is crucial to analyzing the insurer's financial difficulty. The examination also may reveal corrective actions that the receiver should implement for successful rehabilitation. In all cases, the thrust of the investigative examination is to disclose what went wrong, determine what corrective action is necessary, reconstruct critical data/programs to support asset collection, and identify those legally responsible for the demise of the insurer. In appropriate cases, life and health guaranty associations may be able to provide support and assistance in connection with asset recovery efforts. In life and health, joint and

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common interest agreements are commonly used by regulators, receivers, and guaranty associations to preserve protections for privileged communications and work products. Quite often property/casualty (P/C) guaranty funds enter into confidentiality agreements with receivers to exchange information and work towards preparing a company for liquidation if that is the ultimate outcome.

The receiver may retain the services of accountants or examiners who have expertise in determining whether the insurer's financial condition gives rise to any causes of action, as well as marshalling assets and quantifying liabilities. The job of such an examiner goes beyond the role of an auditor. Here, in addition to probing for the cause of the financial difficulty, the examiner must identify for the receiver all transactions or business dealings that may produce assets for the insurer's policyholders and creditors, either by avoidance or rescission of certain transactions or by other legal action. Some state insurance departments may have experts in-house whose services are available to the receiver; otherwise, the receiver should consider retaining appropriate outside consultants.

B. General Conduct of an Investigation or Post-Receivership Examination

The receiver and the examiners should make themselves aware of the state statutes governing insurer receiverships. These statutes frequently detail the elements of causes of action that the receiver and examiners should investigate. For example, certain transactions are deemed preferential and may be voidable. Other transactions may be classified as fraudulent and may be set aside as such. The receiver and the examiners should seek advice of legal counsel on such statutes and, in particular, the applicable statutes of limitation. Counsel also may be helpful by providing guidelines for examiners to follow in conducting the investigation. It is crucial that the receiver take the requisite legal action in timely fashion to avoid the bar of such statutes. (See Chapter 9—Legal Considerations.)

The investigative examination of an insurer can start with records maintained by the insurance department. These records may include: transcripts and exhibits from administrative proceedings against the insurer; holding company registration statements; market conduct reports rate filings; recent Form A filings; work papers related to the last statutory examination, including the report thereon; annual and quarterly financial statements; and correspondence files. The receiver should also procure a complete set of the audit work papers of the insurer's certified public accounting firm, including the firm's permanent and correspondence files, as well as a complete set of the work papers from the insurer's consulting actuaries. The receiver should also thoroughly review the minutes of meetings of the board(s) of directors and any board or executive committees of the insurer and its subsidiaries. If possible, the minutes of any related holding company should be reviewed.

These records may provide the receiver with specific areas of concentration for the investigative examination. The examination will be broad in scope with a special emphasis on large or unusual transactions. The insurer's files on any suspect transactions must be reviewed completely; the receiver may need to engage a forensic accountant to assist the receiver's counsel in this review.

Once the examination reveals potential causes of action to pursue, a cost-benefit analysis should be conducted. If the potential benefit does not warrant the anticipated cost of the legal action, administrative remedies may be available. In order to conduct such an analysis, the receiver needs a full understanding of the potential claims, including the legal requirements that must be met in order to prevail on them.

C. Reference to Special Issues Regarding Claims Involving: Federal Home Loan Bank, Life/Health, and Large Deductible

In Chapter 5, there is a section that discusses special issues regarding particular claims, namely: 1) claims of the Federal Home Loan Bank (FHLB); 2) life and health claims; and 3) claims under large-deductible programs. As large-deductible programs involve both policy claims and the collection of amounts due under those policies, both subjects are covered in that subchapter.

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IV. VOIDABLE PREFERENCES

The receiver of an insolvent insurer faced with the need to gather the assets of the insurer's estate should bear in mind that many state liquidation statutes authorize the receiver to retrieve 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 assets that the insurer transferred to a creditor to satisfy prior debts and resulted in the creditor receiving a greater percentage of its claims against the insurer than other creditors in the same class. The statutes in various states differ significantly in substance, scope, and form. Some states may not have voidable preference provisions in their insurance receivership statutes. However, provisions regarding voidable preferences may exist in a state's general laws, and there may be applicable case law on the subject. The receiver should consult the statutes and case law in the insurer's state of domicile to ascertain which voidable preference laws may be applicable and to learn the requirements of those statutes.

The concept and general elements of voidable preferences are discussed in detail in Chapter 9—Legal Considerations of this Handbook. In general, a voidable preference may be found if:

- There was a transfer of the insurer's property.
- The transfer was made during a statutorily specified time period.
- The transfer was made to satisfy an "antecedent debt."
- The transfer results in a "preference."

It may be necessary for the receiver to establish that there was intent to create a preference or that the creditor had reason to believe the insurer was insolvent in order for the transfer to be voidable. It may also be possible for the receiver to recover a voidable preference from persons other than the party to whom the insurer's property was transferred, such as "insiders" of the insurer who were involved in the preferential transaction and, in some cases, subsequent holders of the property. In some instances, however, the receiver's right to pursue such remedies may conflict with the rights of other creditors to pursue the same.

Preferences are dealt with in Section 604 of Model #555. This provision delineates the conditions under which a receiver can avoid a preference and attempt to recover the assets that were given to the antecedent creditor. The preference period under Model #555 is two years. Not all preferences can be avoided by the receiver. Subsection 604(B) provides that preferences can be avoided if:

- The insurer was insolvent at the time of the transfer.
- The transfer was made within 120 days before the filing of the petition commencing delinquency proceedings.
- The creditor receiving it or being benefited thereby had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent.
- The creditor receiving it was:
    - An officer or director of the insurer.
    - An employee, attorney, or other person who was, in fact, in a position to effect a level of control or influence over the actions of the insurer comparable to that of an officer or director, whether or not the person held that position.
    - An affiliate.

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Subsection 604(C) states which preferences may not be avoided even if they would otherwise be avoidable under Subsection 604(B). Basically, preferences may not be avoided if they were made in exchange for an item of value to the insurer, if they were made in the ordinary course of business in accordance with ordinary business terms, or if they were in the form of an appeal bond.

V. FRAUDULENT TRANSFERS

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 any of the following sources: 1) a specific state statute; 2) the Uniform Fraudulent Conveyance Act to the extent adopted in the particular state; and/or 3) the common law of fraud. Fraudulent transfers are covered by Section 605 of Model #555. The receiver should consult counsel to ascertain which theories are available to recover fraudulently transferred assets.

Like voidable preference statutes, rules against fraudulent transfers authorize the receiver to rescind certain transactions and bring previously transferred assets back into the insolvent insurer's estate. Fraudulent transfer laws vary from state to state, but most permit the receiver to avoid transfers for inadequate consideration or transfers aimed at obstructing or defrauding other creditors.

Receivers may be able to recover fraudulent transfers from the person who received the transfer, "insiders" at the insurer who were involved in the transfer, and, in some cases, subsequent holders of the property transferred. Certain additional requirements may be applicable, and special rules may apply to certain reinsurance transactions, such as commutations. See Chapter 9—Legal Considerations for further details.

VI. OTHER SIGNIFICANT TRANSACTIONS

In addition to considering fraudulent transfer laws and voidable preference statutes, a receiver reviewing the reasons for an insurer's financial problems and attempting to marshal its assets should determine whether there have been any suspect transactions. Suspect transactions are unusual transactions that would not normally occur in the ordinary course of business. Some of these transactions may at first glance appear to be ordinary, but upon closer examination, they are found to have not been entered into for the benefit of the insurer. These are transactions that may have deceptively portrayed the insurer's financial condition, delayed discovery of its insolvency, or resulted in actual losses for the insurer. Included in the category of suspect transactions are transactions that did not comply with applicable legal requirements, were not commercially sound, or lacked financial viability.

A receiver may advance various theories to recover funds for the estate regarding losses or damages caused by suspect transactions. For example, causes of action for recovery may be based upon common law fraud, violations of the federal Racketeer Influenced Corrupt Organizations Act (RICO), fraudulent transfers, or breach of fiduciary duty. These and other causes of action are addressed fully in other sections of this Handbook and are not repeated here.

This section focuses on identifying potentially suspect transactions that are not discussed elsewhere in this Handbook. The transactions identified do not frame an exhaustive list of all suspect transactions, nor are the identified transactions necessarily fraudulent. In fact, if properly negotiated and administered, the transactions may be perfectly legitimate. However, the receiver should review the following types of transactions for due diligence. Suspect transactions may be difficult to detect and may consist of combinations or variations of one or more of the transactions described.

A. Reinsurance

Reinsurance balances often represent significant assets and liabilities of insolvent companies, whether from assumed or ceded business. It is commonly the case in a P/C insurer insolvency that these balances will represent the largest asset to be marshaled. Because reinsurance transactions are complex and involve large sums that may have a material effect on the balance sheet, these transactions present numerous opportunities

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for fraud, misappropriation, or mismanagement by or upon the insolvent company. The receiver's investigation should, therefore, include a review of the company's reinsurance structure, and especially any extraordinary transactions in the years immediately preceding the company's demise.

General Considerations

Delegation of the collection of reinsurance recoverables, without proper accounting and management controls, to managing general agents (MGAs) and other third parties has been a common source of large accruing balances. Therefore, the more common asset recovery activity in this area is in record construction and documentation of the accrual of balances due (see Chapter 7—Reinsurance). Aside from the instances covered below, the larger amount of the receiver's reinsurance recovery work usually should focus on the concepts that: 1) reinsurers respond and pay based on a proper accounting and documentation of the balances due; and 2) because of the frequent mismanagement of these transactions by insurers that have become insolvent, reinsurers are skeptical of information from an insolvent insurer. The receiver must dispel this skepticism.

It is often necessary to conduct a full review or reconstruct reinsurance transactions accruing pre-receivership, as well as documenting post-receivership reinsurance balances. Post-receivership balances include reinsurance balances resulting from claims covered by the guaranty funds and adjudication of non-fund covered claims. See Chapter 2—Information Systems (especially the Uniform Data Standards [UDS] section), Chapter 5—Claims, and Chapter 6—Guaranty Funds for more on the relationship between post-insolvency accruing liability and reinsurance recoverable balances.

In the context of life and health company insolvencies, state laws generally provide the life and health insurance guaranty associations the right to elect to continue reinsurance and to succeed to the rights and obligations of the insolvent ceding insurer with respect to contracts and policies covered, in whole or in part, by the guaranty association. The election must be made within 180 days of the liquidation date and is subject to certain statutory requirements. This right to continue reinsurance is reflected in the Section 8(N) of the NAIC's *Life and Health Insurance Guaranty Association Model Act* (#520), which has been adopted in most states.

Footnote suggestion: Section 612 of Model #555 similarly reflects the rights of life and health guaranty associations to elect continue reinsurance and to succeed to the rights and obligations of the insolvent insurer under reinsurance agreements, subject to the requirements of state receivership and guaranty association laws.

Secured Reinsurance Balances

Reinsurance balances frequently will be secured to ensure collectability and preserve the insurer's statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. The security often includes letters of credit (LOCs) and trust accounts. Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations.

It may be necessary to establish procedures to monitor the security during the receivership. Some LOCs will require renewal, while others will have an "evergreen clause" providing for automatic renewal. Also, some security arrangements may require that the amounts held be increased by the reinsurer. Pre-receivership transactions regarding these security arrangements should be reviewed to ensure compliance with the related reinsurance agreements, security agreements, and statutes.

Commutations

A commutation is a mutual release of all obligations between the parties for consideration. Commutations terminate the rights and liabilities between parties, including premiums due, paid losses,

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outstanding losses and incurred but not reported (IBNR) losses, loss adjustment expenses (LAE) where applicable, and present or projected profit. There are many valid reasons for commutations. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between insurers and reinsurers, and provide some protection or limitation of exposure from the insolvency of the reinsurer.

Commutations, however, may also give rise to abuse. A commutation may unfairly benefit the reinsurer by relieving the reinsurer of considerable exposure for less than fair consideration. Further, in a rehabilitation proceeding, if the cash payment received from a commutation is less than the loss reserves that must then be recognized by the insurer, then the surplus of the insurer will be reduced.

Statutory accounting principles allow an insurer's reserves to be reduced by authorized reinsurance. If an insurer's net reserves have been carried at nominal value due to a substantial credit for reinsurance recoverable, the elimination of the reinsurance setoff credit as a result of a commutation could have had an adverse impact on the insurer. For example, a related reduction in surplus could have an adverse impact on the insurer's solvency ratios and could exacerbate capacity problems. Under such circumstances, a receiver should carefully review the commutation to determine whether the benefit to the insurer outweighed the disadvantages.

In measuring the surplus impact of a commutation and comparing the assets and liabilities assumed, it should be kept in mind that the assets received are usually easily quantifiable, whereas the reserves are not. Thus, what may appear to be a break-even transaction on the surface may, in fact, result in a large loss to one party because of the way the reserves were determined. It usually is helpful to know if a qualified actuary has reviewed the assumed block of reserves, supplementing case reserve estimates with projections of IBNR development, related LAEs, and use of industry data where necessary. Also, because of the inability of insurers to discount their reserves for statutory purposes, a commutation may appear on the surface to produce a loss to the insurer. The long-term economics of the transaction, however, may be sound when consideration is given to the future investment income to be earned from the commutation process. The receiver should also assess the potential adverse consequences of any commutation. In sum, commutations should be reviewed to determine if they were negotiated at arm's length and were fair and reasonable to the insurer; the receiver may need to engage an independent actuary to assist in this review.

Section 605 of Model #555 addresses the avoidance of reinsurance transactions incurred on or within two years before the date of the initial filing of a petition commencing delinquency proceedings under certain conditions. Section612 of Model #555 relates to the continuation of life, disability income, and long-term care (LTC) reinsurance in liquidation and the right of the guaranty association (GA) to elect within 180 days of the liquation to continue that reinsurance subject to the requirements of Section 612 of Model #555. Some states' voidable preference and fraudulent transfer statutes include specific sections dealing with commutations that occur within a short period before the filing of a petition for the appointment of a receiver. The receiver should be aware of these special rules, which may allow the rescission of a commutation for the benefit of the insurer and its creditors.

Stop-Loss Treaties

A stop-loss treaty, or aggregate excess reinsurance contract, indemnifies an insurer if in any year the losses on retained accounts exceed a specified amount. The determination of whether the specified amount has been exceeded is usually made after the application of all other reinsurance and the benefits or recoveries under surplus, quota share, and catastrophic excess of loss treaties. The premium for a stop-loss treaty can be based on a fixed dollar amount, or it may be a ratio of annual retained premium (calculated by reducing gross premium income by premiums for other reinsurance, such as surplus treaties, quota share treaties, and catastrophic excess of loss contracts). The purpose of a stop-loss treaty is to protect against an aggregation of losses during a particular period of time.

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Stop-loss treaties are also subject to abuse and, consequently, should be carefully evaluated. The amount of loss protected against may be unreasonable in light of the loss experience of the insurer. As a result, there may have been an improper motive in paying a premium for a stop-loss treaty for which the insurer was not likely to receive any real benefit. The premium may have been excessive when compared to similar coverage generally available.

Unauthorized Reinsurance

Unauthorized reinsurance is reinsurance placed with non-admitted or unauthorized reinsurers that are not authorized to transact insurance business in the cedent's domiciliary state. Under statutory accounting principles, an insurer's liability for loss reserves is carried net of reinsurance. Generally, unauthorized reinsurance may not be used to reduce loss reserves unless the reinsurer's liability is secured by trust funds, funds held by the cedent, or LOCs. Care should be taken to ensure that these potential estate assets are identified and secured.

Unauthorized reinsurance may be appropriate when placed with a financially sound reinsurer. The placement of reinsurance with unauthorized reinsurers, however, is subject to abuse. For example, it may be a means of diverting funds to an affiliate. The placement of reinsurance with financially weak non-admitted reinsurers may indicate an improper motive for obtaining such reinsurance.

Portfolio Transfers/Loss Assumption Reinsurance

Generally, a portfolio is one of the following: 1) an entire book of business; 2) a book of business in force at a certain time; or 3) outstanding losses unpaid at a certain time. Typically, in a portfolio transfer, the reinsurer assumes the reinsureds' obligations to pay losses on the assumed portfolio in return for the payment of a premium and the transfer of related loss reserves and security, as applicable.

Portfolio transfers should be reviewed to ensure that the transfer was entered into for legitimate business reasons and inured to the insolvent insurer's benefit. The receiver should consider whether the business transferred was an integral part of the insolvent insurer's business. Did it represent a highly profitable segment of the business, or was it marginal or even a contributor to operating losses? What were the long-term prospects for the portfolio transferred? How did it fit with the balance of the business retained by the insurer? Did the transfer effect a novation of the underlying insurance policies or reinsurance contracts? Did the transferor's policyholders or reinsureds consent to the novation? Answers to these questions should indicate whether a particular portfolio transfer might be a suspect transaction.

Transfers of a profitable portfolio could temporarily prolong the insurer's life while undermining the long-term financial viability. Transfers between affiliated parties should be carefully reviewed. Because certain bulk transfers require insurance regulatory approval, it should be determined if there was compliance with applicable requirements.

Surplus Relief Treaties

Comparing premium income to surplus is a common test of whether an insurer is taking on too much risk. Typically, the desired ratio is 3:1. In other words, annual premium income greater than three times surplus may be a warning signal that the insurer is assuming too much risk. Regardless of the test applied, if an insurer reaches the maximum amount of premium income supportable by its surplus, it either must cease writing new business or shed some of its premium income or liability to maintain its financial health.

One method of reducing premium income is to enter into a reinsurance treaty whereby the insurer cedes premium in exchange for a *pro rata* reduction in its liabilities. This practice allows the insurer to continue to write business. A surplus relief treaty is generally considered to be proper if the liabilities ceded are not set off by commission paid to the reinsurer and if the reinsurer does not protect itself against an adverse loss experience by having the insurer ultimately pay the liabilities. In other words,

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if the insurer has ceded the premium for the business and has transferred the underlying liabilities, the treaty likely will not be a suspect transaction. (See Chapter 9—Legal Considerations.)

If scrutiny of the surplus relief treaty reveals that the insurer superficially ceded premium and the business but in reality provided a stop-loss to the reinsurer or otherwise protected the reinsurer from liabilities, then the transaction may have been improper. It may be difficult to trace such a transaction because it can be accomplished in separate documents. This type of arrangement would give a false picture of the insurer's solvency, as it would mask its true premium-to-surplus ratio by understating premium and, at the same time, not relieve the cedent of the risk of loss associated with the underlying business.

Finite Reinsurance

Another way that an insurer occasionally attempts to improve its balance sheet is by entering into financial reinsurance transactions. There are many forms of these, but the potential concern behind these types of transactions is to examine whether they were performed simply to shift liabilities off the books of the insurer onto the books of the reinsurer without any real transfer of risk for those liabilities. Any reinsurance contracts that do not appear to have effectuated a real transfer of risk of loss to a reinsurer should be examined closely by the receiver. These contracts may not only be voidable, but there may be additional recourse against the reinsurer for participating in the financial reinsurance transactions. (See Chapter 7—Reinsurance and Chapter 9—Legal Considerations.)

Affiliated Reinsurance

In some cases, the insurer cedes its risks to an affiliated reinsurer. The reinsurer then dividends funds to common ownership. There are also affiliated pooling transactions that may be used to inappropriately transfer funds among the pool participants.

B. Large-Deductible Policies

NAIC has adopted the *Guideline for Administration of Large Deductible Policies in Receivership* (#1980) in 2021. The Guideline or similar policy has been adopted in several states. Large-deductible recoveries can represent a significant source of recoveries for insolvent companies, especially those P/C companies that wrote workers' compensation insurance. These recoverables may be a significant amount, and the receiver should examine the scope of the large-deductible business written and the collection and collateral procedures employed by the company.

1. General Considerations

   a. The receiver's recovery of large-deductible recoverables is dependent on the claims handling and reporting of both claims covered and those not covered by guaranty funds.
   b. The key to effective collection and collateral administration is ensuring that the historical records for paid losses under the deductible policies and the program design are maintained and available. Another key is retaining the personnel that have knowledge and history of the insurer's deductible business operations.
   c. Collateral for Large-Deductible Balances.
      - The importance of collateral cannot be overstated; adequate collateral must be established prior to liquidation and maintained throughout the receivership.
      - Large-deductible balances frequently will be secured to ensure collectability and preserve the insurer's statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. Particular attention should be paid to security arrangements where the insured's collateral is held by third parties, especially affiliates of the insurer.

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- Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations.

2. Communication

Deductible collection, in addition to requiring collateral, is dependent on communication of all parties (i.e., between receiver and insured, receiver and guaranty association, and guaranty association and insured). It must be quickly established with insureds as to the procedure for ongoing claim processing, continuation of their responsibility to reimburse the deductible payments, and responsibility to maintain appropriate collateral. Guaranty associations must also recognize that they will be required at times to communicate with insureds regarding claims handling. All parties should be mindful of security concerns related to communication of sensitive claims data. The Secure Uniform Data Standards (SUDS) server hosted by the National Conference of Insurance Guaranty Funds (NCIGF) is a useful tool for communication between receivers and guaranty associations. The collection process should proceed with minimal delay as the passage of time will affect the success of collection efforts. In these efforts, it is imperative that the guaranty associations and the receiver work together and offer consistent messages to the insured regarding any collection issues. It should also be noted that the release of collateral from a receiver to a guaranty association may not fully satisfy the policyholder's obligation for costs related to the claim under a state's guaranty association law.

3. Deductible Collection Procedure

   a. A working process must also be established quickly between the receiver and the guaranty associations to provide claim handling, payment information, and all other required claim financials to allow the receiver to bill and collect loss payments.
   b. The information would include the receiver providing the guaranty associations all pertinent information to establish the policies that are deductibles along with effective dates, deductible limits, treatment of allocated loss adjustment expense (ALAE), and deductible aggregates where available.
   c. Copies of deductible policies should be made available if required.
   d. Guaranty associations will provide, through the establishment of a UDS data feed, all financial information regarding deductible claims that they are handling.
   e. The receiver will collate data from guaranty associations and review historical billing information to invoice the insureds on a monthly or quarterly basis.
   f. The receiver will calculate and track the payment history pre-liquidation and post-liquidation within the deductible and within a deductible aggregate for the policy if applicable. This ensures that the insured is only billed for amounts that remain within its deductible.
   g. To assist in the collection process, the receiver and the guaranty association should work to provide sufficient information and explanation to allow the insured to recognize its obligation. In the event where the insured refuses to pay, the receiver will either begin litigation or draw on collateral—or both. This should be coordinated with the guaranty associations.

4. Professional Employer Organizations

   a. Policies issued to professional employer organizations (PEOs) often have large-deductible endorsements.
   b. Because of the prevalence of abuse in the underwriting of PEOs, post-liquidation collection of deductible payments may be challenging.
   c. Clients may have been added without notice (or payment) to the insurer. Client class of business may have been misrepresented or expanded to include riskier classes of business—all of which may lead to inadequate or exhausted collateral.
   d. Client companies of PEOs may not have received notice of cancellation, leading to coverage disputes. If collateral is inadequate and the PEO does not have assets to pay the deductible

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reimbursement in full, the policy terms might make the client companies liable for the shortfall, either for their own exposure or on a joint-and-several basis. However, this might not be a meaningful source of recovery because it could be impractical, inappropriate, or impossible to collect significant amounts from the clients.

5. Commutations

   a. Generally, commutations are negotiated terminations of the rights and liabilities between insurers and large-deductible insureds. A commutation is a settlement of all obligations, both current and future, between the parties for a lump sum payment.
   b. There are many valid reasons for the commutation of large deductibles. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between the insurer and the insured, and provide some protection or limitation of exposure from the insolvency of the insured. Commutation of long-tail business (i.e., workers' compensation) may be essential for the early termination of the receivership.
   c. Commutations, however, may be a detriment to the receivership if the commutation is consummated for less than fair consideration. A receiver should carefully review the commutation to determine whether the benefit to the insurer outweighs the disadvantages.

C. Inappropriate Investments

Inappropriate investments may have the effect of overstating the insurer's assets on its annual statements and, at the same time, result in an actual loss if the investments are poor. In some instances, earnings from investments are less than they should have been. Investments may be inappropriate for four general reasons: 1) the investments are prohibited and not allowed as admitted assets by insurance laws or regulations; 2) while allowed as admitted assets, the investments are too speculative at the time of investment, given their materiality to the insurer's financial condition; 3) the investments did not meet the insurer's need for liquidity; or 4) the assets do not match the corresponding policy liabilities.

While some states' insurance codes prohibit the acquisition of certain assets, many view such acquisitions as non-admitted assets. However, regulators retain the right to order disposal of assets acquired in violation of law. A receiver should determine whether such acquisitions have occurred and whether the assets still are held by the insurer. If so, the receiver must identify the losses that have occurred on previously acquired assets and losses likely to occur on assets currently held by the insurer. Additionally, a separate inquiry should be made to determine whether the insurer was damaged. If such investments were booked as admitted assets, the result may be an inaccurate financial statement.

It is difficult to evaluate the culpability for making investments in admitted assets that are highly speculative or illiquid. While code provisions require all investments to be sound, an analysis of what are sound investments involves the application of the business judgment rule. This rule protects management, who made informed decisions in good faith without self-dealing, from being judged in hindsight. Insurance codes have prohibitions and limitations on the types and amounts of investments both on an individual and aggregate basis. Insurance codes generally enumerate the types of assets permitted, but that is beyond the scope of this discussion. In general, an insurer first must invest its minimum paid-in capital and surplus in certain defined investments, which generally are thought to be safer than other types of investments. Generally, these types of investments are government obligations. Once the insurer has invested its minimum paid-in capital and surplus in these allowed investments, there are other limitations on investment of an insurer's assets (excess funds investments). The codes are quite detailed with numerous descriptions and limitations, including limitations on the amounts that may be invested in real estate (if any), affiliates, and common stock, as well as the relative percentages of certain investments. (Although affiliates are generally admissible, such assets are usually illiquid if not publicly traded. If they make up a significant portion of surplus, then an investigation should be made into their acquisition and value.) Other

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inappropriate investments may include those that, although admitted, are either high-risk, or are not matched properly to the insurer's cash flow needs.

Investments that violate the applicable insurance code or regulations will not qualify as admitted assets on the annual statement. If such investments have been identified, the receiver should determine:

- When the investment occurred.
- Who authorized the investment.
- For what purposes the investment was made.
- The details of the transaction, including cost.
- Whether corporate formalities were followed.
- The broker and other persons involved.
- Whether the investment is with a related party.

It also is important to review how the questionable investments were reflected on the insurer's annual statement. The booking of non-admissible assets as admitted assets may identify a problem affecting the true financial condition of the insurer and may necessitate further investigation of corporate officers and directors. If the investments have already been disposed of, it is important to determine whether this resulted in a gain or loss. If disposed of at a reasonable gain, then a judgment must be made as to whether it is worth proceeding further with the analysis. If losses were incurred or will be incurred, there may be substantial questions of legal responsibility.

A review of recent transactions should reveal realized losses, and an evaluation of investments still held should reveal where unrealized losses exist. In the event that realized or unrealized losses are identified, a case-by-case evaluation should be made as to whether there is any culpability surrounding the acquisition or disposition of these types of investments. Once again, all the details surrounding the acquisitions should be thoroughly reviewed, particularly focusing on any close or suspicious relationships between the insurer's management, officers or directors and the management, officers or directors of the acquired investment, or with any brokers or agents involved in the sales transaction.

To identify investments that violate insurance laws and, consequently, are not admitted assets, a receiver should begin with a review of examination reports and work papers. Examiners tend to be thorough with respect to identifying assets or investments that are not admitted assets. If no examination report has been prepared, accountants or auditors should review the most current annual statements and supporting schedules to identify and list all investments that are not admitted assets. The following exhibits and schedules should be reviewed:

- Exhibit of Net Investment Income.
- Exhibit of Capital Gains (Losses).
- Exhibit of Non-Admitted Assets.
- Schedule A – Real Estate.
- Schedule B – Mortgage Loans.
- Schedule BA – Long-Term Invested Assets.

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- Schedule D – Bonds and Stocks (including valuations of subsidiary, controlled and affiliated companies).
- Schedule DA – Short-Term Investments.
- Schedule DB – Derivatives.
- Schedule E – Cash, Cash Equivalents, and Special Deposits.

General Interrogatories (which could contain information concerning cryptocurrency and other assets). Other sources include internal and external audits, U.S. Securities and Exchange Commission (SEC) periodic reports (such as annual and quarterly reports on Forms 10-K and 10-Q), and investment committee minutes.

D. Dividends and Intercompany Transactions

State insurance codes have strict limitations on how much money can be paid out as dividends from insurance companies. Some insurance codes provide for the recovery of dividends paid within a certain time period prior to the insurer's insolvency. Accordingly, all dividends should be reviewed to determine compliance with these statutory limitations. The receiver also should determine whether the financial statements were manipulated to make otherwise impermissible dividends possible. Regulators who had responsibility for reviewing the dividends may be contacted to determine what representations were made by company personnel when the dividends were approved.

As part of this process, intercompany transactions should be reviewed to look for disguised dividends. Many companies will have been part of a holding company structure. Oftentimes, a company will have entered into cost-sharing agreements, tax-sharing agreements, investment management agreements, marketing agreements, and other such transactions with affiliates. These transactions should be reviewed closely. When a company is precluded from paying dividends, it may try to disguise what, in fact, are dividends under transactions pursuant to these agreements.

Illegal dividends may be recovered in fraud actions or breach-of-fiduciary-duty actions. The failure of the company's outside accountants or auditors to detect illegal dividends also may form the basis of an action in negligence against the accountants and/or auditors.

E. Management by Others

Another area of suspect transactions is the management of insurers by other entities, including MGAs or third-party administrators (TPAs) acting pursuant to management contracts, as well as corporate or individual attorneys-in-fact. A close examination of the overall relationship, including all contracts, should be made since there is a potential for abuse of these relationships. In some instances, the management contract may be arranged so that, in essence, the insurer fronts for the MGA or the attorney-in-fact, who retains all the profits, and the insurer retains all the liabilities. It may raise a difficult question as to whether there was proper compensation for services or if the MGA or attorney-in-fact misappropriated corporate opportunities. Another abusive practice is causing the insurer to pay the MGA, TPA, or attorney-in-fact for services that it did not provide but were provided by the insurer's employees at the insurer's expense. This, in effect, results in double payment. Detection requires a thorough review of the contracts and an analysis of which entity pays for which function, which may be especially difficult when the operations are all in one facility.

VII. RECEIVERSHIP INVOLVING QUALIFIED FINANCIAL CONTRACTS

Section 711—Qualified Financial Contracts (or Similar Provision) of Model #555 addresses termination of stays , transfers of netting agreements, or qualified financial contracts (QFCs).

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When financial markets are uncertain, it causes heightened scrutiny in the capital markets and among financial institutions about identifying, managing, and limiting risk, as well as the need for adequate capitalization and for understanding the interdependency of the different financial sectors. One source of risk to financial market participants that rises due to the lack of certainty in the financial markets is the treatment of QFCs and netting agreements in the event of the insolvency of state regulated insurers.

A. Definition of Qualified Financial Contract

Model #555 defines a QFC as "any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the commissioner determines by regulation, resolution or order, to be a qualified financial contract for purposes of this Act."

- Commodity contract is defined by reference to the Commodity Exchange Act (7 U.S.C. § 1) (Commodity Act) and is a contract for the purchase or sale of a commodity for future delivery on or subject to the rules of a board of trade or contract market subject to the Commodity Act; an agreement that is subject to regulation under Section 19 of the Commodity Act commonly known as a margin account, margin contract, leverage account, or leverage contract; an agreement or transaction subject to regulation under Section 4(b) of the Commodity Act that is commonly known as a commodity option; any combination of these agreements or transactions; and any option to enter into these agreements or transactions.

- Forward contract, repurchase agreement, securities contract, and swap agreement shall have the meanings set forth in the Federal Deposit Insurance Act (FDIA), 12 U.S.C. § 1281(e)(8)(D), as amended from time to time.

It should be noted that an insurance contract is not a derivative or a QFC because an insurance contract includes the indemnification against loss. Therefore, reinsurance agreements would not be considered a swap agreement.

B. Insolvency Treatment of Qualified Financial Contracts Under the *Insurer Receivership Model Act*, Section 711 Provision[1]

Model #555, Section 711 provides a safe harbor for QFC counterparties of a domestic insurer. The provision largely tracks similar provisions in the Federal Bankruptcy Code and the FDIA, as well as laws of other

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[11] Except where the state has adopted *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (*#1556).

Guideline #1556 Drafting Note: State receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration, or close-out obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition, or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The FDIA also provides for a 24-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC. 12 U.S.C. § 1821(e)(9)-(12). States that permit the termination and netting of QFCs may want to consider adopting a similar stay provision following the appointment of a receiver for certain insurers—generally larger entities that may be significant in size but outside of being subject to a potential federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) receivership.

States that consider the enactment of a stay should take into account the relevant federal rules. In 2017, the Board of Governors of the Federal Reserve System (Federal Reserve), the Federal Deposit Insurance Corporation (FDIC), and the Office of the Comptroller of the Currency (OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB). The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a "stay" under several defined resolution regimes, including Title II of the federal Dodd-

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foreign jurisdictions. These safe harbor provisions for QFCs were adopted to avoid disruptions resulting from judicial intervention that can cause unintended chain reactions and significant systemic impact. Section 711 applies in both rehabilitation and liquidation proceedings.

Section 711 states that a right to terminate, liquidate, or accelerate a closeout under a netting agreement or a QFC with an insurer either due to the insolvency, financial condition, or default of the insurer or the commencement of a formal delinquency proceeding is not prevented by any other provision of Model #555. Section 711 allows a counterparty to net different contracts and realize on collateral without a stay.

Section 711 addresses transfer of a netting agreement or QFC of an insurer to another party. In a transfer, the receiver has to transfer all of the netting agreement or QFC and all of the property and credit enhancements securing claims under the agreement or QFC. This prevents "cherry-picking" and requires the transfer of everything; i.e., all of both the "in-the-money" and "out-of-the-money" positions.

C. Considerations of Qualified Financial Contracts Held by an Insurer Receivership

- Although the *Investments of Insurers Model Act (Defined Limits Version)* (#280) does not include limits on the amount of collateral an insurer is allowed to post, some states have restrictions on derivatives use, including quantitative limits, and limits on the pledging of collateral, based on type and credit quality. The receiver may also need to determine if a derivative use plan, if required, is in effect and if it dictates any collateral requirements.

- If the ability to net exists and there is no stay requirement, it is important that the regulator understand the QFC portfolio before the insurer's failure, either through a recent or ongoing financial examination or through an assessment made during regulatory supervision that precedes a receivership order, while recognizing that the market value of the derivatives positions can vary substantially over relatively short periods of time. The receiver also needs to have a good understanding of the relationship of the QFC contracts to the rest of the insurer's balance sheet. Because most derivatives transactions are used for hedging purposes, if those contracts are terminated as a result of netting, the assets and liabilities will no longer be hedged. It is important

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Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) and the Federal Deposit Insurance Act (FDIA), as well as comparable foreign resolution regimes. Notwithstanding the NAIC's request for inclusion, stays under the state insurance receivership regime (state receivership stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize state receivership stays, if a state implements a stay as contemplated by the Guideline, insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for qualified financial contracts (QFCs). Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, the FDIC, and the OCC have been amended to recognize state receivership stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize state receivership stays.

References: *Restrictions on Qualified Financial Contracts of Systemically Important U.S. Banking Organizations and the U.S. Operations of Systemically Important Foreign Banking Organizations*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 42882 (13 November 2017), available at https://www.federalregister.gov/d/2017-19053; *Restrictions on Qualified Financial Contracts of Certain FDIC Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 50228 (30 October 2017), available at https://www.federalregister.gov/d/2017-21951; *Restrictions on Qualified Financial Contracts of Certain FDIC-Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definition, 82 FR 61443 (28 December 2017), available at https://www.federalregister.gov/d/2017-27971; and *Mandatory Contractual Stay Requirements for Qualified Financial Contracts*, 82 FR 56630 (29 November 2017), available at https://www.federalregister.gov/d/2017-25529.

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to quantify the effect of the loss of the contracts if possible. The receiver may wish to engage outside resources to assist in evaluating the QFC portfolio.

- The receiver should be aware that there may be areas of contention and disagreement by parties in the netting, termination, and closeout of QFC agreements—for example, disagreement over the valuation or in the resolution of transactions where the parties wait too long to terminate the contract.

- Some counterparties may have been accepting less liquid assets, such as private placements based on the relative financial strength of the insurance company; typically, collateral for a QFC will be cash and U.S. Treasury bonds. The moving of over-the-counter (OTC) derivatives to centralized clearinghouses (CCHs) will gradually eliminate less liquid assets, as well as assets with more volatile market values being used as collateral. It is also worth noting that it is possible to have non-admitted assets eligible as collateral. Where assets exceed concentration limits, the excess can be collateral without being an admitted asset.

- The impact of CCHs will be to standardize documentation and collateral requirements. The standard rules for collateral will be more restrictive and be applicable to all parties. These rules will generally allow for only high-quality assets that are more liquid and are expected to have less market value volatility. In addition, all parties will be subject to the same rules for both initial margin and variation margin. In the past, it was not uncommon for counterparties to not require initial margin from their higher quality clients. This will not be the case going forward.

D. Recommended Procedures for State Insurance Regulators/Receivers

To the extent possible, in a pre-receivership situation:

- To the extent a company has a small number of large QFC contracts that are important to the overall investment portfolio and operations of the insurer, in pre-receivership and in rehabilitation, the state insurance regulator or receiver should reach out to the counterparty to determine if the counterparty is agreeable to continuing the contract and performing on the contract when the insurer enters receivership.

- Consider practical strategies for successfully managing the netting agreements and QFCs, not only at the inception of the receivership, but also ongoing during the receivership process.

- Evaluate if the insurer is engaged in netting agreements and QFCs through a market-facing affiliate or non-affiliate, whereby the insurer's contract is with that market-facing entity and the market-facing entity has the contracts with the counterparties.

- Consider the applicability of any federal master netting agreement rules and regulations to the insurer's netting agreements and QFCs. (See the references to applicable federal rules in the preceding footnote in this chapter [2].)

- Evaluate the need to consider the use of a bridge financial institution to transfer and manage the netting agreements and QFCs in a pre-receivership proceeding; i.e., administrative supervision. See Chapter 11—State Implementation of Dodd-Frank Receivership of this Handbook for guidance on the use of bridge financial institutions for a federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) receivership.

- Carefully review the most recent financial statement filings and interim company records to identify the netting agreements and QFCs active at the time of receivership; understand the terms of the agreements and the valuation of the QFCs; and identify the securities held as

[2] See footnote 1 of this chapter.

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collateral and counterparties to the contract. See the Appendix for a Summary of Statutory Annual Statement Reporting of QFCs or the most current Statutory Annual Financial Statement and Instructions.

- Consider how ongoing hedging of obligations and assets can be accomplished during and following a receivership.

Once a rehabilitation or liquidation order has been entered:

- Provide notice of the receivership to counterparties, as appropriate under state law.

- Consider implementing a 24-hour stay on termination of netting agreements and QFCs, if allowed under state law. (See the *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts* [#1556] and the accompanying drafting note in the preceding footnote in this chapter[3].)

- It is important for the receiver to keep track of which transactions have been terminated validly and which have not so that appropriate action can be taken when the validity of the termination is contested.

- Once the set off has occurred, if the receiver disagrees with the counterparties' valuation of either the collateral or the QFC transaction, the receiver would take the next steps to try to negotiate the correct amount and, if unsuccessful, pursue legal action.

- Consider engaging an investment expert to assist in the auditing, investigating, and management of the netting agreements and QFCs within the investment portfolio. Refer to Chapter 3.VI of this Handbook for more guidance on auditing and investigating the investments of the receivership estate.

E. Exhibit—Qualified Financial Contract Annual Statement Reporting (As of 2022)

The subsequent information provides a general description of how and where QFCs are reported within the *Accounting Practices and Procedures Manual* (AP&P Manual) and the statutory financial statements.

Derivative Instruments—*Accounting Practices and Procedures Manual* Disclosure
- *Statement of Statutory Accounting Principles (SSAP) No. 27—Off-Balance-Sheet and Credit Risk Disclosures*
- *SSAP No. 86—Derivatives*
- *SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees*

Derivative Instruments—Annual Statement Disclosure
- Schedule DB – Part A, Section 1 – *Open Options, Caps, Floors, Collars, Swaps, and Forwards*
- Schedule DB – Part B, Section 1 – *Open Future Contracts*
    - Within Part A and Part B, Section 1 identifies the contracts open as of the accounting date, and Section 2 identifies contracts terminated during the year.
- Schedule DB – Part D, Section 1 – *Counterparty Exposure for Derivative Instruments Open*
- Schedule DB – Part D, Section 2 – *Collateral for Derivative Instruments Open*
- Schedule DB – Part E – *Derivative Hedging Variable Annuity Guarantees*
    - Specific to derivatives and hedging programs under SSAP No. 108
- Schedule DL – Part 1 & 2 – *Securities Lending Collateral Assets*

[3] See footnote 1 of this chapter.

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- Notes to Financial Statement – *Investments; Derivative Instruments; Debt* (*FHLB Funding Agreements*)*; Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk; Fair Value Measurements*

On a quarterly basis, the insurer only reports derivative instruments that are open as of the current statement date. Schedule DB – Part A – Section 1 lists the insurer's open options, caps, floors, collars, swaps, and forwards. Open futures are reported in Schedule DB – Part B – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D – Section 1.

Repurchase Agreements—AP&P Disclosure

- *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*

Repurchase Agreements—Annual Statement Disclosure

- Notes to Financial Statement– *Investments*
- Notes to Financial Statement – *Debt*
- Repurchase agreements are disclosed in various investment schedules within the Annual Financial Statement depending on the type of investment (Schedule D, DA, E, Supplemental Investment Risk Interrogatories). The Investment Schedule General Instructions provide the following list of codes to use in the appropriate investment schedule code column regarding investments that are not under the exclusive control of the reporting entity, and also including assets loaned to others. For example, a bond subject to a repurchase agreement would be detailed in Schedule D Part 1 – *Long-Term Bonds Owned* and use a code of RA in Code Column.

Codes
LS – Loaned or leased to others
RA – Subject to repurchase agreement
RR – Subject to reverse repurchase agreement
DR – Subject to dollar repurchase agreement
DRR – Subject to dollar reverse repurchase agreement
C – Pledged as collateral – excluding collateral pledged to FHLB
CF – Pledged as collateral to FHLB (including assets backing funding agreements)
DB – Pledged under an option agreement
DBP – Pledged under an option agreement involving "asset transfers with put options"
R – Letter stock or otherwise restricted as to sale – excluding FHLB capital stock (Note: Private placements are not to be included unless specific restrictions as to sale are included as part of the security agreement.)
RF – FHLB capital stock
SD – Pledged on deposit with state or other regulatory body
M – Not under the exclusive control of the reporting entity for multiple reasons
SS – Short sale of a security
O – Other

VIII. POTENTIAL RECOVERY FROM THIRD PARTIES

As noted above, a number of persons inside and outside of the insolvent insurer may have caused or contributed to the reasons for the insurer's insolvency. Such acts or omissions may be unintentional, but the result is harm to the insurer and thus its policyholders, claimants, and creditors. This section and the next identify by category the acts and omissions of such persons, the causes of action that may be brought, and the foundation that the receiver must establish to prevail in such causes of action.

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Not all actions listed here may have contributed directly in the insurer's problems, and inclusion of an action in the following list does not necessarily indicate that a receiver will find a basis for seeking legal remedies from identified persons. Each situation must be evaluated on its own merits and circumstances. For example, the facts may clearly indicate that an agent wrongfully withheld funds due the insurer, but an investigation of the agent's financial condition might show that there would be little hope of collecting any judgment resulting from successful civil litigation. Therefore, the cost to the estate of pursuing this particular agent may outweigh the ultimate benefit, if any, to the estate.

A. Breach of Fiduciary Duties

Any person empowered to collect and hold funds on behalf of another has a fiduciary duty with respect to any funds collected. MGAs, TPAs, reinsurance intermediaries, brokers, and others may have violated this obligation by:

- Failing to maintain a premium trust account where required by law.
- Skimming premiums.
- Withholding funds without authorization.
- Failing to collect and remit premiums.
- Paying affiliates more than market rate for services.
- Deducting excess commissions and/or fees.
- Taking improper set-offs.
- Improperly using funds to make loss payments.

The investigative examination initiated by the receiver may indicate the presence of these problems. The receiver may need to conduct a more intensive investigation of transactions arising from the suspect MGA or TPA agreement, reinsurance treaty, etc., to determine whether a violation has occurred and the extent of injury to the insurer. Some examples of the information that may suggest a need for further investigation are:

- A significant decline in reported premium volume from one period to the next.
- Gaps in policy number sequence.
- Sharp increases in agents' balances receivable.
- Inordinate delays in collecting reinsurance balances receivable.
- Increase in consumer complaints.

B. Abuses Related to Risk Selection

An insurer may have delegated the authority to bind risks to an MGA or TPA, or may have given a reinsurance intermediary the power to cede or assume reinsurance on behalf of the insurer. Delegation of authority carries with it the duty to perform on the underlying agreement that binds the agent or intermediary to adhere to the insurer's articulated underwriting guidelines and limitations. To the extent any agent exceeded these limits and caused the insurer to suffer financially, the receiver may be entitled to appropriate remedies.

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Some of the ways in which underwriting authority may have been abused are:

- Accepting excluded classes of business.
- Violating territorial limits.
- Exceeding premium and/or product mix limits.
- Using binders improperly.
- Misrepresenting risks.
- Placing reinsurance with insolvent reinsurers.
- Improperly placing reinsurance with affiliated or unauthorized reinsurers.
- Failing to obtain adequate security for balances due the cedent.
- Misrepresenting reinsurance coverage.

As noted above, the takeover investigation may indicate that these problems exist and that a more intensive examination of performance under specific agreements may be in order.

Some examples of information that may suggest a need for deeper investigation in this area are:

- Unusual line codes or state codes in statistical reports or state pages of reports.
- Variances from sales plans and volume projections.
- Schedule F or S problems, mismatches, and unexplained differences.
- Reinsurers' resistance to or questions regarding claims presented.

C. Loss Settlements

As with risk selection, the insurer may have delegated claims settlement authority to a third party, be it an MGA, TPA, or loss adjuster. The third party has the duty to adhere to any guidelines and limitations stipulated in the delegation agreement, as well as to comply with fair claims settlement practices. Typically, these agreements will stipulate the third party's settlement authority, reporting practices, reserving practices, and use of outside experts.

Potential abuses include exceeding the claims settlement authority and establishing inadequate loss reserves in order to maintain a relationship with the insurer. Other indicators of problems are:

- Fluctuations in reported incurred losses.
- Unusually high LAEs.
- Unexpectedly high losses.
- Late development of reported losses.
- Policyholder complaints.
- Low salvage recoveries and/or high ratio of salvage costs to amount recovered.

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- Low subrogation recoveries and/or high ratio of subrogation cost to recovered amount.
- Negative market conduct examination report comments.
- Claims payments exceeding clean claim guidelines in health insurance.

To the extent that an agent's actions caused the insurer's financial suffering, the receiver may wish to pursue litigation or other available remedies.

D. Abuses Relating to Premium Computations

This area is closely related to risk selection in that the parties to whom underwriting authority has been delegated may also have the authority to compute the premium for the risks, as well as compute, collect, and remit premium adjustments.

The compensation of the party in question, especially an MGA, is generally a commission based on premiums written. Consequently, the agent may deliberately underprice the premium or fail to compute additional premiums in order to write the risk and generate a commission.

Similarly, the insurance broker, the policyholder, and intermediary (if reinsurance is involved) might deliberately suppress information relating to compensation. The receiver should look for:

- Change in pattern of premiums audit activity.
- Unusual lag in reporting losses.
- Unexpectedly high incurred loss ratios.
- Uncollectible adjustment premiums.
- Captive cell arrangements

E. Professional Malpractice

Insurers frequently retain outside professionals, including attorneys, auditors, certified public accountants (CPAs), investment advisors, actuaries, and loss reserve specialists. The receiver should retain an expert from the same profession to review the activities of the insurer's professionals and to determine if their actions met the minimum standards of the profession.

Types of actions that may result in litigation or other proceedings against such persons include:

- Incompetence or failure to meet professional standards.
- Failure to divulge conflicts of interests.
- Billing abuses.
- Failure to timely discover or disclose insolvency or other deficiencies of the insurer that prolonged the insurer's operations and increased its debts.

Many professional organizations promulgate a code of ethics and technical performance standards that the receiver may wish to obtain as a source of professional standards against which a breach may be measured. This is an area of considerable complexity, however, so the receiver should consider retaining the services of knowledgeable legal counsel.

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It is particularly important for the receiver to review whether certain professionals who were responsible for reporting on the financial condition of the insurer, such as auditors and actuaries, performed their duties in accordance with their applicable standards. Even in cases where the actual cause of insolvency was due to misfeasance or malfeasance by the directors and officers (D&O), other professionals may be liable for not discovering and disclosing the problems. If an auditor breached and/or failed to meet its duties of care, such breach and/or failure may be the proximate cause of damages to the insurer and its policyholders, creditors, and shareholders by reducing the value of the insurer and deepening the insurer's insolvency. For instance, if an auditor gives a clean opinion on an annual statement, reporting an insurer to be solvent when it should have detected and reported the insurer's insolvency if it had properly performed its duties, then the insurer's financial condition may continue to deteriorate, causing an even greater loss of surplus or increase in insolvency.

Some jurisdictions have awarded damages against auditors for what is referred to as the "deepening of the insolvency." This theory of damages was initially used in bankruptcy cases but has been applied to the insurance insolvency settings. Some courts have found "deepening of the insolvency" to be a separate cause of action even though it would still primarily be based upon some kind of professional negligence action. However, this theory is not universally accepted. In most states, auditors are required, as a condition of providing annual audit services to insurers, to provide a letter of qualification to the commissioner of insurance stating that they understand that the annual audited financial statements of the insurer and the auditor's own report with respect thereto will be filed and that the insurance commissioner intends to rely on this information in the monitoring and regulation of the financial position of the insurer. Such reliance may form the basis of a claim. Examples of professional malpractice of an auditor may include the failure to detect and disclose:

- Risks and accounting errors associated with an insurer's insurance program.
- Dissipation and misspending of funds by the insurer's officers and directors or controlling companies.
- Inadequacy of an insurer's reserves.
- Diversion of audit premiums or other assets.
- Existence of retroactive reinsurance or other reinsurance that could not be counted as an asset.
- Any significant deficiencies in the insurer's internal controls.

If such failures mask the true financial condition of the insurer so that the insurer continued to operate and slide further into insolvency, the auditor could be liable for the increase in insolvency from the date of that failure (i.e., the failure to report the insurer's deficiencies or insolvency) and the date when the insurer was actually placed into an insolvency proceeding.

Similarly, other professionals, such as actuaries, may be liable for the deepening of the insolvency if they breach their standards of performance and understate the insurer's reserves to the extent that, had they properly stated the reserves, the insurer would likely have been put into an insolvency proceeding sooner.

F. Income Tax

Insurance companies placed into liquidation often have net losses for federal income tax purposes. They are required to file federal income tax returns. (See Chapter 3—Accounting and Financial Analysis.) In addition, they may carry back the net operating losses and capital losses for a three-year period and recover prior years' federal income taxes. If the company is included in a consolidated return, the losses may be used to offset income from other companies in the consolidated group.

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As part of the receiver's investigation, it should be as certain whether the company has entered into a tax-sharing agreement. A tax-sharing agreement provides for the allocation of tax among members of a consolidated group may enforce the insurer's rights to tax recoveries. The receiver should determine whether any tax obligations or refunds due the insurance company have been paid and should be aware that intercompany tax allocations are frequently not recorded.

See *Exhibit 4-1* for a chart of potential recoveries from third parties.

IX. POTENTIAL ACTIONS AGAINST MANAGEMENT (DIRECTORS AND OFFICERS), SHAREHOLDERS, AND POLICYHOLDERS/OWNERS

A. Directors and Officers

The receiver may seek to recover damages from an insurer's D&O under one or more of the following theories:

1. General Mismanagement

In most states, case law requires that corporate officers and directors exercise ordinary or reasonable care and diligence in discharging their duties. The standard varies by jurisdiction. In most states, officers and directors are protected by the "business judgment rule" for their good faith actions. (See Chapter 9—Legal Considerations.)

The receiver should focus on what the D&O did or did not do. Accordingly, the receiver should begin the investigation by identifying the D&O and examining their qualifications to serve in their respective capacities. Such persons are held to minimum requirements of background, experience, and skill for each position. These prerequisites may be defined by statute or contained in the company's bylaws. The receiver should ascertain that the minimum requirements were met. The statutory remedy for an officer or director failing to meet qualifications is removal. However, the willful failure of other officers and directors to enforce timely action may lead to their liability if it contributed to the insurer's insolvency.

The receiver should pay attention to the directors' and officers' actions during the time leading up to the commencement of the receivership. If, prior to initiation of receivership, the D&O knew or should have known that the company was hopelessly insolvent, their failure to take remedial actions may be considered mismanagement. That is, continuing operations of the company may result in a larger dollar amount of the insolvency than would have occurred had management taken remedial actions, such as ceasing to write new business, going into run-off, or voluntarily consenting to receivership. In some jurisdictions, this "deepening of the insolvency" is considered an element of damages in an action against the D&O.

An officer or director is accountable for the results of the operations of the insurer. Whether accountability translates into liability in directors' and officers' litigation would appear to be dependent on answers to the following questions:

- Did the officer exercise reasonable and ordinary care in monitoring the behavior of subordinates?
- Did the officer act promptly to take appropriate corrective action?
- Did the officer attempt to conceal the failings or wrongdoing?
- Was the officer an active co-conspirator?

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- Did the officer obtain adequate information before making a judgment?

The receiver should review all minutes of the board, board committee meetings, and related activity. Records of attendance at board meetings should be scrutinized. Particular attention should be given to officers' compensation and directors' fees, as well as to excessive travel or preferential use of company property. The receiver also should examine investment transactions for improper or self-dealing in ventures in which officers and/or directors had an interest. An absentee or empty-headed/pure-hearted director is not absolved and may incur additional liability because of continuous absences or non-feasance.

2. Racketeer Influenced Corrupt Organizations

The availability of the federal RICO Act to receivers is discussed in-depth in Chapter 9—Legal Considerations.

At least some causes of action under RICO require demonstration of fraud. In such cases, the concern expressed below regarding collectability of reinsurance and errors and omissions (E&O) liability coverage would apply to these RICO actions as well.

3. Fraud

Civil liability is not the only remedy available to a receiver. In appropriate cases, consideration should be given to referring the matter to local, state, or federal law enforcement authorities for criminal enforcement. Alleged fraudulent or criminal activity may involve only one or two persons. It is not necessary to prove a pattern of activity, and it should include a comprehensive evaluation on impact to the estate. Fraud is often used as a defense or basis to deny coverage by liability insurers covering D&O of the insurer and may be used as a defense by reinsurers.

4. Voidable Preferences and Fraudulent Transfers

As discussed earlier, statutes prohibiting voidable preferences and fraudulent transfers often allow the receiver to pursue insiders who knowingly participated in the prohibited transactions. A forensic analysis will help identify potential voidable preferences or fraudulent transfers.

5. Activities that Give Rise to Potential Recoveries

Recoveries from the directors and/or officers may be founded on a variety of acts or failures to act that may be difficult to uncover. Major things to consider are outlined in the following paragraphs. Refer to Chapter 9—Legal Considerations for more detail.

a. Self-Dealing

All transactions between the insurer and vendors owned or controlled by D&O and/or their immediate family members should be examined for propriety. Leases of office space, data processing equipment, and furniture and equipment can be used to skim funds from insurers for the improper benefit of owners/officers. Similarly, there have been instances in which the insurer paid excessive management fees to organizations controlled by related parties. Other possible areas for abuse are claim service organizations, software vendors, auto repair shops, attorneys, consultants, and shared office space.

b. Executive Compensation

Travel and expense reimbursements to officers and directors should be examined for abuses, such as travel with no clear business connection, travel to resort areas accompanied by family members,

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etc. Special facilities, such as leased or company-owned luxury cars, boats, or residences maintained for executives may also be suspect.

Some scandals have identified artworks, antiques, oriental rugs, or other high-end items purchased with company funds for the primary benefit of its officers.

c. Investment Transactions

Real estate owned by D&O may have been sold to the insurer at an inflated value or exchanged for other property of greater value. Mortgage loans may have been granted to family members based on overstated appraisals or in violation of company investment policies.

Other areas of potential abuse include secured loans in which the collateral may be improperly secured or below investment quality.

d. Underwriting Transactions

Poor underwriting results may have been the result of actionable misconduct, such as:

- Accepting risks in violation of the insurer’s published underwriting guidelines.
- Failing to prevent or correct over-lining (writing prohibited classes of business).
- Failing to obtain motor vehicle records on automobile risks and safety, and engineering reports on commercial property risks or workers’ compensation risks.
- Taking on additional risk when the premium is insufficient to cover the risk.
- Placing reinsurance with unacceptable reinsurers and/or failing to obtain adequate security (LOCs, trust funds, or funds withheld) to cover unauthorized reinsurance.
- Failing to keep new business writings within prescribed limits.
- Failing to monitor the activities of MGAs and TPAs.

e. Claim Operations

Claim operations are vulnerable to liability for unlawful conversion of funds, which usually requires active participation by an employee or agent of the insurer. Persons in senior management positions may be culpable and subject to litigation to the extent that they were aware of activities, such as:

- Improper payments to claimants.
- Payments made to non-existent claimants.
- Payments to non-existent providers or service vendors.
- Inflated invoices for LAEs linked to a kickback scheme.
- Deliberate and material under-reporting of incurred losses.

The degree of culpability will be determined by answers to at least the following questions:

- Did the officer exercise reasonable and ordinary care?

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- Did the officer take prompt corrective action?
- Did the officer attempt to conceal the failings or misconduct?
- Was the officer an active co-conspirator?

f. Actuarial and Financial

An officer may have negligently or intentionally misstated actuarial data, either through improper valuation of policy reserves or case reserves for P/C losses, or by negligent or intentional failure to maintain sufficient data on which to base a reasonable estimate of loss reserves. The degree of culpability would appear to hinge first on intent and then on the qualifications of the officer. Alternatively, a group of officers and/or directors acting in concert may have intentionally tampered with reserve data or deliberately filed false financial statements.

g. Failure to Act in the Best Interests of the Company

A corporation's officers and directors have a common law duty of loyalty to that corporation that precludes, among other things, seeking private profit or advantage from their office. In most cases, the standards of conduct are clearly defined. The officer or director must not place his or her private gain above the best interests of the company and its survivability as a going concern. The receiver should carefully scrutinize insider stock trading, employment contracts, "golden parachutes," "poison pills," bylaws, etc., to verify that key personnel did not breach this duty.

6. Directors and Officers Indemnification

Consideration should be given to the existence and effect under applicable law of indemnification provisions in the company's bylaws and in state corporate laws.

7. Errors and Ommissions, and Directors and Officers Insurance

Many companies purchase E&O and D&O insurance that may provide coverage for certain types of conduct described above. As part of the receiver's investigative examination, all such policies should be identified and examined. These policies will almost certainly be claims-made policies that 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," which could extend the time in which to file a claim. In most cases, the receiver should purchase the tail coverage if his/her investigations have not been completed. The presence of insurance may be a factor in the cost/benefit analysis with respect to assessing causes of action against officers and directors. If insurance does exist, consideration should be given as to whether causes of action are covered by the insurance. Certain causes of action may be excluded by the policy, and it is important for counsel to review the policies before any suits are filed. One common exclusion that should be considered is the "regulatory exclusion" clause, which will likely be present in the policy under review. Another common exclusion is the "insured versus insured" clause, which may be in the policy under review.

B. Shareholders and Policyholders/Owners

Some jurisdictions permit alter-ego actions against shareholders, usually in closely held corporations, under common law or by statute. It may not be necessary to establish that management was negligent or guilty of fraud to recover from the shareholders. Where permitted, such recoveries may be limited, as in Arizona, to the par value of the outstanding shares.

In certain situations, it may be possible to assess policyholders or shareholders. Reciprocal inter-insurance exchanges and some old-line mutual insurers may have issued assessable policies that required

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policyholders to pay amounts over and above their premiums. Impairment to surplus usually is sufficient to trigger assessment.

Recoveries from shareholders and policyholders are special situations not likely to be encountered in most receiverships, and the amounts to be recovered and the procedures for recovery are specific. Thus, the receiver's attention is directed to the statutes and other authorities.

C. Significant Developments in the *Insurer Receivership Model Act* (#555)

In litigation between the receiver and affiliates of the insolvent insurer, Section 113 of Model #555 prohibits the affiliate from using any evidence that was not included in the records of the insurer at the time of the transaction. As an example, it is not unknown for inter-affiliate loans from the insurer to have side agreements excusing repayment under various circumstances. Under Section 113, if the side agreement is not fully documented at the time of the loan in the records of the insurer, the borrowing affiliate may not present that agreement as a defense to the receiver's collection efforts.

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I. INTRODUCTION

Claims processing is the most visible, tangible part of a receivership proceeding. Because policyholder protection is the basic goal of any insurance receivership, the adjustment and adjudication of claims is closely monitored by interested parties. Accordingly, the claims process should be carefully developed and administered.

A receiver should consider the different circumstances under which claims are adjudicated. There are several variables that may affect the way the claims process is handled, each of which, as well as state law, will have an impact on the type of claims procedure that must be established:

- Whether the insurer has any assets.
- Whether the insurer is a primary carrier, an excess carrier, a professional reinsurer, or a primary carrier that assumed reinsurance obligations.
- Whether the insurer underwrote property/casualty (P/C); fidelity/surety; a health maintenance organization (HMO) or a preferred provider organization (PPO); or life, accident, and health risks.
- Whether guaranty associations are involved.
- Whether the proceeding is judicial or administrative.
- Whether the proceeding is a conservation, rehabilitation, or liquidation.
- Whether the claim arises under an insurance policy or other contract.
- Whether the insolvency crosses state or international borders.
- Whether the insurer handles claims adjudication internally or outsources this function to third parties.

For a discussion of the legal aspects of claims processing and payment, see Chapter 9—Legal Considerations.

The following discussion is ordered chronologically and, unless indicated otherwise, assumes that the insurer is insolvent and that the receivership proceeding is a liquidation. One of the first tasks for any receiver is to establish a claims procedure and publish the procedure to potential claimants. Once established and published, the claims procedure is implemented. It may be prudent to file the claims procedures with the receivership court and seek the court's approval of the procedures prior to implementation of the procedures. The receivership court ultimately approves the claims that the receiver has adjusted and recommended for payment or denial. Establishing appropriate reserves is an integral part of the process. The final step is payment.

This section addresses the timetable for the filing of claims, the different types of creditors and their claims, and provision of notice to claimants. The receivership court's order defines the required notice to potential creditors and establishes deadlines for the filing of claims.

A. The Fixing Date

One of the first steps in any insurance insolvency proceeding is to establish the exact date upon which the rights, obligations, and liabilities of the insurer and its creditors are determined or "fixed." Most states use the date of entry of the liquidation order or, in some cases, rehabilitation order, for this purpose. (See Section 501(B) of the *Insurer Receivership Model Act* [#555], commonly known as IRMA.) However, as to some policyholder claims, the fixing date is often required to be the date when the statute or court order terminates the insurer's policies. The effect of the fixing date is significant: It provides a reference date upon which the insurer's liability and creditors' rights are determined. The most common legal distinction

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made is that between contingent and absolute claims. In essence, a claim is contingent if a liability-imposing event has occurred, but it is uncertain that the claim will be made or coverage and liability established. An absolute or non-contingent claim is one of certain liability. Although there may be a question as to the ultimate amount of the liability or when it may be due, there is no doubt that some debt will be due. An example outside the liquidation context helps to illustrate these distinctions. Assume that A negligently drives his car into the rear of B's automobile. As a result of the incident, B has a contingent claim against A. If B sues A, and B is awarded a final judgement, B as an absolute claim against A. In short, a claim remains contingent until liability is certain.

Identification of the fixing date may be subject to statutes applicable to both life/health and P/C insolvencies in several states that require continuation of coverage for a specified period after liquidation, usually 30 days. Most state statutes require that a life insurer's policies continue in full force and effect, at least until the receiver reinsures or transfers the policy liabilities to another insurer.

B. Claim Filing Deadlines

1. What Is a Claim Filing Deadline?

A claim filing deadline is the deadline for filing proofs of claim against the estate. (See Section 701(A) of IRMA.) The purpose of the claim filing deadline is to enable the receiver to: identify existing or potential claims against the estate; adjust and adjudicate claims; make distributions; and eventually close the estate. A claim received after the filing deadline should be classified as a late claim. Timely filed claims may be amended or supplemented subject to certain limitations provided notice of the loss or occurrence giving rise to the claim was provided on or before the claim filing deadline. Late-filed claims may be accepted but may not be paid until all timely filed claims of the same priority have been paid in full, or it will be moved to a lower priority of distribution within the estate. Under IRMA, late-filed claims are assigned to Class 9, provided that the claim was late due to certain specified criteria (IRMA, Section 701 and Section 801(I)). Other claims filing dates may apply.

In some circumstances, claimants need not file a claim to preserve their rights (e.g., policyholders of a life insurance company). Unearned premium claims may be treated similarly in P/C liquidations. It is recommended that the receiver discuss with the guaranty association which claimants are required to file a proof of claim. It is the receiver's responsibility in such circumstances to develop a list of claimants who are deemed to have filed claims prior to the claim filing deadline. As always, it is imperative to check local statutes for the appropriate procedure and rule of law.

a. Effectiveness as Against Federal Claims

Whether claim filing deadlines cut off untimely claims of the federal government pursuant to federal super priority statute 31 U.S.C.A. § 3713 remains unsettled. For a more extensive discussion of this and other claims issues, see Chapter 9—Legal Considerations.

b. Applicability in Rehabilitations

Whether a claims deadline date will be established in a rehabilitation proceeding depends upon the specific circumstances and applicable law. In rehabilitations of a limited or set duration, a claim filing deadline may enable the rehabilitator to ascertain the amount of outstanding claims and implement a plan to return the insurer to solvency. A deadline may also allow the rehabilitator to conserve liquid assets to pay current obligations while a rehabilitation plan is being developed or the amount of outstanding claims is being assessed. In other rehabilitations, it may be appropriate to set no claim filing deadline until a final dissolution plan has been settled.

2. How Is a Claim Filing Deadline Established?

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A court order is required pursuant to the applicable statutory requirements to establish the claim filing deadline for a particular receivership. (See Section 701 of IRMA and Chapter 6—Guaranty Associations for claim deadlines applicable to guaranty associations or ancillary receiverships.) The claim filing deadline established for claims against the receivership estate will also apply to the claims against a guaranty association.

Some state statutes specify the maximum period of time for the claim filing deadline bar date. If there is flexibility within the statute, the length of this period often will depend upon the complexity and size of the receivership and the type of business written. The assumption of blocks of business by a solvent insurer may eliminate the need for many claims to be filed at all. There can be a general correlation between the length of the claim filing deadline and the amount of the estate's administrative expenses.

3. Deemed Filed Claims

In circumstances where the insurer has better information about claims than the policyholders have, the receiver may be able to avoid the administrative expense of handling some or all proofs of claim by establishing a "deemed filed" procedure. Under such a procedure, the receiver may establish a list of policyholders and claimants based on the insurer's books and records, which shall provisionally state the amounts claimed. Each person whose name appears on such a list shall be deemed to have filed a proof of claim in a timely manner. Claimants are given notice and provided an opportunity to correct errors and prove their claims before final allowance. This procedure works well for unearned premium claims and claims for investment values in life insurer insolvencies. Most state statutes do not require holders of life or annuity contracts to file claims.

D. Developing the List of Creditors

The first step in this process is to develop a master mailing list of creditors from the insurer's books and records and other interested parties.[1] Most state statutes or receivership courts require notice by first class mail to the last known address of the known claimants, as well as by publication. In some states, notice shall be given in a manner determined by the receivership court.

The following persons usually will be included in the insurer's mailing list:

- Guaranty associations.
- Policyholders.
- Third-party claimants.
- Secured creditors.
- Government agencies.
- Wage claimants.
- General creditors.
    - Reinsurers and reinsureds.
    - Intermediaries.

[1] See *Elmco Properties, Inc. v. Second National Federal Savings Ass'n*, 94 F.3d 914 (4th Cir. 1996) for a receivership involving a savings association.

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- Managing general agents (MGAs) and third-party administrators (TPAs).
- Claims adjusters.
- Defense attorneys.
- Vendors.

- Equity (stock or share) holders.

E. Proof of Claim Forms

Once the list of claimants is developed, the receiver typically sends a proof of claim form to each person identified. The proof of claim form, which is the basic prerequisite to the allowance of a creditor's claim, serves a number of useful purposes. First and foremost, it identifies the claimant and the nature and extent of the claim. The receiver also may use the form to calculate the extent of the insolvency, to identify any obligations the claimant may owe the insurer (e.g., through the identification of any setoffs), to set reserves, and to determine the estate's right to collect reinsurance. In some cases, health claims may not have to file a proof of claim. An example is where the health insurer uses a TPA and is covered by the guaranty fund; there should be no need for the TPA to adjudicate the same claims twice.

Many proof of claim forms have been developed over the years. Claim forms to be used in any particular proceeding should be tailored to the circumstances presented. For example, the receiver should consider whether claims forms must be filed by all claimants. Most state statutes permit the receiver to dispense with the issuance of claim forms in a life receivership. The receivership simply draws a list of creditors from the insurers' books and records. In some states, filing with a guaranty association may constitute filing with the receiver for purposes of satisfying a claim filing deadline, but the receiver may need additional information from the claimant that the guaranty association did not elicit. Guaranty associations and receivers should coordinate their respective claim filing procedures to the extent possible. With receivership court approval, receivers may deem open claims as reflected on the books and records of the delinquent insurer as timely filed. In such circumstances, proofs of claim need not be filed by insureds or third-party claimants for such claims.

Before a proof of claim form is created, the receiver may wish to determine the number and types of claim forms that will be needed. The first task is to identify in broad categories the various classes and types of claimants. Then the receiver can determine what information is required for each type of claim. With this information, specific proof of claim forms can be developed for each category of claimant based on the type of business written. Some receivers use only one claim form but use control numbers, such as an alphanumeric system, to designate the type of claim presented in the form. This saves the cost of developing separate forms. Receiverships involving surety business may necessitate the use of a separate proof of claim form for each type of surety bond. The objective is to facilitate the exchange of information between the claimant and the receiver in order to adjust and later adjudicate a claim.

The more specific the information that can be elicited in the initial proof of claim form, the less follow-up will be required. Receivers should be encouraged to request submissions from creditors that the company in receivership has reinsured in accordance with the format of reporting under the reinsurance contracts in question. This should just be complemented by a comprehensive overview and breakdown of the total claimed by such reinsured creditor. The receiver, however, may require the claimant to present supplementary information or evidence, may take testimony under oath, may require production of affidavits or depositions, or may otherwise obtain additional information or evidence. (See Section 702(C) of IRMA). The class determinations should be subject to a right of appeal by the claimant. The prompt determination of creditor class permits a faster wind down, as well as facilitates more prompt calculations and distributions for creditor claims. It may be unnecessary to determine the amount of receivership claims for a creditor class if receivership assets are unavailable for that creditor class.

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Most statutes require claimants to provide certain basic information. (See Section 702 of IRMA.) The following information typically is required:

- The nature and particulars (e.g., the who, what, when, where, and amount) of the claim asserted.
- The consideration for the claim.
- The identity and amount of any security held on the claim.
- Any payments made or received on the claim.
- A copy of each written instrument upon which the claim is founded or a statement of the reasons a copy of the instrument(s) cannot be provided.
- The amount and a description of the source of any salvage or subrogation collected or that may be collected.
- An affirmation (notarized) that the insurer justly owes the sum sought and that there is no setoff, counterclaim, or defense to the claim (Section 702 A of IRMA).
- The name and address of the claimant and any attorney representing the claimant.

Additionally, IRMA requires that the claimant provide: 1) its Social Security number (SSN) or federal employer identification number; and 2) any right of priority of payment or other specific right asserted by the claimant (Section 702 A of IRMA).

The receiver may decide to use the same claims and policyholder service forms that the insolvent company previously employed because the information required is fairly uniform, and the use of different forms could be confusing to the service providers and policyholders. Additionally, many estates make proof of claim forms available for easy access via the receiver's office website.

The receiver decides what additional supporting documentation will be required to prove a claim and in what form it should be submitted. (See Section 702 C of IRMA.) Different documentation will be needed for different types of claims. For example, death benefit claims require the furnishing of a death certificate. Accident and health (A&H) claims may require a physician's certification and copies of medical bills. Return premium claims may be established simply by submitting a bordereau of all cancelled policies and return premium amounts attributable thereto, while computer summaries may be required to prove cumbersome or complicated claims. When policyholders claim return premium, the receiver may require additional documentation, such as copies of cancelled checks. Reinsurance claims may require yet another form of documentation. Life insurance claims usually require the policyholder to furnish the original policy. If the original cannot be provided, a copy thereof may suffice. If neither the original nor a copy of the policy can be furnished, a lost policy form should be executed and submitted to the receiver.

The level of detail required in the proof should conform to industry standards and statutory guidelines, as well as make it convenient for the receiver to communicate with the claimant and add the information to its database for claims management. Some estates may not process a claim that does not include all the requested information. One of the most critical needs of general creditors involves financial information on an insolvent ceding company. Providing regular financial statements of the company would be beneficial to interested parties, such as guaranty associations, reinsurers, and other receivers or regulators. It should be noted that whenever a reinsurer of the company in receivership has claims against the estate or where a reinsured creditor at the same time is a reinsurer of the estate, receivers should use the guidance provided in Subsection F—Coordination and Communication With Reinsurers.

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The receiver must determine who may submit a proof of claim on behalf of an entity and what form of verification is required. Because corporations can act only through their designated agents, it is best to determine and inform corporate claimants who may sign on their behalf (e.g., officers, directors, MGAs or attorneys). Generally, a director does not have authority to act for a corporation because directors must act as a body unless otherwise authorized by the company's bylaws. In most instances, the notarized signature of an individual who attests to his authority to do so will suffice. The signature of a trustee should be received when dealing with trust claims, and the trust document should be provided to the receiver to verify the identity of the trustee. If in doubt as to the capacity or authority of an individual who submits a claim on behalf of a corporation, partnership, or trust, the receiver may require that the claimant provide a certificate of incumbency, signed by another authorized officer or representative, as to the signer's authority to bind the entity. In the case of a corporation, partnership, trust, or individual, the receiver may also require a signature guarantee if in doubt as to the identity of the individual executing the claim. Careful drafting of the attestation will ensure that such authorization has been given to the signatory. Note that the availability of notarizations may depend upon the residence of the claimant. Although most foreign countries maintain their own systems for verification, notaries may be found at most American embassies. Consideration should be given to electronic signatures and proof of claims submission

When developing proof of claim forms, it is helpful to have in mind the volume, type, and class of claims that creditors may submit. Claimants, including guaranty associations and reinsured creditors, may have hundreds of outstanding claims against the insured. Some claimants may be permitted to file a single omnibus proof of claim for all claims against the receivership estate. Section 702(D) of IRMA allows a single omnibus claim to be filed by guaranty associations, which may be periodically updated without regard to the claim filing deadline, and the guaranty association may be required to submit a reasonable amount of documentation in support of the claim. Also, for reinsured creditors, the receiver will want to decide whether these claims need to be submitted individually or on a bordereaux basis. There are certain advantages to bordereaux submissions, which are dictated by the sheer volume of claims, the requirements of the treaty, and the receiver's need to efficiently process reinsurance recoveries. Ceding treaty retrocessionaires may only be able to file claims on bordereaux. There are other claims submission methods that might be used for reinsurance recoveries, depending upon the complexities of the situation. In the final analysis, the preferred submission approach ordinarily is the one that permits an orderly and efficient administration of claims on a computer system and often closely follows the procedures formerly in effect when the company was in operation.

In some states, if applicable, claims must be submitted on the liquidator's proof of claim form unless the liquidator grants an exception. Therefore, one approach to the claims filing process for reinsurers would be to allow for claims to be submitted in any format acceptable to the receiver; if the receiver, or the court, agrees, a claim would not have to be submitted on a proof of claim form.

To the extent omnibus proof of claims by reinsurers/intermediaries are allowed under your state's law, another consideration to expedite the filing of certain types of claims would be to allow reinsurers/intermediaries to file "place holder" claims, like those of guaranty associations, whereby the reinsurers/intermediaries timely file claims but are permitted to supplement their claims as additional information becomes available later in the receivership process. When appropriate, deem filing practices would be allowed for certain claims in receiverships. Generally, such orders are only sought in situations involving claims for which adequate claims documentation/proof exists within the records of the insolvent insurer.

III. NOTICE

Once a receivership order has been entered, whether it is for rehabilitation or liquidation, one of the first actions taken is to mail notices of the receivership to the company's agents, policyholders/members, reinsurers, and other parties related to the receivership. These notices should contain information regarding the claims processing filing

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process and references to the receiver's office website. The website should be kept updated with receivership information relevant to interested parties. The receivership website should not only provide information for consumers, but also provide an overview of the current status of the receivership, including past and upcoming deadlines, as well as provide access to court orders relevant to the receivership. To simplify the administration of the website, such information can be provided in the format of a simple table as some receivers' websites already do. Similar receivership notices are also provided to insurance departments of other states where the company is licensed.

Once a claims procedure has been established, the next step is communicating the procedure to all creditors. The receiver should check the domiciliary statute for any applicable time constraints in sending notice.

Ideally, in the case of surety bonds, insureds, their agents, and obligees should be advised of the status of their policies and of the procedures to be followed to make a valid claim. Among other things, the notice typically will inform them of the insurer's insolvency, whether policies have been or will be cancelled, and the procedures for presenting claims. The notice also may be used to describe, in general terms, the anticipated course of the liquidation. Some states require the notice to describe the guaranty association's involvement, if applicable. If a guaranty association is or may be involved, the receiver may want to jointly draft the notice with the association. The receiver should be cognizant of the effect of the receivership on guaranteed renewable and non-cancellable business.

The form of notice should be adapted to the circumstances. The notice may consist of the actual proof of claim form, with appropriate instructions for its use. The notice should identify the rights fixing date and claim filing deadline and its significance. Highlighting the penalty for failing to file by the claim filing deadline may help to avoid problems later. Posting notices, proof of claim forms, and claim filing deadines on the receiver or estate's website is a best practice.

In multistate receiverships, notices to life insurance policyholders and annuity or investment contract holders should be coordinated with affected guaranty associations through the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA). The receiver also may consider coordinating with the National Conference of Insurance Guaranty Funds (NCIGF) in multistate receiverships on the issuance of notices sent to P/C policyholders. Guaranty associations may request that the receiver include appropriate guaranty association information in the receiver's notice.

A. Contents: Plain Language

Most people will be receiving a receivership notice and proof of claim form for the first time. It is important that all forms be written as simply and clearly as possible. When appropriate, bilingual or multilingual notices can be issued.

B. Service

For the initial mailing of proofs of claim, receivers may send notices and proofs of claim as claimants are identified or initiate the mailing process once all potential claimants are identified. For ease of reference and tracking, proofs may be numbered either before issuance or upon receipt, and a procedure may be implemented for recording the mailing, undelivered return, receipt and processing of all proofs. Notice commonly is given by mail and occasionally by publication. The receiver should be aware that there are constitutional issues with respect to the deprivation of property rights. Specifically, identifiable creditors of the estate, who have a known or reasonably ascertainable address, may be entitled to mailed notice of the proceedings affecting their claim. *Elmco Properties Inc. v. Second National Federal Savings Association*, 94 F. 3d 914 (4th Cir. 1996). (See Chapter 9—Legal Considerations.) Mailing should be done in the manner and form prescribed by the domiciliary receivership statute (e.g., certified, first class, bulk), with appropriate documentation and records to demonstrate issuance, in case a challenge arises later. Publication may be required by law and is advisable for unknown claims. In most cases, the court order establishing a claim filing deadline will also require published notice of the receivership. Refer to applicable statutes or the court order to determine the timing, media, and frequency of published notice.

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Proofs of claim themselves may be issued by mail or through the receiver's website. A copy of the entire proof of the claim distribution list should be maintained and supported by verification by the individual(s) handling the distribution.

IV—CLAIMS PROCESSING

The receiver should make decisions at the commencement of the liquidation about proof of claim filing requirements and the claim evaluation process. Making these decisions upfront affords timely notice to claimants prior to the expiration of any claim filing deadlines and permits the development of claim forms and procedures consistent with such decisions. Each of these topics are discussed below:

A. Filing Methods

State laws typically permit the presentation of claims by a variety of delivery methods, including U.S. mail, personal delivery, or private delivery service. The receiver may also allow claimants to present their claims by facsimile or electronic (i.e., computer) transmission. The receiver should determine in advance whether to require original or electronic signatures, verification under oath, and acceptable forms of supporting documentation—whether actual receipt, postmark, or receipt of delivery to a courier by the claim filing deadline.

State law may provide the receiver with discretion to exempt preexisting claims from the proof of claim requirement. In exercising such discretion, a receiver would notify claimants with pending claims reported prior to the entry of the receivership order that their claims are deemed on file. Upon finalizing such decisions, the receiver should develop clear and timely communication protocols that address the requirements for presenting claims against the estate.

In developing claim filing protocols, the receiver should be cognizant of information-sharing requirements with other stakeholders, such as state insurance regulators, guaranty associations, and reinsurers.

1. Documenting Receipt of Proofs of Claim

As noted, the receiver should determine at the outset what constitutes "receipt" of a claim; i.e., whether proofs of claim are considered received on the date they are mailed or on the date they are actually received at the designated address. This determination will affect whether claims are timely filed or late. Documenting the date of receipt of proofs of claim is a critical receivership function that should follow established business protocols.

2. Guaranty Association Claims

The receiver should establish effective communication with the affected guaranty associations at the earliest possible date in the insolvency. (See Section 303 and Section 405 of IRMA.) This is the essential first step to efficient referral of claims to the appropriate associations. After claims have been referred to the guaranty associations, claimant inquiries can be directed to the appropriate guaranty association or claim handler. The receiver may also need to monitor claims where more than one guaranty association is involved. If guaranty associations are unable to commence claim payments shortly after the liquidation date of the insolvent insurer, the receiver may want to establish a transitional prepayment plan for hardship categories, such as workers' compensation claims, pharmacy benefits, or impounded automobiles. Such payments may be appropriate for subsequent treatment as early access distributions to or direct reimbursement by affected guaranty associations. See Section 802(D) of IRMA. (Note: Section 802(D) of IRMA relates specifically to workers' compensation payments in P/C cases). In the case of a life and health multistate insolvency, such payments may be used to provide funding to support assumption transfers of business or to provide

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initial funding for covered claims. In either event, the funding would be considered early access in accordance with Section 803 of IRMA. The referral of a claim to a guaranty association does not terminate the receiver's involvement with the claim. The receivership estate may have responsibility for claims that are excluded from guaranty association coverage or for portions of claims that exceed the applicable guaranty association coverage limit. A collaborative approach to the resolution of such claims between the receiver and guaranty association should be considered. Where guaranty associations administer covered claims, it is also critical for the receiver and guaranty association to coordinate information sharing so that the receiver is able to notify, cede, and recover losses from reinsurers. Many state laws exempt guaranty associations from proof of claim requirements and claim filing deadlines. IRMA permits guaranty associations to file a single omnibus proof of claim for all claims of the association, which may be updated periodically without regard to the claim filing deadline. (See Section 702(D) of IRMA.)

B. Proof of Claim Evaluation

This section outlines the general steps a receiver usually takes when reviewing claims filed against an insurer. It also identifies policy or administrative questions the receiver should consider at the beginning of the claims evaluation process. IRMA provides that the liquidator may adopt, with the approval of the receivership court, procedures for the review, determination, and appeal of claims that will be preliminary to review by the receivership court. (See Section 707(A) of IRMA).

Prompt and efficient resolution of claims should be management priorities for the receiver. IRMA provides that the liquidator shall review all duly filed claims and shall further investigate as the liquidator considers necessary. However, a liquidator is not required to process claims for any class until it appears reasonably likely that assets will be available for a distribution to that class. (See Section 703(A) of IRMA). If there are insufficient assets to justify processing all claims for any class, then the liquidator shall report the facts to the receivership court and make appropriate recommendations for handling the remainder of the claims. (See Section 703(K) of IRMA.) The liquidator may allow, disallow, or compromise claims that will be recommended to the receivership court unless the liquidator is required by law to accept the claims as settled. (See Section 703(A) of IRMA).

The receiver should manage the claim staff to achieve these goals. To the extent that the ultimate claim resolution is dependent upon the outcome of a guaranty association's claim administration, the receiver should consider coordinating with the applicable guaranty association on ultimate claim resolution when closure of the receivership estate is in view.

Completion of the claims evaluation process will enable the receiver to effectuate distributions to policyholders and creditors; generate insurance recoverables; and resolve subrogation and salvage, coordination of benefits, and loss-sensitive underwriting recoveries. The receiver in a health insurance insolvency should evaluate coordination of benefits owed from other parties, as well as subrogation recoverables. Inquiries to be made include whether collateral is being held by the creditor in connection with the claim and whether there are other third parties who may be pursued, such as indemnitors. Proof of claim forms can be a source of such information.

Receivers and guaranty associations may need to coordinate on entitlement to collect and retain salvage and subrogation recoveries. The decision in *Cal. Ins. Guarantee Ass'n v. Superior Court*, 64 Cal. App. 4th 219, 220-21 (Ct. App. 1998) resolved whether the receiver or the California Insurance Guarantee Association (CIGA) was entitled to the sums CIGA recovered through subrogation actions after it had paid covered claims. The Court held that to the extent CIGA pays covered claims, it was entitled to retain the amounts it recovers through subrogation actions. Conversely, to the extent CIGA pays covered claims with "early access distributions" or other assets from the insolvent insurer's estate, the estate is entitled to proceeds of any subrogation action. Id. at 229. In instances where pre-receivership payments were made by the insurer prior to guaranty association assumption of a claim, those payments typically constitute subrogation of the receivership estate under state law. In the case of surety claims, the receiver will need

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to review the underwriting file to determine subrogation or salvage potential and the identity of any third-party indemnitors. The estate should notify third-party indemnitors and solicit their involvement and support in settling the claims. Failure to properly and timely notify third-party indemnitors can result in the loss of indemnification through failure to give the indemnitor reasonable opportunity to minimize loss.

1. Review of Timely Filed Claims

Timely filing of a proof of claim may determine whether a claimant receives priority payment and, if so, at what level of priority. The receiver accordingly must determine whether each claim is timely filed.

Determinations of timeliness are made with reference to the claim filing deadline and the receipt or postmark rule. Claims received thereafter are categorized as late and subordinated in priority under state law. State law may provide a limited exception to the claim filing deadline for late claims. The receiver should review the applicable state law to determine whether a claim qualifies under the limited exception. (See Section 801 of IRMA.) For example, in some states, a late-filed claim may be a deemed timely filed claim if the claimant can show that they were entitled by virtue of an open claim on the books and records of the company to receive actual notice of the receivership and claim filing procedures but was not sent such notice. In one jurisdiction, a court held that the claims filing deadline should not be extended as a remedy for a receiver's failure to give notice of the appointment of a receiver. (See *In re Liquidation of American Mutual Liability Insurance Company*, 802 N.E.2d 555, (Mass. 2004).)

Although the law on this point is fact-intensive, a receiver may not be able to rely on constructive or published notice in circumstances where the existence of a claim was contained in the insurer's books and records.

Other examples of deeming late claims timely may include: 1) creditors who received transfers that were subsequently voided by the receiver or surrendered assets transferred to them; 2) secured creditors whose security was valued below the amount of their claims (Section 701(B) of IRMA); and 3) reinsurers whose reinsurance contract is terminated by the liquidation, giving rise to a termination claim under Section 701(C) of IRMA.

a. Post-Deadline Maturity of Timely Filed Claims

Certain timely filed claims may not be absolute for a variety of reasons. The receiver may request the Court to set an absolute, or final, or contingent claim deadline, by which timely filed claims must be made absolute or fixed. Claims not made absolute, liquidated, or mature by that deadline are date would be denied.

2. Review as to Form

a. Policyholder Protection Claims

Some jurisdictions permit policyholder protection claims by first party insureds for claims that are incurred but unreported or not known at the time of the claim filing deadline. Such claims may be allowed if they are amended or supplemented consistent with statutory or judicial rules and procedures. The receiver should consult applicable law to determine whether to allow such claims. Other states expressly prohibit policyholder protection claims. (See Chapter 9—Legal Considerations.) Statutes in some states either provide expressly, or courts have decided, that such claims may be allowed. Absent such guidance, some receivers require that the initial proof of claim be specific and may not be amended in any material respect after the claim deadline expires. Other receivers allow proof of claim amendments of

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all types until assets are distributed. Receivers should consult their local statutes and applicable court decisions on this issue.

b. Contingent Claims

Most states provide for the filing of contingent claims by first-party insureds, subject to an additional deadline for liquidating such claims. Contingent claims may be allowed if the claim is liquidated and the insured presents evidence of payment of the claim on or before the contingent claim filing deadline established by the Court. A contingent claim is a known loss or occurrence that is presented by an insured prior to the entry of a judgment or a determination of the insured's liability. Contingent claims do not include, and should be distinguished from, claims presented by third parties where liability or damages had not been established prior to the filing of the claim. (See Section 705 of IRMA.)

IRMA and most state laws provide third-party claimants with a direct right to file claims with the liquidator prior to the expiration of the claim filing deadline. (See Section 706 of IRMA.) In such instances, an insured may also file a contingent claim for the same occurrence raised by the third party. Section 706 of IRMA provides that the liquidator may make recommendations to the receivership court for the amount allowable on insured/third-party claims, basing this recommendation on the probable outcome of third-party claims against the insured. But distributions will be withheld and reserved pending the outcome of such a dispute or litigation between the insured and the third party. When the third-party claim is resolved, the reserved distribution will be paid to the insured or third-party claimant, as appropriate, and any excess amount reserved will be redistributed pro rata to other claimants in the receivership.

Section 706 of IRMA provides a procedure for resolving multiple claims filed by different parties against an insured that may exceed policy limits. In the case of multiple claims and irrespective of the IRMA provisions, it is imperative to apportion the varying claims without preference to the policy proceeds, and it is important to file for claim approvals with the receivership court before any claims are paid under the insurance policy. The receivership court claim approvals should be filed with due and proper notice to all parties that may be affected by such claim payments. It is recommended that defense costs be paid pro rata, even before all claims have been resolved and settled against a policy, provided that proper notice is sent to all affected and interested parties.

Section 706 of IRMA provides that the third-party claimant waives certain rights against the insured by filing a claim against the liquidator for the insured's insurance policy benefits, but the waiver will be ineffective if the claimant withdraws the claim or the liquidator avoids insurance coverage.

c. Amendment and Supplement of Claim Information

Amendment and supplement of information supporting a previously asserted timely filed claim can assist the receiver in the disposition of a claim that was contingent, unliquidated, or immature at the time of its filing. Consistent with the applicable statutory requirements, the receiver may determine the types of amendment or supplement that will be allowed. Amendments may include, but are not limited to, correcting or updating the amount, correcting technical defects, and providing sufficient documentation supporting payments or damages. Some states may allow insureds to file contingent claims that include reasonable attorneys' fees for services rendered after the date of receivership in defense of approved claims, provided the insured has actually paid the fees and evidence of payment is presented prior to applicable deadlines established by the Court or before assets are distributed.

d. Assumed Reinsurance Claims

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As for the policies of a P/C insurer, the liability for claims that a P/C reinsurer has assumed generally are limited to those arising out of reinsured events that occurred on or before the liquidation date (unless the court or statute directs otherwise). A receiver should decide at the beginning of the receivership how to evaluate the claims of ceding companies under reinsurance contracts. This decision will dictate the form of notice to ceding companies and the form of the proof or documentation cedents must use to file claims against the insurer. The receiver may opt to let the insurer's assumed reinsurance business run off and have cedents file their current claims against the insurer, allowing the cedents to amend their claims from time to time.

Another option that receivers have proposed is to require all ceding companies to file a proof of claim against the insurer as of the date of the receivership order (or a reasonably close date) for all reported and unreported losses. Under this alternative, the receiver takes a snapshot at the fixing date. Paid losses are recognized as reported if covered under the reinsurance contract. Outstanding claim reserves and incurred but not reported (IBNR) claims reserves are actuarially calculated and discounted to present value. This method allows the receiver to evaluate cedents' claims at an earlier stage in the receivership. Because the receiver will want to employ consistent evaluation methods for all claims that include IBNR, the proof of claim form may require that the claimant report the basis for the IBNR calculation. It is important for the receiver to determine the existence and extent of retrocessional reinsurance that might be available to cover assumed claims. This reinsurance can represent a significant asset of the estate. (See Section 3(b) below.)

e. Claims Under Occurrence Policies Under the *Insurer Receivership Model Act*

IRMA provides insureds the right to file a claim for the protection afforded under the insured's policy, irrespective of whether a claim is then known or if the policy is an occurrence policy. Further, any obligee shall have the right to file a claim for the protection afforded under a surety bond or a surety undertaking issued by the insurer as to which the obligee is the beneficiary, irrespective of whether a claim is then known. When a specific claim is made by or against the insured or by the obligee, the insured or the obligee shall supplement the claim, and the receiver shall treat the claim as a contingent or unliquidated claim. (See Section 704 of IRMA.)

Having concluded that a proof of claim was timely filed (or properly amended), the receiver should next review the claim to determine if all required information has been provided and if the form has been completed in accordance with the applicable instructions. IRMA provides that the liquidator need not review or adjudicate any claims that do not contain all applicable information and may deny or disallow any such claims (subject to notice). (See Section 703(I) of IRMA.)

If additional information is required, the receiver should specify a deadline for its submission, advising that the claim will be denied if the information is not submitted by that date. Review of applicable statutes for guidance on this point is suggested.

3. Review of Claims Based on Contract Provisions

The next step in the review process often consists of a substantive review of the claim. Here the receiver determines whether the claim may be allowed on its merits. This section presumes that the receiver has claim files to review (i.e., that the files are not in the possession of a guaranty association). The initial issue is the review of coverage: Is the claimed loss covered under the terms and conditions of the insurer's policy or contract, or is it excluded from coverage? The issue is resolved by referring to the policy or contract, the insurer's claims manuals, and underwriting files.

a. Policyholder Claims

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The starting point in the review of any policy claim filed against an insurer is the insurance policy or contract. The receiver treats the claim as if the insurer were reviewing it in the normal course of business prior to receivership. The receivership process and the procedures required by the receivership statutes and court are not a substitute for the sort of policy examination and initial claim review that the insurer followed before receivership.

The receiver first determines whether the policy was in force at the time of the loss. If not, the receiver will ascertain why the policy was not in force. Did the policy expire because of the insured's failure to pay premium? Did the term of the policy expire prior to the loss? If the insurer or insured cancelled the policy before receivership, the receiver must decide whether the applicable statutory or contractual procedures for cancellation were satisfied. The receiver also must determine whether the loss occurred before any cancellation of the policy by court order or by operation of law as a result of entry of the order of receivership. In the case of surety bonds, the receiver needs to determine that the bond was in force at the time of the occurrence upon which the claim is predicated. The receiver should be aware that some bond forms cover events that may have occurred prior to issuance of the bond, as well as during the term of the bond. In addition, the receiver will need to determine whether the obligee (claimant) has adequately discharged its obligations under the contract to both principal and surety in such a fashion as not to have prejudiced the surety's position.

Next, the receiver reviews the terms of the policy to ascertain whether the claim is within the scope and limits of coverage of the policy and not otherwise excluded. IRMA provides that no claim shall be allowed in excess of the applicable policy limits or otherwise, beyond or contrary to the coverage provided. (See Section 703(A) of IRMA.)

In the case of a policy with aggregate limits, the receiver should determine how many claims have been filed against the policy and whether the aggregate limit has been exhausted. (See Section 706(D) of IRMA). If guaranty associations are paying claims under the policies, they should be notified of the extent to which the aggregate limit has been eroded. The receiver also will want to determine if the policy's terms provide procedural defenses to the claim, such as late notice, lack of cooperation, coinsurance, or coordination of benefit provisions (e.g., in a health insurance policy).

The insurance policies under which the claims arise must be read in conjunction with the insolvent insurer's reinsurance agreements. A reinsurer's obligation to pay may only be triggered if the claims under a policy exceed a specified retention point. In some instances, the retention point may only be met if claims under a policy can be characterized as a "single incident" under the terms of the reinsurance agreement. The receiver must determine when claims under a policy constitute a single incident for reinsurance recovery purposes. As the reinsurer may argue that the claims at issue involve multiple incidents, the receiver should carefully review case law from the applicable jurisdiction when making this determination.

In the case of claims under policies of life insurance, the receiver should be sensitive to contestability issues. For example, some claims may be contestable because of misrepresentations contained in the policy application. Suicide claims may not be payable if the death occurred within the policy's contestable period, typically two years. In the case of A&H claims, the receiver should be alert to preexisting conditions that might render a policy claim void. Other areas to watch for are work-related claims that could be covered under a workers' compensation policy or claims resulting from automobile accidents that could be covered by the insured's auto policy.

IRMA provides that a judgment or order against an insured or insurer entered after the date of the initial filing of a successful petition for receivership, or within 120 days before the initial filing of the petition, and a judgment or order against an insured or the insurer entered at any time by

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default or by collusion need not be considered as evidence of liability of the amount of damages. (See Section 703(E) of IRMA.)

b. Assumed Reinsurance Claims

Most states accord cedent claims the same priority as claims of general creditors. (See Chapter 9—Legal Considerations.) In cases where there are insufficient assets to satisfy all policyholders' claims, the receiver should determine whether a review of general creditor claims is necessary. If it appears that the insurer's assets will cover only a portion of policyholder priority claims, there may be no need to evaluate general creditor claims unless the insolvent company has retroceded a portion of its reinsurance business. In such case, the receiver will need to evaluate and fix the amount of all or at least certain ceding company claims in order to pursue available reinsurance recoverables.

Assuming reinsurance recoverables are available or that assets are available to distribute to general creditors, the receiver will review all such claims. Review of the individual reinsurance contract ensures that the reinsurance contract covers the claim being asserted. The receiver should verify that the contract was in force at the time of the receivership, because the cedent and the insurer may have entered into a commutation agreement terminating the reinsurance agreement or some other agreement that establishes the rights of the parties (such as a novation, loss portfolio transfer, assumption, assignment, or settlement). If so, then the receiver should determine whether the commutation should be honored or whether there is some basis for setting it aside (such as the creation of a voidable preference). If the commutation is determined to be valid, no other claims should be allowed against the insurer under that reinsurance agreement.

As with a direct policy claim, the receiver should determine whether reinsurance claims are covered, proper notice of the claim was provided, and premium and other amounts due under the reinsurance contract have been paid. The receiver should also offset claims due from the cedent (e.g., for unpaid premium, salvage, etc.).

c. Certain Other Types of Contracts

The receiver may need to review the terms of the employment contracts with directors, officers or other individuals. IRMA provides that claims under employment contracts should be limited to payment for services rendered prior to the receivership order unless explicitly approved in writing by the commissioner prior to receivership or by the receiver post-receivership. (See Section 703(F) of IRMA.) The receiver also should carefully review the terms of all leases. IRMA provides that the claim of a lessor for termination of a lease shall be disallowed to the extent the claim exceeds the rent reserved by the lease (without acceleration) for the greater of one year, or 15% (not to exceed three years) of the remaining term of the lease following either the date of the filing of the petition or the date of repossession or surrender of the leased property (whichever comes first), plus any unpaid rent due. (See Section 703(L) of IRMA.)

The receiver also should carefully review the terms of all netting agreements or qualified financial contracts (QFCs). IRMA provides suggestions for the receiver as to how to deal with these types of contracts. (See Section 711 of IRMA.)

4. Review of Guaranty Association Claims

When a receivership triggers guaranty association coverage, the receiver should coordinate the approval and disapproval of claims with the guaranty association(s). Consulting the applicable statutes may enable the receiver to determine whether guaranty association payments bind the receiver. Coordination affects, among other things, the amount recovered under the insurer's reinsurance treaties or reinsurance agreements.

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The receiver should establish appropriate procedures at the beginning of the receivership in order to accommodate guaranty association claims. For example, receivers often allow guaranty associations to file an omnibus proof of claim form that can be amended from time to time. Typically, the receiver's forms for guaranty associations will include sections asking the guaranty association to segregate its claim by administrative expenses, allocated and unallocated loss adjustment expenses (LAEs), unearned premium payments, and policy loss payments. The receiver should review the guaranty association's claim for validity of liability and reasonableness of amount claimed. The receiver should be cognizant of the operational differences between life/health guaranty associations and P/C guaranty associations. P/C guaranty association claims are typically related to terminated policies, whereas life/health guaranty associations obligations can also include claims related to the continuation of benefits under the insolvent insurer's contracts.

Life/health guaranty associations may satisfy coverage obligations by transferring those obligations to a different insurer through an assumption reinsurance agreement negotiated by the NOLHGA or through ongoing administration of policies and claims in run-off where assumption reinsurance is not available. Consequently, the nature of the claims and expenses incurred by life/health guaranty associations can differ from the claims and expenses of P/C guaranty associations. In addition, life/health guaranty associations have statutory and subrogation claims to assets of the insolvent insurer to assist the association in satisfying its obligations. Early access agreements frequently permit the receiver to audit the guaranty association's records concerning the association's handling of claims.

The level of scrutiny given to a guaranty association claim depends on the circumstances. When the guaranty association provides complete coverage for affected policyholders, the receiver in cooperation with guaranty associations may wish to so notify policyholders (or have the associations do so) and thereafter deal only with the omnibus proof of claim filed by the association. Most state guaranty association statutes provide that a guaranty association's adjustment of covered claims usually binds the receiver, up to the amount the guaranty association has allowed, subject to statutory limitations. Although Section 703(A) of IRMA obligates the liquidator to accept claims as settled by a guaranty association when required by law, it prohibits the allowance of any claim in excess of the policy limits or contrary to the coverage provided under the terms of the insurance policy.

In other situations, limitations on guaranty association coverage—including caps, crediting rate limits, copayments, deductibles and net worth—may make it necessary for the receiver to undertake a separate review of claims. The receiver should keep accurate records for, and coordinate with, all affected guaranty associations concerning the tracking of per-occurrence and aggregate limits of coverage under policies where there are multiple claims and claimants. Coordination with guaranty associations is essential.

Claims covered by guaranty associations may be reinsured. It is important for the guaranty associations to report development on these claims so that reinsurance notice requirements can be met. Lack of reporting can hinder the collection of reinsurance recoverables. Because guaranty associations ultimately benefit from reinsurance collection, the receiver and the guaranty associations have a common interest in collaboration.

5. Review Claimant Standing

A claimant's standing to file a particular claim against a receivership estate should also be reviewed by the receiver. IRMA provides that with respect to claims of co-debtors, if a creditor does not timely file a proof of the creditor's claim, then an entity that is liable to the creditor together with the insurer (or that has secured the creditor) may file a proof of the claim. (See Section 709 of IRMA.)

C. Claims Valuation

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All claims should be assigned a value for allowance. In general, the determination of a claim's value is subject to the contractual agreement under which it arose and any statutory limitations. However, the receiver may be inhibited by statute from valuing claims in the same manner as the insurer did before receivership. In a typical surety insolvency, for example, the receiver and the receiver's legal counsel may face myriad issues as to what must have occurred prior to the fixing date for the bond claimant to pursue a claim in the receivership (e.g., how the bond claim is to be valued when the receivership order has interrupted the normal surety repair/completion of a bond principal's default, etc.). IRMA permits the liquidator to apply to the receivership court for approval to disallow *de minimis* claims. A *de minimis* amount shall be any amount equal to or less than a maximum *de minimis* amount approved by the receivership court as being reasonable and necessary for administrative convenience. (See Section 703(H) of IRMA.)

1. Secured Claims

Generally, the value of security held by secured creditors can be determined by converting the security into money according to the terms of the security agreement, by agreement with the receiver or by the supervising court. IRMA allows the value of security to alternatively be determined by agreement or litigation between the creditor and the liquidator. (See Section 710(A) of IRMA.) The value of the security is then credited against the claim. Valuation of secured claims may affect the overall recovery and distribution of assets to the other creditors of the estate. IRMA provides that the claimant may file a proof of claim for any deficiency, which shall be treated as an unsecured claim. If the claimant surrenders the security to the liquidator, the entire claim must be treated as unsecured. The liquidator may recover from property securing an allowed secured claim, the reasonable, necessary costs and expenses of preserving, or disposing of, the property to the extent of any benefit to the holder of such claim. (See Section 710(C) and (D) of IRMA.)

A receiver should proceed with caution when valuing secured claims. The value of the security may be overstated on the books and records of the insolvent insurer.

2. Claims Estimation

The long-tail nature of certain claims, such as workers' compensation or mass tort, in a P/C receivership can present special issues for receivers. Under some rehabilitation plans, claims may be permitted to develop in a normal fashion. In other rehabilitation proceedings and almost all liquidation proceedings, however, the receiver may be ready to distribute assets before all claims are fully developed. In addition to the typical issues of coverage, liability, and damages, the receiver should have a plan for valuing long-tail claims that complies with applicable state law.

Before a claim may be allowed, the receiver needs timely and accurate evidence:

a. That the policyholder has, in fact, sustained a loss within the coverage of a valid policy and in a specific or determinable amount. The receiver evaluates the merits of the underlying claim. Under many states' statutes, a judgment against the policyholder entered after (and, in some states, even before) the date of liquidation may not be binding evidence of either liability or the amount of the loss. Nor does an insured's settlement bind the receiver, unless the insured can demonstrate that it is both bona fide and fair to the insurer as well as the insured. Collusive or side agreements between the insured and one or more of the claimants, consent judgments, and covenants not to execute should be reviewed to determine whether the judgment or settlement is reasonable.

b. That a third party has asserted and proven a claim against the policyholder on a timely basis, in an amount that can be reasonably determined. Again, judgments should be evaluated by the receiver for reasonableness. Each claim must be evaluated on its merits.

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Some claims will fail to meet the requirements for proof and liquidation set out above, even though, were it not for the receivership's requirements, the claims would eventually have matured into enforceable claims. Late-maturing and even "contingent" claims are nevertheless an important component of the company's liabilities, both because of the significance of the claims themselves and because, when allowed, late claims may generate reinsurance recoverables for the estate.

c. The receiver's flexibility in dealing with late-maturing claims may be limited by statute. Nevertheless, a procedure to deal with late-maturing claims should be developed in any estate involving long-tail exposures or where reinsurance recoveries are a consideration. The methodology used by the receiver will depend upon the individual estate, applicable state law, and the nature of the claims and the records available. A number of alternative approaches are available to the receiver:

   i. The receiver might deny all claims that have not matured within a specific period after entry of the liquidation order. This "cut-off" approach may be appropriate where the insolvent insurer wrote simple, short-tail business or where the estate has few assets and recoverables. However, if the insolvent insurer wrote more complex business with a longer tail, the cut-off approach may defeat policyholder expectations and limit the receiver's right to collect from reinsurers.

   ii. Extensions of a claim filing deadline may ameliorate, but not eliminate, the risk that a policyholder with a legitimate claim will be left without a remedy. It sometimes helps and may be statutorily required to establish a second claim filing deadline, prior to any distribution to stockholders, in order to afford late claims an opportunity for recovery. Where permitted by state law, some receivers have obtained approval for plans under which a claim deadline is extended and policyholder claims are allowed for distribution as they mature. This "run-off" approach may delay the distribution of assets and/or closure of the estate.

   iii. IRMA provides that a claim that is not mature as of the coverage termination date may be allowed as if it were mature, except it shall be discounted to present value. (See Section 703(D) of IRMA.)

   iv. The receiver should determine whether the law in the domiciliary state would allow a plan to estimate and pay claims pro rata. While some states' receivership statutes (e.g., Illinois, Missouri, and Utah) expressly permit the estimation of policyholder claims, receivers in other jurisdictions might seek receivership court approval for a claims estimation plan with proper notice to interested parties. Case law that allows for claims estimation when a state statute permits estimation for the payment of claims or recovery of reinsurance proceeds includes *Angoff v. Holland-America Ins. Co.*, 937 S.W.2d 213 (1996), providing that "the Missouri insolvency statutes grant the receiver considerable discretion in evaluating the determining claims by estimation using actuarial evaluation or other accepted methods of valuing claims with reasonable certainty, including determinations for IBNR losses to the extent that those types of claims can be determined with reasonable certainty." State law may provide that estimated contingent claims may be allowed, but at a lower priority level than non-estimated claims (e.g., Illinois). Case law in another state provides that the receiver should not pay receivership distributions based on actuarial estimates of claims. See *In re Liquidation of Integrity Ins. Co.*, 2006 WL 2795343 (N.J. Super. A.D.). The court rejected the holding in the *Holland-America Insurance Company* case that permitted claims estimation because it was based on Missouri statute, whereas New Jersey had no such provision.

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Assuming that a claim estimation plan is in accord with state law, the receiver should be aware of the following:

- Some state statutes have been amended to address the handling of contingent and unliquidated claims by providing an opportunity for estimation of contingent claims without lowering the priority of distribution of the claim. These few state statutes specifically allow for the estimation of claims, but some (e.g., Illinois) provide a separate priority of distribution level for holders of such allowed claims.

- Another approach to estimation assumes that each policyholder is assigned a case reserve established in the policyholder's name and a proportionate share of the total projected IBNR. Although largely untested in this country, this technique has worked well in other countries in the liquidation of reinsurers.

- Even if IBNR estimations are acceptable for purposes of distribution from the estate, estimation may not be a valid basis for recovering reinsurance. (See Section 611(I) of IRMA.)

3. Claims in a Life/Health Insolvency

Few receivership statutes directly address the issue of valuing life and annuity claims, but there is a well-developed body of case law on the subject. In any event, it often will be necessary to assess the type of policyholder claims at issue to evaluate whether groups of policyholders are being fairly treated in any rehabilitation, liquidation, or assumption reinsurance transaction.

4. Mature Claims

Life insurance claims have the advantage that, in most cases, the condition precedent to claim liability is fairly clear: The policyholder is either alive on the relevant date or not. If the events triggering the insurer's obligation to pay on a life policy have occurred on or before the fixing date, then the receiver's claims process is substantially similar to that of a going concern, centering on proof of death, premium and cash value accounting, and beneficiary designation. Immediate annuities present slightly different problems, but essentially the claim of the owner of such an annuity ought to be the present value of the future stream of payments.

5. Immature Claims

Challenges can arise in connection with policies for which the principal liability-creating event has not yet occurred at liquidation. Few such claims would be considered contingent because the policyholder usually has significant rights at the liquidation date, including surrender rights or rights to unearned premium. Court decisions, going back to the early 1800s and ending in the 1940s as the assumption/guaranty system developed, support the allowance of claims based on these immature policies in the amount of a fairly adjusted reserve, or alternatively in the amount of the difference between premiums expected to be paid in the future and claims expected to be recovered by the policyholder—all discounted to present value.

In evaluating policyholder claims against life insurers, the receiver should look at the company's own reserves, after suitable investigation, to quantify individual policy claims. These reserves will typically equal or exceed cash or surrender value on the policies. Cash or surrender value, being the sum that the policyholder could obtain at any given moment from a solvent insurer, is usually the largest component of such a reserve and establishes a minimum number for the receiver's valuation. Other policy features are usually captured in the company reserves as well, including special premium considerations, renewal commitments, advantageous mortality charges, and above-market crediting rates. Annuity contracts may have features that affect the actual value of the contract. There may be a

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cash value, an account value, a surrender value, or other valuations used by the company to represent the amount payable to a claimant at a given point. Also, tax consequences may be incurred by a contract holder if their tax-qualified retirement contract is paid out and not rolled over into a qualifying contract within the time allowed by the IRS.

On the other hand, statutory reserves usually do not reflect the likelihood that some policyholders, had the insurer continued in business, would have permitted their policies to lapse. One approach to lapse issues would be to consider that because lapse is an election completely within the control of the policyholder, it would not be appropriate to reduce the claim in respect of an election that, at the date of liquidation, the policyholder had not made. Other analyses, however, are also possible.

In a life/health receivership, the receiver will frequently conclude that traditional proofs of claim are either unnecessary or irrelevant. The company's records often form a better base for a claim valuation than anything the policyholder could construct. The actuarial techniques that ought to be employed in the valuation are outside the competence of most policyholders. Finally, application of a single actuarial method to all claims will permit them to be evaluated on a consistent basis. Part or all of the policyholder claims arising from life insurance policies and annuity contracts will be covered by guaranty associations. State guaranty association statutes typically require a pro rata distribution of receivership assets to guaranty associations based upon the reserves that should have been established for the covered policies. In addition, guaranty associations may have other creditor rights. Accordingly, the receiver should coordinate with the affected guaranty associations as to valuation issues.

D. Notice of Claims Determinations

Once the receiver has completed the review of proofs of claim, the claimants should be advised of their claim determinations. In some states, the receiver will not send a determination letter if the claim has been resolved by a guaranty association. Some receivers merely file with the supervising court a report or recommendations as to the allowance or disallowance of each claim and require claimants to file any objections with the court. Other receivers give claimants notice and an opportunity to object before reporting to the court. As discussed below, Section 703(B) of IRMA follows this procedure. If the latter procedure is used, notice of the full or partial allowance of a claim should inform the claimant of the amount that the receiver will recommend to the supervising court for adjudication and the class of the claim for priority of distribution purposes.

In the case of the partial or total disallowance of a claim, the notice should state the reason for the disallowance and inform the claimant of the amount of time, specified by statute or court order, that the claimant has to object to the determination. Many states provide that claimants be given 60 days from the date the notice was mailed to submit written objections to the receiver. IRMA provides 45 days. (See Section 703(C) of IRMA). IRMA allows the liquidator to accelerate the allowance of claims by obtaining waivers of objections. (See Section 703(C) of IRMA.) IRMA also provides that preliminary notice of the amount of the claim determination may be given to any reinsurer that is or may be liable with respect to the claim at least 45 days before the notice is given to the claimant. If the reinsurer does not object to the claim determination, it is bound by the determination. (See Section 703(B) of IRMA.) Advance notice to reinsurers may not be practical under some circumstances, such as where the case is settled at mediation on the eve of trial or where the reinsurer has expressed disinterest in the claim determination because it intends to dispute liability. Notice to a reinsurer can help establish proper documentation when a reinsurer denies having been notified of the loss.

Once an objection is received, the receiver should consider whether the determination should be altered before proceeding to a court hearing on the objection. IRMA provides that whenever objections to the liquidator's proposed treatment of a claim are filed, and the liquidator does not alter the determination of the claim as a result of the objections, the liquidator shall ask the receivership court for a hearing. (See Section 707(B) of IRMA). However, there is case law supporting the proposition that the commissioner

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may not have a statutory obligation to provide claimants a formal hearing when determining a claim (*Garamendi v. Golden Eagle Insurance Company*, 128 Cal. App. 4th 452, 27 Cal. Rptr. 3d 239 (Cal. Ct. App. Dist. 1. Div. 1. 2005)). Because it may be cost-prohibitive to have hearings on every claim objection, the receiver may settle or otherwise resolve an objection without the need for a hearing. The procedures for hearings on claim objections are discussed further below.

Prior to the court's approval, the receiver may revise the determination. This enables the receiver to correct any errors that were made and to amend the determination in light of any subsequently provided information or negotiations. The receiver should remind the claimant to advise the receiver of any change of address or the information provided in the proof of claim. Naturally, if the receiver changes an initial denial of a claim to an allowance or partial allowance determination, the receiver should notify the claimant of the amended determination.

In addition to policy claimants, the receiver should give notice of claim determinations to other directly affected persons, such as reinsurers. The reinsurance contract contemplates the reinsurer receiving notice and an opportunity to participate prior to the court approving the claim. The receiver should pay particular attention to the requirements contained in the insolvency clauses of applicable reinsurance agreements. Similarly, if the insurer underwrote surety bonds, such as contract performance or payment bonds, then the receiver will want to provide notice of the determination to indemnitors of the bonds, any collateral depositors, and the bond principal. Notice will enable the receiver to obtain any information those persons have with respect to the claim and will put them on notice that the receiver may be looking to their collateral or indemnification agreements for reimbursement of the insurer's liability under the bond. If not established by statute, the receiver should set a deadline for the claimant to respond to the claim determination. If a timely response is not received, the claim determination should become final, subject to court adjudication.

E. Judicial Review of the Receiver's Claims Determinations

Depending upon the degree of oversight exercised by the supervising court, the receiver may be expected to account to the court for all claims processed. IRMA provides that the liquidator shall present reports of claims settled or determined by the liquidator to the receivership court for approval. The reports will be presented from time to time as determined by the liquidator and shall include information identifying the claim and the amount and priority of the claim. (See Section 708 of IRMA.) After the receiver makes the claims determinations, those decisions may be presented to the supervising court in the form of a recommendation for allowance or disallowance, in whole or part. This next section outlines the procedural steps that may be taken in making, filing, and presenting recommendations for final court approval.

1. Documenting the Recommendation

The first step is to make sure that claims determinations have been properly documented. The receiver may want to have a separate file for each claim filed in the receivership, containing the proof of claim and other relevant information. Files may be organized numerically either on a date of loss or policy basis. A status sheet or checklist may be attached at the front of each file detailing the status of the claim, including the recommendation to allow or disallow the claim, the priority of the claim, status of reinsurance, and other notes. Information in the status sheet should be entered into an electronic claims system. After the recommendation has been documented, the receiver then presents the claim, depending upon its status, to the court for approval or for a contested hearing, if the claimant filed a timely objection to the receiver's determination.

2. Presenting Recommended Approvals to the Supervising Court

The receiver may obtain court approval of recommended claim allowances, or the receiver may obtain advance approval for the payment of claims within a specified claims priority. In the event of

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advance approval, the receiver may report back to the receivership court if there is uncertainty as to whether claims fall within the approved claims priority class.

If the receiver does not seek advance approval for payment of claims within a creditor class, claims may be presented to the court by listing the claims and amounts approved or, if required, by a full financial accounting. The court usually will enter an order confirming the allowed claims. When the court approves a claim and all possible appeals have been exhausted, the receiver's staff should be notified that the legal action has concluded so that the allowed claims may be placed in line for eventual distribution.

3. Review of Recommended Rejections

This section outlines a general procedure for the denial of claims in a receivership. IRMA provides that disputed claim procedures are not applicable to disputes with respect to coverage determinations by guaranty associations as part of their statutory obligations. (See Section 707(C) of IRMA.) Some states follow the practice of conducting individual hearings on denied or disallowed claims. The receiver's goal is to complete the process as quickly and smoothly as possible. The receiver may use in-house counsel or retain outside counsel to handle hearings, depending upon the complexity of the receivership and the disputed claims. The receiver should consider the potential expense involved in contested claims proceedings in deciding whether to force a hearing or pursue settlement or arbitration.

The claims hearing process begins when the receiver files a notice with the supervising court and notifies the claimant and other directly affected persons. Various courts require different notices, and legal counsel should be consulted to assure that the receiver is following the correct procedure. Usually, the notice sets forth: 1) the time and date of the hearing; 2) the procedure to be followed at the hearing; 3) the amount claimed; 4) the relevant priority status of the disputed claim(s); 5) the reason for the denial or priority status assigned; and, 6) whether an objection was filed. In some instances, due to the volume of claims, a special master may be appointed to hear the disputed claims rather than the judge of the supervising court. If a special master is appointed, the parties should meet as soon as practicable to establish the exact procedure to be followed. The receiver's staff should work closely with the legal counsel conducting the proceeding.

Assuming all notice requirements have been satisfied and any special procedures have been implemented, claims hearings typically follow a routine procedure. If permitted, multiple hearings should be scheduled at the same time to conserve estate assets and resources. Depending upon the complexity of the hearing involved, the receiver's staff and other resources may be needed. The receiver's counsel generally will need testimony from members of the claims staff or the receiver, along with production of relevant records. Expert witnesses also may be required. Receivers should take care to discuss the need for expert witnesses with legal counsel due to the costs involved.

At the close of a claims hearing, the court typically issues a report or decision. Assuming the receiver's recommendation is upheld, the receiver should note the deadline for appeal of the order. If there is an appeal, it is best to complete the appeal process as soon as possible. If the decision is not appealed, or an appeal is concluded, the final order of the court can be entered into the receiver's records, along with any change in claim status. The final disposition by the receivership court of a disputed claim is deemed a final judgment for purposes of appeal. (See Section 707(D) of IRMA.)

4. Arbitration

Judicial review of the receiver's determinations is not always mandatory. Depending upon the nature of the legal right or claim involved and the applicable law, arbitration may be required. Although the arbitration provision contained in a policy or reinsurance agreement may be unenforceable against a receiver, careful review of these contracts is necessary to determine whether arbitration may benefit the receiver or the estate and, if not, whether arbitration can be avoided. Review of applicable laws on

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enforceability is essential. Legal counsel may assist the receiver make this determination. If arbitration is an attractive option or cannot be avoided under applicable law, then the receiver should become familiar with the specifics of the arbitration clause in each contract.

Arbitration is a contract-based proceeding, subject to statutory and case law in the particular jurisdiction whose law may govern the proceeding. Careful review of the agreement with legal counsel is essential. Numerous legal questions arise in the context of arbitration proceedings, and no receiver should enter into arbitration without the assistance of competent counsel. For example, the choice of arbiters can be critical. The receiver may wish to consult with other receivers to identify arbitrators for recommendation. If one party refuses to name an arbiter, however, the other may seek court intervention to facilitate the process.

Section 105(E) of IRMA recognizes the propriety of arbitration to resolve reinsurance disputes. (See Chapter 7.)

F. Establishing Claim Reserves

Establishing appropriate claim reserves may be just as important to an insurer in receivership as to a solvent company.

1. Why Reserve?

The nature of the receivership will dictate if, how, and when reserves should be established. A rehabilitator is particularly concerned with the company's reserves in assessing the company's prospects for a successful rehabilitation. It may appear that a liquidator should not be concerned with reserves because the insurer usually has been adjudged insolvent, and the liquidator's charge is to adjudicate the claims and close the estate. However, the liquidator will be concerned about reserving from the standpoint of reinsurance claims. Reinsurers need data from which to establish IBNR loss reserves, as well as reserves for existing claims. The receiver's failure to furnish this information on a timely basis may lead reinsurers to attempt to avoid their obligations.

Accordingly, the receiver should determine the reporting requirements established in the insurer's reinsurance contracts and other reserve requirements imposed by the court or by law. Accurate reserve information is equally important for determining the prospects for attracting a potential purchaser or investor and for calculating the availability of assets for early access distributions to guaranty associations. It is frequently possible to bring significant assets into the estate of a P/C company by negotiating commutations with reinsurers, but such an effort is difficult without reliable, credible, and current reserves. The receiver also should determine when reserve information must be presented to the court, if at all. And there also may be deadlines imposed as to when reserve information must be submitted. This often is the case where receiver reports must be submitted to the court, guaranty associations. or regulators within a specified period. In other words, it is important for the receiver's staff to know the needs of the different users of reserve information.

Further, it may not be useful to obtain an actuary's estimate of IBNR claims and applicable reserves more than once per calendar year, as there may not be enough new data or developments to change the earlier reserve estimate for IBNR. This also means that to the extent that the receivership's claims payment rate is affected by estimates of IBNR claims, the claims payout rate may not be adjusted more than once per calendar year.

Whether a receiver can use actuarial estimates of IBNR for the purpose of collecting reinsurance proceeds from reinsurers depends upon the applicable statutes and case law. (See *Angoff v. Holland-America Ins. Co.*, 937 S.W.2d 213 (1996); *Quackenbush v. Mission Ins. Co.*, 62 Cal. App. 4th 797 (1998)). In *Holland-America*, claims estimation for reinsurance recoveries was permitted on the basis of a state statute that authorized claims estimation for that purpose. In the *Integrity* and *Quackenbush* cases, claims estimation of future IBNR losses would not be permitted for collection of reinsurance

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proceeds because, in those cases, the applicable state statutes required that unliquidated or undetermined claims could not share in the assets of the insolvent insurer.

IBNR claims will arise in two contexts, namely: 1) IBNR losses from policyholder protection proof of claims in which the actual claim is unknown and has not been submitted to the receiver; or, 2) further IBNR loss development from known claims, but the amount or extent of the future IBNR loss development is unknown. A final bar date by which all claims must be presented should be established so that the estate can determine the universe of claims and wind down its affairs over time, thereby saving the costs of keeping a receivership estate open indefinitely. Although the final claims deadline may resolve whether IBNR claims may be presented for policyholder or protection claims, the final claims deadline is likely to allow, as timely filed and proper claims, known claims for which there may be continued IBNR loss development.

How IBNR loss development on known claims may affect reinsurance recoveries, recoveries by insureds, and third parties from guaranty associations or recoveries by guaranty associations from receivership estate assets are important issues. For example, at the closure of the receivership, there may be many known claims for which the future stream of benefit payments could be calculated by the receiver, guaranty association, and/or claimant, such as the value of future benefit payments for workers' compensation claims. If the receiver or guaranty association purchased an annuity in settlement of all future benefit payments due a claimant, including an IBNR component, would the *Integrity* and *Quackenbush* courts reject the settlement because it included IBNR loss development? Or would a claim settled in this way be considered liquidated and non-contingent? The settlement payment should satisfy the court's concerns about having a liquidated and determined claim, but this would be a case of first impression.

Without any accommodations being made for future loss development, guaranty associations may still have obligations to the aforementioned claimant after the receivership is closed but will not receive any distributions from the receiver for these losses. Similarly, claimants will receive no payments for their post-receivership loss development if such development is not allowed by the receivership court or guaranty associations.

Receivers should address IBNR claims before making final receivership distributions and closing the receivership estate, bearing in mind: 1) whether the applicable state statute permits IBNR claims; and, 2) whether IBNR loss development can be made liquidated and certain under different alternatives (e.g., an annuity in settlement of all known and unknown losses as described above). Receivers should also evaluate the extent of reinsurance recoverables available for IBNR losses, and the reinsurers of the insolvent insurer should be given notice and an opportunity to participate in the settlement of claims involving IBNR.

In the case of a life insurer, an actuarial evaluation may be necessary both to value the business, within a positive or negative range, and to estimate total liabilities so that the guaranty association or the receiver can effectuate assumption of the in-force blocks of business by a solvent insurer. The evaluation should be done for each line of business. Life, annuity, and A&H blocks should be considered separately. Proper liability reserving is necessary in any receivership to project ultimate distribution amounts to various creditor classes. Caution must be exercised in establishing loss reserves, however, as reserve reductions that do not reflect actual liabilities can trigger negative tax consequences.

2. Reserve Adjustment

It may be appropriate to adjust outstanding case or claim reserves. In some cases, case or claim reserves will be adjusted continually as additional information becomes available. Reserve adjustments may be required if, for example, amendments to proofs of claim are permitted after the claim filing deadline or the supervising court extends the claim filing deadline. Such adjustments

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typically affect the amount of a letter of credit (LOC) that a reinsurer must post, early access distributions, tax liabilities, and the future payout rate for other claims. The receiver should also estimate the future administrative costs to pay all claims and to wind up the receivership, including the cost of concluding litigation to recover assets.

Notice of reserve adjustments should be disseminated as necessary. The receiver may be required to report the adjustments to reinsurers and the supervising court, among others. The timing of these reports will depend upon the court's requirements and applicable law. The receiver's staff should identify the needs of the different users of information and determine when information should be provided.

G. Assignment of Claims Issues Considerations and Guidelines

There has been an increase in the number of assignments of claim that are presented to receivers. The development of best practices for administering the assignment of claims drew upon the experience of receivers, state insurance regulators, and interested parties. See Exhibit 5-3 for further guidance on assignment of claims.

V. PAYMENT OF APPROVED CLAIMS

Theoretically, distribution of the insurer's assets to claimants in a liquidation proceeding is different from normal business practice. While claims against an insurer in rehabilitation may be paid either in the normal course of business as they become due or pursuant to a rehabilitation plan, in a liquidation proceeding, the insurer's assets must be distributed to creditors in the order set forth in the priority of distribution statute. This section addresses some of the many issues the receiver must address once the claims evaluation and approval process has been completed and the asset distribution process begins. See generally Article VIII of IRMA.

A. Priority of Distribution in Receiverships

All state receivership statutes and Section 801 of IRMA provide a priority of distribution scheme. The liquidator must become familiar with the priority of distribution scheme of the domiciliary state's receivership statute at the outset of the receivership process. Typically, statutory priority schemes require that claims in a higher priority class must be paid in full or funds reserved to pay them in full before any payment may be made to lower priority claims. Also, the statutes typically require that all claims in a class must receive substantially the same *pro rata* distribution.

The receiver must keep in mind that the same claimant may hold several claims, not all of which have the same priority. There also may be different types of claims within a particular class of creditors (e.g., landlord claims, vendor claims, and assumed reinsurance claims are different types of general creditor claims). A receiver must avoid creating subclasses within a priority class. (See In re Conservation of Alpine Insurance Company, 741 N.E. 2d 663 (Ill. Ct. App. Dist. 1. Div.4. 2000).) The following discussion is based on the scheme of priorities established by Section 801 of IRMA. Secured creditors and special deposit claimants are outside the scheme of priorities established by Section 801. Secured creditors are covered by Section 710 of IRMA, and special deposit claimants are covered by Section 1002(C) of IRMA.

1. Secured Creditors

Secured creditors include anyone holding a perfected security interest in or lien against the property of the insurer (e.g., mortgages, trust deeds, pledges and security interests perfected under applicable law, excluding special deposit beneficiaries). Once determined, the value of the security is applied against the creditor's claim, with the deficiency, if any, treated as an unsecured claim. The priority of the deficiency claim depends upon applicable state law. IRMA also provides guidance to the receiver

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for the disposition of specific types of secured claims; i.e., claims involving surety bonds or undertaking, and obligees or completion contractors. (See Section 710(B) of IRMA.)

2. Special Deposit Claimants

Some states require deposit or trust accounts for the benefit of policyholders as a condition to authorization of the insurer to transact business in that state. Although owners of special deposit claims often are loosely referred to as secured, they do not, strictly speaking, have a "security interest." Some special deposits are made for the benefit of all policyholders, while others specially protect residents, property, or lines of business in the state where the deposit is established.

States differ in their treatment of special deposit beneficiaries' claims in the domiciliary receivership. Some apply the rules applicable to holders of partially secured claims; i.e., treating the deficiency as an ordinary policyholder claim. Another method gives effect to the special deposit arrangements, but it applies the "hotchpot" principle to payment of any deficiency. Under this method, special deposit beneficiaries receive no additional payment on their claim until all other claimants in the same class have received assets sufficient to make their percentage distribution equal to that of the special deposit claimants. The treatment to be accorded special deposit claimants may be articulated in the receivership statute.

There has been litigation in various state jurisdictions regarding the handling of special deposits for insurance company liquidations. A Massachusetts case provides that an insurance commissioner, acting as ancillary receiver of a foreign insurance company, cannot take any action to remove special deposit funds until all special deposit claims have been satisfied. (See generally, *Commissioner of Ins. V. Equity Gen. Ins. Co.*, 191 N.E.2d 139 [Mass. Sup. Jud. Ct. 1963].)

In North Carolina, a "special deposit claim" has been defined as any claim secured by a deposit pursuant to statute for the security or benefit or a limited class or classes of persons. (See *State ex rel. Ingram v. Reserve Ins. Co.,* 281 S.E.2d 16, 20 [N.C. 1981]. N.C. GEN. STAT. § 58-30-10 [19]). Special deposits are expressly excluded from general assets. *Id.*

In most receiverships, it is difficult for receivers to collect special deposits posted in other state jurisdictions without a court order and provision having been made for the payment of all policyholders in such state jurisdictions. Thus, the receiver will need to develop a claims distribution plan that takes the special deposits into account and avoids unlawful preferences, being mindful that the state jurisdiction in which a deposit is posted may use the special deposit to satisfy unpaid policy claims in that state jurisdiction.

3. Class 1—Receiver's Administrative Expenses

The expenses of the receiver in marshaling and distributing the insurer's assets are paid out of the unencumbered assets before any other claims are paid. Most statutes treat administrative expenses as claims having a first priority. Some statutes accord the same priority to a guaranty association's administrative expenses. However, some guaranty association expenses may be classified as policyholder benefits, which is an area of disagreement between guaranty associations and receivers. As will be discussed below, Section 801 of IRMA provides two alternatives as to classification of the priority of guaranty association claims. Reinsurers may argue that if the receiver is making reinsurance recoveries under reinsurance treaties, then all premiums due under the treaties should be treated as an administrative expense. Under general contract law, ratification of a contract may be found under a variety of circumstances, such as: intentionally accepting benefits under the contract after discovery of facts that would warrant rescission; remaining silent or acquiescing in the contract for a period of time after having the opportunity to avoid it; or recognizing the validity of the contract by acting upon it, performing under it, or affirmatively acknowledging it (17A C.J.S., Contracts § 138). Reinsurers' claims should be evaluated on a case-by-case basis, but there may be benefits to the estate from treating the reinsurers' claims as administrative expenses. The reinsurance contract

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obligations may be binding on the receiver as administrative expense obligations if the receiver has legally "ratified" the reinsurance contract. The assets available to pay all other creditors are those remaining in the estate, net of the cost of recovering and administering them. The process of estimating administrative expenses is a difficult one, as it will depend on many factors, some of which are beyond the control of the receiver. The receiver should establish a contingency reserve for administrative expenses before recommending any payments on claims of lower priority.

4. Class 2—Guaranty Association Expenses

Guaranty associations may have several types of expense claims, not all of which may have the same priority. IRMA provides two alternative priority schemes depending on how a state wishes to classify certain expenses of guaranty associations. The first alternative places expenses of the guaranty associations, including defense and cost containment expenses of a P/C guaranty association, in Class 2; i.e., after administrative expenses of the receiver. The second alternative places the defense and cost containment expenses of P/C guaranty associations in Class 3 with other policyholder-level claims, while the remaining expenses of the guaranty associations are placed in Class 2. No significance or deference should be given alternatives under IRMA based on whether an alternative is labeled as alternative one or two. Receivers should note case law providing that however a guaranty association's claims are classified, the claims of an out-of-state guaranty association should be of equal priority with the claims of the guaranty association in the receivership state (in *re Liquidation of American Mutual Liability Insurance Company*, 747 N.E.2d 1215 [Mass. 2001]).

5. Class 3 and Class 4—Claims for Policy Benefits

Many state statutes accord priority status to claims for policy benefits behind only the administrative expenses of receivers and guaranty associations. This status applies not only to the claims of policyholders, but also to those claiming through them, including guaranty associations and liability claimants whose claims were covered under one of the insurer's policies. Claims under life insurance or annuity policies include claims for investment values, as well as death benefit and annuity payments. Premium refunds and unearned premium claims, however, are treated as general creditor claims under the former Model Act, and some state statutes, although guaranty associations often cover such claims, at least in part. Some states and IRMA accord the same priority rank to policy loss and premium refund claims. A review of the applicable receivership statute generally will inform the receiver as to how to treat such claims. As sub-classifications within a priority level should be avoided, case law provides that the receiver cannot divide policyholders into those who were insured only by the insolvent insurer and those who had additional insurance through other carriers (in re *Conservation of Alpine Insurance Company*, 741 N.E. 2d 663 [Ill. Ct. App. Dist. 1. Div. 4. 2000]).

a. Deductible and Limits

The policyholder's claim is for the amount that the insurer should have paid. The insurer's liability attaches after the deductible has been paid by the insured (e.g., non-advancement policies). However, for some policies (e.g., some workers' compensation policies), the insurer is required to pay the claim and seek the deductible from the insured, thereafter, known as large deductible policies. It is common for insureds to post collateral with the insurer for deductible payments that may be made by the insurer, for which the insurer then seeks reimbursement from the insureds. There are three available model alternatives that provide for the disposition of large deductible policy recoveries between receivers and guaranty associations: 1) Section 712 of IRMA; 2) the *Guideline for Administration of Large Deductible Policies in Receivership* (#1980); and 3) the NCIGF Model Large Deductible Act (NCIGF Model). Individual state statutes based on the NCIGF Model or Guideline #1980 may differ from Section 712 of IRMA in certain respects. See Section VII.C. for more information on large-deductible programs.

b. Previous Guaranty Association Payments

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A guaranty association that pays all or part of a policyholder's claim acquires the policyholder's rights in the receivership estate, with occasional additional privileges, such as an exemption from certain filing deadlines. The policyholder's claim, or the claim of the liability claimant under the policy, is reduced proportionately, but it usually is not expunged. In some states, a guaranty association may make payment directly to the liability claimant if the claimant waives any further claim against the insured. The receiver should remember, however, that guaranty associations only process "covered" claims and that insureds with claims that the guaranty association does not cover will be instructed to handle their own claims and then seek reimbursement from the estate.

c. Cut-Through

As an enhancement to security, insurance policies or reinsurance agreements sometimes obligate a reinsurer to pay the policyholder directly in the event a covered loss cannot be paid due to the insolvency of the direct insurer, pursuant to a cut-through clause or endorsement. A number of controversies have resulted from these provisions, including the issue of the validity of such agreements. Insofar as the arrangement purports to affect the obligation of the reinsurer to the cedent, or of the cedent to the insured, the receivership estate may be affected. The receiver should seek the guidance of legal counsel concerning rules applicable in the local jurisdiction. Some jurisdictions have allowed insureds direct access to reinsurers even in the absence of a cut-through clause or endorsement. In such cases, courts will look to the relationship among the parties. (See *Koken v. Legion Insurance Co.*, 831 A.2d 1196 (2003), where the court allowed a cut-through where the insolvent insurer had fronted the reinsurance arrangement.)

d. Assignments

Policyholders sometimes assign to a third person their rights to recover from the insurer. Although the general rule is that the assignee stands in the shoes of the assignor, the receiver should determine the validity of any assignment with reference to applicable law.

e. Separate Accounts for Life and Annuity Policyholders

A special form of assets is separate account assets. Separate accounts are accounts established by life and annuity insurers in association with specific types of policies or other business, such as pension plans. Generally, separate accounts are created and administered in accordance with specific regulatory or statutory guidelines. Typically, such statutes provide that assets properly maintained in separate accounts will not be chargeable with liabilities arising out of any other business of the insurer. It has been held that the status of separate account assets is preserved in receivership.

6. Class 5—Federal Government

In general, claims of the federal government may be paid after administrative and policyholder claims. However, the receiver is well-advised to obtain a release from the federal government prior to making any final distributions. This is because the federal government may not be bound by the receivership court's claim filing deadline or the estate's classification and payment of certain claims, and it could seek to hold the receiver personally liable if, for instance, it takes the position that it should have been paid in the place of other creditors.

For a discussion of the federal super priority statute and the 1993 U.S. Supreme Court decision in *U.S. v. Fabe*, see Chapter 9—Legal Considerations.

7. Class 6—Employee Compensation

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Most priority of distribution statutes assign a higher priority to certain claims for employee compensation earned pre-receivership. This priority generally applies to wages limited in amount and earned within a specified time, but it may not apply to the wages of the insurer's officers and directors, including stockholders who are employed in such positions.

8. Class 7—General Creditors

The populace of general creditors is often large and diverse. It frequently includes the persons described below.

a. Brokers, Agents and Intermediaries—Personal Versus Agency/Derivative Claims

These categories are considered together, since the primary problem arising in connection with broker balances and similar claims is a tendency of all concerned to lose track of the capacity in which the obligation is incurred and to attempt to lump together amounts that derive from quite different sources. A distinction should be made between the divergent and often conflicting interests of the intermediary, especially a broker, acting as the insurer's agent for the collection of premiums as the representative or subrogee of the insured, and acting on his own account, notably for commission. Identifying the capacity in which the broker served is essential for the receiver to determine the relative priority of the broker's claims and the extent to which such claims may be combined, if at all, for purposes of setoff.

b. Cedents

In the relatively few cases where creditors of this class receive a distribution, the receiver may be able to set off interest deemed received by cedents on premature draw-downs of LOCs against the distributions due them. Legal counsel should be consulted on the issue of setoff. (See Chapter 9—Legal Considerations.)

c. Certain Claims of Directors and Officers

IRMA provides that, except as expressly approved by a receiver, expenses arising from a duty to indemnify the directors, officers, or employees of the insured should be excluded from the class of administrative expenses and, if allowed, are Class 6 claims. (See Section 801 of IRMA.) (But in *Weingarten v. Gross*, 563 S.E.2d 771 [Va. 2002], fees and costs incurred by directors in their defense of an action brought by a receiver were held to be entitled to payment as an administrative expense under applicable statutory law.

d. Reinsurers

Reinsurers may be creditors of insolvent ceding insurers for premiums or other contract-based financial obligations, such as salvage and subrogation recoveries. Receivers should be aware of the fact that such recoveries may be held in trust and, thus, would be payable in full, not *pro rata*. Similarly, the cedent may hold as the reinsurer's trustee funds withheld and the proceeds of drawn-down security until such time as the funds are applied to appropriate claims. Excess amounts then may have to be returned directly to the reinsurer instead of merged with the general assets of the estate, and the reinsurer's claim to such amounts may be considered the claim of a trust beneficiary, not a general creditor. Depending on the terms, express or implied, of the instrument creating the relationship, the reinsurer's claim for interest on these amounts may not be valid. Setoff is an issue when addressing reinsurers' claims, and legal counsel should be sought. Before making payments of salvage, subrogation, or other amounts due the reinsurers after the receivership commences, it is advisable to obtain written assurances from reinsurers that they will honor reinsured claims submitted by the receiver.

e. Other General Creditors

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This category includes: trade creditors, landlords, and utilities, for pre-receivership debts; bondholders, excluding surplus noteholders; secured creditors with deficient security; and, in some jurisdictions, late-filing insurance creditors and claimants for unearned premium.

9. Class 8—State and Local Government Claims and Some Legal Fees

State and local government claims that are not included in another class are placed in this class. Some examples of non-Class-8 governmental claims are policy benefit claims under policies issued to the government entity or current sewer or water bills on the insurer's office.

Class 8 also includes the legal expenses incurred by the management of the company in defending against the receivership proceeding. There are significant limitations on these claims.

10. Class 9—Claims for Penalties, Punitive Damages, or Forfeitures

If the policy issued by the insolvent insurer specifically covered punitive damages, penalties, and forfeitures, these claims would be in the policy benefits class.

11. Class 10—Unexcused Late-Filed Claims

Under IRMA, if the claimant can show that there was good cause for the delay, claims filed after the claim filing deadline, as discussed above in Section II(B), are evaluated in the class they would have been in if timely filed. If there is no good cause, the claims are placed in Class 10. Most receivership statutes have standards for good cause. (See Section 701(B) and (C) of IRMA.) In some state receivership statutes, there may be some ambiguity on the treatment of late-filed claims.

12. Class 11—Surplus Notes

IRMA provides that claims within this class will be subordinated to other claims in this class if there is a pre-receivership subordination agreement in existence.

13. Class 12—Interest

Interest is not often allowed on claims in receivership after the date of entry of the receivership order, on the general theory that if interest were allowed, it would run equally in favor of all claimants and simply result in a proportionately greater deficiency. Special cases, however, do exist: Holders of secured interests may be allowed interest to the extent their security is sufficient, and creditors in general sometimes may collect interest on their debts before any distribution to shareholders, on the theory that the receivership is to be conducted as if there were no insolvency. Many state laws are silent on this point, but others provide that interest on a given class of claims should be paid or provided for before such payment is made to any lower class. A review of the state's receivership statute may indicate whether interest should be paid as part of any claim. IRMA allows interest on claims in Classes 1—11 if the liquidator proposes and the court approves a plan to pay interest. (See Section 801(K) of IRMA). Even if the contract upon which the claim is based allows for interest, legal precedent provides that interest shall not be allowed if statutorily prohibited. (See *Swiss Re v. Gross*, 479 S.E.2d 857 [Va. 1987].) Also, legal precedent provides that if claimants are entitled to post-allowance interest on claims, such interest should not be paid at the same priority level of the underlying claim (in re the *Liquidation of Pine Top Insurance Company*, 749 N.E.2d 1011 [Ill. Ct. App. Dist. 1. Div. 4. 2001]).

14. Class 13—Equity Interests

After all higher priority classes are paid, any remaining funds are paid to the owners of the insolvent insurer. Like surplus notes, any pre-liquidation subordination agreements among the owners will be honored. Before making a distribution to the owners, the liquidator should be sure to reserve adequate

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funds to pay any post-discharge expenses, such as the cost of responding to future inquiries from claimants and the costs associated with disposal of estate records.

B. Setoffs

In general terms, the claim of a creditor or debtor in a receivership is defined as the net amount due after the application of any permissible setoff. Section 609 of Model #444 addresses setoff. As the subject of setoffs in an insurer receivership is complex and often the subject of litigation, the receiver should consult legal counsel. For a detailed analysis of this subject, see Chapter 9—Legal Considerations.

C. Currency Conversion

Variations in foreign exchange rates can become a problem in the distribution of the insurer's assets if the insurer has creditors in foreign countries. The receiver may need to evaluate foreign currency in three situations:

- An insured incurs a loss in a foreign country under a policy denominated in dollars. In issuing such a policy, the insured may be deemed to have assumed a certain degree of foreign exchange risk for foreign currency exposures. However, the insured did not assume the risk of exchange variation during the period when the insurer's insolvency delays payment of the claim.

- An insured incurs a foreign currency loss under a policy denominated in the foreign currency. In this case, the insured may have assumed the risk of currency variation either between loss and payment or pending the insurer's receivership.

- At the time of receivership, the insurer holds funds or other assets in foreign currency. Some can readily be converted to dollars while others, such as reinsurance assets and outstanding premium receivables, cannot.

Foreign exchange risk characteristically is quite random and runs both ways. Prudent financial management does not attempt to predict the direction of future currency variation, but it only plans to match anticipated foreign debt with foreign assets. Unfortunately, this matching produces difficult problems that the receiver must sort out.

Receivers are forced, sooner or later, to restate the value of all assets and claims in a common currency; otherwise, they cannot calculate a distribution. The only question is when they should do so. The English Insolvency Rules still automatically use the date of liquidation, which is certainly the most straightforward technique. American law does not generally contain direction on this point. Applying a differential standard is likely to seriously complicate the claims process without appreciably improving the fairness of the result. Where the foreign exchange balances are significant, the prudent course may be to accept claims denominated in foreign currency, converting them to dollars at a date shortly before distribution, and planning the conversion of assets to occur at or near the same date.

The actual process of conversion of claims valuation may not be as complicated as it sounds. For example, the receiver might announce a suitable benchmark standard, such as the average of bid and asked prices for the relevant currency as published in The Wall Street Journal or offered by major banks. The U.S. Department of Treasury (Treasury Department) also maintains a listing of values for the purpose of assessing *ad valorem* (i.e., value-added) customs duties.

Expert assistance may be needed in cases where the currency in question is not readily transferable or has little or no market. Experts also may be helpful in the management of foreign currency assets between takeover and distribution, as well as the matching of assets to anticipated liabilities.

It is helpful to address currency issues at the outset of the receivership, particularly in the case of international insolvencies. Some statutes do not contemplate such issues. The receiver should have the

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supervising court approve the receiver's practices and procedures on this point when the court enters the order allowing claim payments.

VI. INTERIM AND FINAL DISTRIBUTIONS

With the approval of the receivership court, a receiver may declare and pay one or more partial distributions on claims, as those claims are allowed, as well as a final distribution. All claims allowed within a priority class are paid at substantially the same percentage. (See Section 802(A) of IRMA.) IRMA specifically permits the liquidator to pay benefits under workers' compensation policies after entry of the liquidation order if certain conditions are met and only until the appropriate guaranty association assumes responsibility for payment or determines that the claim is not a covered claim. (See Section 802 D of IRMA and Chapter 6—Guaranty Associations.) Procedures for continuation of pharmacy benefits should also be addressed. In some cases, it will be preferable to continue the company plan for a period of time. In other cases, the guaranty funds have ongoing vendor relationships and can make a transition expeditiously. IRMA and most state laws also require the liquidator to make early access payments to guaranty associations from distributable assets of the liquidation estate. (See Section 803 of IRMA and Chapter 6—Guaranty Associations.) State law should be reviewed in all cases to determine specific requirements and authority regarding partial distributions, priority of claims, workers' compensation prepay procedures, pharmacy benefit continuation, and early access.

In determining the percentage to be paid on claims, the receiver may consider the estimated value of the insurer's assets, including estimated reinsurance recoverables, and the estimated value of the insurer's liabilities. (See Section 802(B) of IRMA.) But see, for example, the aforementioned *Integrity*, *Quackenbush,* and *Holland-America* legal cases for additional information on how IBNR claim estimates and corresponding reinsurance recoveries were addressed in other receiverships.

An insurer's assets often consist of readily available (i.e., liquid) assets and those that may not be readily collected or liquidated. The latter category may include litigation recoveries, subrogation and salvage recoveries, reinsurance recoverables for claims that the receiver recently approved, the proceeds of difficult collection actions, or the sale of real estate. If liquid assets are substantial and the collectibility of other assets is uncertain, the receiver may be able to pay an interim distribution from available assets, with later payments coming from other assets, if and when liquidated.

Distribution of property in kind may be made at valuations set by agreement between the liquidator and the creditor and as approved by the receivership court. (See Section 802(C) of IRMA.)

A receiver may find that estate closure can be expedited by entering into a settlement with the guaranty funds on long tail liabilities, such as workers' compensation, that may remain open after the estate is otherwise resolved. The settlement should be negotiated with the involved guaranty funds and include a distribution for claim payments, as well as administrative expenses. The NCIGF can assist with coordination with the appropriate guaranty funds.

A. Unclaimed Funds

Often, small sums of money remain at the end of the distribution process, usually unpaid distributions (i.e., misdelivered or unclaimed checks). The receiver should not treat these assets as "found money." State law typically requires the receiver to retain unclaimed or unproved assets for a specified time, during which the assets should be deposited with an appropriate financial institution, and at the end of which the assets may escheat to the state. The receiver should consult the relevant receivership statute, escheat statutes, and legal counsel, particularly in regard to circumstances in which a state may be entitled to interest on funds held for escheat. The retention of escheated funds may also present challenges for closing the receivership. The receiver should consider the use of a trust for escheated funds on approved claims if the receiver is ready to close the receivership estate, but the required time period has not passed for the payment of escheated funds to states. Under the trust approach, the escheated funds are paid to the

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trust, the receivership is closed, and then the trustee (i.e., the commissioner or former receiver) of the trust pays the escheated funds to states permitted under applicable state law.

IRMA provides that any funds that are unclaimed after the final distribution should be placed in a segregated unclaimed funds account to be held by the commissioner for two years, or in the alternative, that such funds should be handled in accordance with state unclaimed property laws. (See Section 804 of IRMA.)

Receivers should also check the applicable state agency for escheated funds to see if there are unclaimed funds that are owed to the entity in receivership.

B. Surplus Assets

In rare cases, assets may remain after the principal amount of all non-equity claims have been paid "in full." In some states, payment in full means principal plus interest on all timely filed claims. In a few states, where assets remain after such claims have been paid in full, a second claim filing deadline may be set, and the foregoing process may begin anew, albeit on an abbreviated basis. The receiver should review the applicable law to determine how to proceed in such cases. It has been held that a receiver may request court approval for payment of statutory interest on allowed claims where receivership assets exceed the amount necessary to pay all claims in full. (See *Wenzel v. Holland-America Insurance Company*, 13 S.W.3d 643 [Mo. 2000].)

C. Equity Distributions

Finally, in the rarest of cases, shareholders, mutual insurer members, and other owners of an insurer are paid. The receiver should take care to ensure that the administrative expenses of the estate are paid before the final distribution is made and should retain an amount sufficient for common post-receivership expenses (e.g., record storage, etc.)

VII. SPECIAL ISSUES REGARDING CLAIMS

This section discusses special issues regarding particular claims, namely: 1) claims of the Federal Home Loan Bank (FHLB); 2) life and health claims; and 3) claims under large-deductible programs. As large-deductible programs involve both policy claims and the collection of amounts due under those policies, both subjects are covered in Section VII.C. of this chapter.

A. Federal Home Loan Bank claims

Insurance companies are increasingly likely to be members of, and have a borrowing relationship with, one of the 12 FHLBs (each, an "FHLBank"). The FHLBanks are federally chartered cooperatives under the Federal Home Loan Bank Act (FHLBank Act), regulated by the Federal Housing Finance Agency (FHFA), and their business practices are subject to the terms and limitations of the FHLBank Act and FHFA regulations. Although each FHLBank is a separate legal entity with its own geographical territory and its own specific policies, the FHLBanks share a common mission and have similar business models.[2]

An insurance company can only be a member of the FHLBank in the district where the insurer is domiciled or where it maintains its principal place of business as defined by FHFA regulations.

[2] For additional information regarding the mission and purpose of the FHLBanks, visit http://www.fhlbanks.com.

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If a newly appointed receiver finds that the delinquent insurer has a relationship with an FHLBank, they should promptly determine from the insurer's records:

- The amount owed to the FHLBank.
- The interest charged on that debt.
- The payment due dates.
- The collateralization of this debt, and whether and how it is over-collateralized.
- The amount of FHLBank stock held by the insurer.

Armed with this data, the receiver should establish goals for the program, including whether it is better to service the loan due to its low cost or to repay it, and whether reduction of overcollateralization or stock redemption would aid the receivership materially.

Once the goals are established, an initial friendly dialogue should be undertaken with the bank. In general, the bank's principal concern will be avoiding default. Overcollateralization will be important to the bank in service to this first goal. If the receiver can persuade the bank that some reduction in collateral will not unduly increase default risk for the bank, the bank may be more accommodating. While prepayment may create hedging issues for the bank, avoiding prepayment is generally a secondary goal, and the bank may show greater flexibility in permitting it. Similarly, stock redemption may be permitted more freely if the bank is in sound financial condition. For the dialogue to be productive for the receiver, they should first become generally informed about the bank's condition and management structure. It will be helpful for the receiver to remind the bank that no FHLBank has ever lost a penny due to an insurer insolvency, (as of this writing). The receiver should strive to induce the bank to treat resolution of the insurer's financial problems as a common public policy goal in which the bank should be interested at least for the preservation of harmonious relations between the FHLB system and insurance regulators.

The Exhibit 5-4 elaborates further on these topics.

B. LIFE/HEALTH CLAIMS

1. Overview

The processes for handling claims in life/health and P/C receiverships differ substantially due to the nature of the policies and the coverage provided by the guaranty associations. In a life/health receivership, coverage will continue for policies covered by the guaranty association to the extent provided by the state guaranty act, and a primary focus is dealing with these continuing obligations.

Role of Guaranty Associations and the National Organization of Life and Health Guaranty Associations

In a multistate life/health insolvency where guaranty associations across the country are triggered, the guaranty associations will—to the extent of their statutory limits—guarantee, assume, or reinsure policy obligations, and in turn will be subrogated to the policyholder claims against the estate. In these situations, the NOLHGA will play a key role in the coordination of policy and financial analysis, preparation of bid packages, analysis of bids, negotiation of assumption agreements, and policyholder notification. For a description of how the NOLHGA operates, see Chapter 6—Guaranty Associations.

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Other possible issues relevant to life insurance company insolvencies include notice for and court approval of assumption agreements, opt outs (by policyholders and guaranty associations), closings for transfers of obligations, early access distributions, and guaranty association coverage limits.

2. Annuities

In the insolvency of an annuity insurer, special consideration should be given to any single premium immediate annuities that were issued to form the basis of funding of periodic or lump sum payments in personal injury settlements, commonly known as structured settlement annuities.

These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS tax codes (primarily 104(a)(2)) and various Revenue Rulings in order to preserve the tax benefit to the beneficiary or payee. However, some older annuities (prior to 1986), although not issued to a QA company, may nonetheless enjoy the same tax benefits. Generally, periodic payments are excludable from the recipient's gross income only if the payee is not the legal or constructive owner of the annuity and does not have the current economic benefit of the sum required to purchase the periodic payments.

When these blocks of business are resolved in the insolvency context (typically through assumption reinsurance), extreme care must be taken to ensure that the resolution does not compromise the tax benefits to the payees. It is strongly recommended that competent and experienced tax counsel be retained to guide the receiver through this potentially complicated process.

Structured settlement annuities are typically issued to fund the settlement of underlying tort actions, and the amounts of these annuities tend to be fairly large, reflective of the seriousness of the injuries sustained by the beneficiaries. The nature of these policies should be taken into consideration when determining the appropriate notice to these beneficiaries.

3. Non-covered Claims

State life and health guaranty acts provide for the continuations of certain policies covered by the guaranty association. The liquidator should determine how any portion of the policy that is not covered by the guaranty association and any non-covered claims should be handled under the state's receivership act and case law.

C. BEST PRACTICES FOR SUCCESSFUL BILLING AND COLLECTION OF LARGE-DEDUCTIBLE PROGRAMS IN LIQUIDATION

1. Overview

A large-deductible workers' compensation policy or program is a method of insuring workers' compensation risk with the employer assuming some of that risk in a deductible of $100,000, $250,000, or even higher per claim and an insurer taking on the remaining risk. Large-deductible programs for workers' compensation can be complex arrangements and depend on the employer's fulfillment of its obligation to reimburse all claims within the deductible. If the employer is unable to fulfill that obligation, the financial consequences to the employer could be catastrophic, and the employer's inability to pay could have a cascading impact on the financial health of the insurer. In order to manage this risk successfully, insurers and state insurance regulators must have a clear understanding of the nature and size of the insurer's exposure. Additionally, they must ensure that there are adequate measures in place to limit and mitigate the risk of the employer's failure to pay and ensure injured workers will receive benefits in compliance with state law.

Professional employer organizations (PEOs) often operate workers' compensation programs that are backed by large-deductible policies. A PEO is an outsourcing firm that provides services to small and

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medium-sized businesses under a contractual co-employment agreement with its clientele. Where permitted by state law, these services generally include workers' compensation coverage obtained by the PEO in its own name. If the PEO assumes most of the risk of that program by purchasing a large-deductible policy, it recovers the estimated cost through the fees it charges its clients. If those fees are inadequate to cover the actual costs of the claims, or the PEO fails for any other reason to reimburse its share of the claims, the insurer incurs an unexpected liability. The failure of the claim reimbursement mechanism has been a significant factor in a number of insurer insolvencies. For further information and guidance on high-deductible workers' compensation insurance and PEOs, refer to the NAIC's *2016 Workers' Compensation Large-Deductible Study*.

2. Administration of Large-Deductible Plans

The administration of large-deductible plans is affected by entry of an order of liquidation. In such cases, there are three versions of applicable model legislation for states to consider. The most recent is Guideline #1980. The three model alternatives are as follows:

- Section 712—Administration of Loss Reimbursement Policies of IRMA.
- Guideline #1980.
- The NCIGF Model.

Each of these three alternatives provide statutory guidance that articulates the respective rights and responsibilities of the various parties, greatly enhancing the ability to manage complex large-deductible programs post-liquidation. Generally, all approaches provide for the collection of large-deductible reimbursements from policyholders, clarify entitlement to reimbursement, and ensure that the claimants are paid. The most significant difference is the approach taken to address the ultimate ownership of and entitlement to the deductible recoveries paid by the employer or drawn from collateral as between the estate and the guaranty fund, and collateral as between the estate and the guaranty fund. Section 712 of IRMA generally treats these funds as general assets of the estate, while Guideline #1980 and the NCIGF Model apply them directly to the payment of claims. It should be noted that the NCIGF Model has evolved over time based on additional experiences from insolvencies, and the NCIGF continues to modify its model as warranted; as a result, states that have based their laws on the NCIGF Model have done so with varying language.

3. Communication and Reporting Between the Liquidator, Policyholders, and Guaranty Associations, Including Administration of Self-Funded Policyholder Programs

    a. 1. Claim Payment, Reserve, and Reimbursement Reporting

The administration of large-deductible programs requires strong communication and reporting programs between the liquidator, guaranty associations, and policyholders. Under all three model alternatives, the liquidator is required to administer large-deductible programs and related collateral securing large-deductible obligations, consistent with the policyholder's policy provisions and large-deductible agreement (LDA), except where those provisions conflict with the statute. All three model alternatives make provision for two types of LDAs: 1) those that permit direct payment by the policyholder; and 2) those that require initial payment by the insurer or guaranty association with reimbursement by the policyholder. Both arrangements necessitate the reporting of claim payments and outstanding claim reserves to the liquidator for billing, guaranty association reimbursement, and establishing collateral need requirements. The liquidator's Uniform Data Standard (UDS) should be deployed as the reporting protocol for guaranty association claim payments and outstanding claim reserves. Policyholders that continue self-payment under their LDA will need to continue or establish a claim information reporting protocol with the liquidator through the policyholder's third-party claim administrator or through a proprietary claim information aggregator. All three model alternatives require the liquidator to form an independent opinion on outstanding claim reserves reported by policyholders and

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guaranty associations, including an allowance for adverse development and IBNR liability to ensure that collateral remains adequate throughout the administration of the program.

b. Agreements Between the Liquidator and Guaranty Associations

An agreement between the liquidator and the guaranty funds may be advisable, though it is less important in states that have enacted one of the three model alternatives or other comprehensive statutory framework for the liquidator's administration of large-deductible programs. The model alternatives can serve as an outline for the issues that should be addressed in such an agreement in states that have not enacted pertinent legislation. Among other things, an agreement should address: 1) whether large-deductible recoveries are estate assets subject to the liquidator's distribution regime or directly pass through to the guaranty association on account of its prior claim payments; 2) claim reporting protocols; 3) frequency of collateral review and reimbursement activity; and 4) administration of collateral for under collateralized non-performing policyholder accounts.

c. Converting Policyholder Accounts From an Incurred to Paid Basis Under the Model Act.

Generally, LDAs are on a paid basis with collateral for the reserves. However, liquidators may encounter contractual arrangements where an LDA is constructed such that policyholders pay periodic large upfront payments that were accounted as premium based on losses incurred, as opposed to paid basis. After a certain number of years, the LDA provides policyholders with an opportunity to elect paid basis rather than incurred basis, which converts the incurred payments to collateral. The liquidator may wish to negotiate a conversion at the outset of liquidation. Conversion of a policyholder's LDA at liquidation from an incurred to a paid basis is beneficial to policyholders in several ways. Most importantly, conversion at liquidation treats pre-liquidation incurred loss payments made by the policyholder to the insurer as collateral and, thus, property of the policyholder pledged to the insurer and restricted to the satisfaction of that policyholder's claims, rather than as a general asset of the liquidation estate. Conversion also offers flexibility to a policyholder as to the type of security provided to an insurer in satisfaction of the collateral requirement. Conversion affords policyholders the ability to use an LOC to secure an insurer for the outstanding portion of their loss, rather than payment of cash, since the outstanding bill after conversion is reflected in the liquidator's collateral need analysis, rather than an incurred loss billing.

The liquidator should consider notifying large-deductible policyholders of these important policyholder rights at the inception of a liquidation proceeding and offer policyholders the opportunity to elect to convert their large-deductible programs from an incurred to paid basis memorializing any elections with an endorsement that otherwise follows and requires the policyholder to adhere to the provisions of applicable law.

d. Large-Deductible Billing by the Liquidator

The liquidator should establish a large-deductible billing and collection program that bills policyholders on a periodic basis (e.g., quarterly). The liquidator's invoice to policyholders should communicate a claim payment summary that includes detail such as the insurer or guaranty association's check number, date of payment, payee, account year, and remaining large-deductible limits. Large-deductible programs that are paid directly by policyholders should also report their claim payments to the liquidator on a similar periodic basis so that the liquidator can establish appropriate claim reserves, track the exhaustion of the policyholder's deductible limits, report to reinsurers, and collect reinsurance. Consideration should be given to using one of many proprietary billing and collection software programs to automate the large-deductible billing and collection process. Large-deductible recoveries that are subject to guaranty association reimbursements should be aggregated and distributed on a quarterly or other periodic basis that balances the liquidator's accounting requirements and the guaranty associations' reimbursement needs.

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e. Annual Collateral Review by the Liquidator

Guideline #1980 and the NCIGF Model require the liquidator to perform a periodic collateral review for each policyholder account. Consistent with the typical LDA, this review should be performed annually to ensure that the liquidator holds adequate collateral to support a policyholder's large-deductible obligations and to release any excess collateral held back to the policyholder. This review should include: a report to the policyholder on total incurred claims; claims paid; outstanding reserves, including an appropriate allowance for adverse development and claims IBNR; any additional safety factor; and total collateral need. The liquidator's collateral review should result in a report to the policyholder and an invoice for additional collateral need or a release and distribution of excess collateral. The liquidator should consider whether any additional safety factor should be included for nonperforming policyholder accounts. Guideline #1980 provides flexibility on the timing of the annual review, enabling the liquidator to perform the annual review process throughout the calendar year so that all policyholder account reviews are not due at the same time.

4. Administration Fees

Section 712(G) of IRMA provides:

The receiver is entitled to recover through billings to the insured or from large deductible policy collateral all reasonable expenses that the receiver or guaranty associations incur in fulfilling their responsibilities under this section. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants.

Further, Section 712(F) provides, in part:

The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at any priority; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

Several states have adopted statutory provisions similar to the provisions regarding handling of large deductibles in an insolvency and provide for the receiver to retain reasonable actual expenses incurred from the reimbursement to the guaranty association(s). Similarly, statutes may provide for the guaranty association to net expenses incurred in collecting a reimbursement.

Subsection (F) of Guideline #1980 provides:

a. The receiver is entitled to recover through billings to the insured or from collateral all reasonable expenses that the receiver incurred in fulfilling its collection obligations under this section. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants or guaranty associations.

b. To the extent the receiver cannot collect such expenses pursuant to paragraph (1), the receiver is 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.

c. To the extent such amounts are not available from reimbursements or collateral, the receiver, or guaranty associations if provided under an agreement with the receiver under Subsection D(5), shall have a claim against the estate as provided pursuant to [insert state priority of claim statute].

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When there is no statutory guidance, receivers should include a provision for reimbursement of reasonable actual expenses in an agreement with the guaranty associations regarding the collection and allocation of large deductibles.

5. Policy and Collateral Definitions

It is important that state laws define large-deductible workers' compensation policies and large-deductible collateral. Defining the treatment of such policies and associated collateral is imperative for developing polices and processes for administering the collection of assets. The following definition is taken from Guideline #1980. The definitions in the other model acts are similar. However, the term used in IRMA is "loss reimbursement policy."

"Large-deductible policy" means any combination of one or more workers' compensation policies and endorsements, and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:

a. Pay directly the initial portion of any claim covered under the policy up to a specified dollar amount, which the insurer would otherwise be obligated to pay, or the expenses related to any claim.

b. Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term "large-deductible policy" also includes policies that contain an aggregate limit on the insured's liability for all deductible claims, a per claim deductible limit, or both. The primary purpose and distinguishing characteristic of a large-deductible policy is the shifting of a portion of the ultimate financial responsibility under the large-deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer, and the insurer remains liable to claimants in the event the insured fails to fulfill its payment or reimbursement obligations.

The dollar amount of "large" will vary by state law. While many states might associate a minimum financial threshold, it is more important to consider the administration of the policy compared to a traditional policy. Deductible amounts can include: claim-related payments by the insurer for medical and indemnity benefits; allocated LAEs, such as medical case management expenses; legal defense fees; and independent medical exam expenses. It is critical that the policy specify the claim-related payments that are the responsibility of the policyholder and not be inside agreements or other agreements outside of the policy.

Collateral held by the insurer should be defined as amounts held as security for the insured's obligations under the large-deductible policy. The policy should specify acceptable financial instruments that can be held for the large-deductible policy. Typical collateral requirements include: cash, LOCs, surety bonds, or other liquid financial means held for the benefit of the insurer.

Guideline #1980 defines "large-deductible collateral" to mean "any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay to the insurer as may be required for other secured obligations."

6. Responsible Party for Collection of Large Deductible Reimbursements

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It is critical to immediately establish the party responsible for billing and collecting large-deductible payments or reimbursements. While some states might have specific statutory language that specifies the entity responsible, some statutes might be silent. In the case where the statutes do not specify responsibility, it is recommended that the receivers and guaranty associations enter into an agreement that allows for the most efficient administration of the large-deductible collections.

Specific consideration should be given to large-deductible policies that provide coverage in multiple states and have claimants subject to the jurisdiction of multiple guaranty funds. If feasible, the most efficient approach for such policies would likely be for the receiver to administer the deductible billing and collection process. Throughout the life of the estate, claimants continue to incur benefit payments and expenses, and deductible collection efforts may last beyond the life of the estate. The party responsible for collections needs the ability to compromise and settle the future obligations.

The receiver should make provisions in its discharge motion and court order, to the extent possible, regarding the transition of ongoing deductible collections to the guaranty association, as well as the disposition of any collateral being held by the receiver.

7. Treatment of Collateral in Receivership

When collateral has been posted by or on behalf of a large-deductible policyholder, what does the receivership estate actually own? The answer is generally found in the documents pledging the collateral to the insurer.

IRMA defines "property of the estate" to include "all right, title and interest in property includ[ing] choses in action, contract rights, and any other interest recognized under the laws of this state."[3] In states without an explicit statutory definition, the common-law definition is substantially similar.

This means that the insurer's right to draw on the collateral automatically becomes an asset of the receivership estate, but the collateral itself is not an estate asset unless and until it is drawn. In the first instance, the conditions and procedures for drawing the collateral should be spelled out in the relevant contract documents, which could include third-party instruments, such as LOCs or surety bonds, but state law could provide additional rights[4] and will specify what the receiver may do when the documents are silent, incomplete, or missing.

Possession and control over the collateral are distinct from ownership. The insurer could already be in possession of the collateral before the receivership, or the receiver might act to take possession by enforcing applicable contract rights or by negotiating an agreement. Nevertheless, this does not immediately give the receiver the right to use the collateral to pay claims. The defining characteristic of collateral is that it is intended to serve as a backstop in case the policyholder does not meet its obligations to pay all reimbursements promptly and in full. Commonly, the right to draw on collateral only attaches after the policyholder has defaulted or has consented to a draw, or, if the collateral is an LOC, after the issuer has given notice of nonrenewal, in which case, the receiver must act promptly to call the LOC or obtain replacement collateral). There could also be the opportunity to negotiate an agreement under which the policyholder turns over the collateral and makes a lump-sum payment to commute any further reimbursement obligations, or the collateral might have been structured from the outset as a "working" loss fund from which the insurer was expected to pay claims in the ordinary course of business.

In any case, while it is essential for the receiver to preserve and exercise the right to access the collateral as needed, it is also essential to ensure that collateral is not dissipated to pay claims that the

[3] Section 104(V)(1) of IRMA.
[4] For example, Section 712(D) of IRMA specifically provides that the relevant provisions of the policy are not controlling "where the loss reimbursement policy conflicts with this section."

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policyholder should be funding. Special consideration needs to be given in situations where the policyholder is at risk of being or becoming judgment-proof, or where rights to the collateral are shared with other creditors of the policyholder and prompt action is necessary to preserve the receiver's priority.

When the guaranty association is paying the claims, it is generally entitled to receive the proceeds of any policyholder reimbursements, including draws on the collateral. Under laws substantially similar to IRMA, these payments are considered early access distributions, but without the necessity for court approval, which may be subject to subsequent clawback, while Guideline #1980 and the NCIGF Model treat them as the ultimate source of funding for the underlying claims, so that they belong unconditionally to the guaranty association.[5] Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral,[6] unless there is a formal written agreement assigning that right to the guaranty association.

Finally, there is always the hope that the policyholder's reimbursement obligations will be oversecured or will become oversecured as claims are run off. In that case, any excess collateral will revert to the policyholder or the policyholder's guarantor. State law might expressly provide a process for determining when excess collateral is being held by or on behalf of the receiver,[7] or the ability to return collateral before the estate is closed might be part of the general powers of the receiver. However, because workers' compensation is a long-tail exposure with significant risk of adverse reserve development, receivers must take great care not to make premature or excessive return distributions.

8. Issues Raised by Net Worth Exclusions and Deductible Exclusions

Unlike other lines of insurance, workers' compensation insurance is generally exempt from the statutory caps on guaranty association coverage so that the guaranty fund is usually obligated to pay workers' compensation claims in full. However, individual states may have adopted caps on guaranty association coverage.[8] States have created this exception to honor their state's promise that injured workers will be paid the full benefits to which they are entitled. The general purpose of these exclusions is to avoid any obligation for the guaranty association to pay losses that can and should be borne by the policyholder. Net worth exclusions make guaranty association protection unavailable to policyholders with net worth above a specified threshold, while deductible exclusions expressly prohibit guaranty association coverage for amounts within a policy deductible.

Unless these exclusions are drafted and implemented carefully, there is a risk that they could result in delays in claims payments or even a complete loss of coverage. In some states, claimants might be protected by an uninsured employer fund, but that is not the purpose of those funds, so even if such a fund exists in your state, it should be a priority to ensure that however it is done, the estate, employer, or guaranty association will provide for payment in full of all benefits due under the state's workers' compensation laws. If this is not possible under current law, regulators should advocate for a change in the law. A variety of successful approaches are available; there is not a single one-size-fits-all solution that is best for every state.

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[5] Compare Section 712(C)(3) of IRMA with Section C of Guideline #1980 and Section 712(C) of the NCIGF Model.
[6] See Section (E)(3) of Guideline #1980 and Section 712(E)(3) of the NCIGF Model.
.
[7] See, e.g., Section (E)(4) of Guideline #1980 and Section 712(E)(5) of the NCIGF Model.
[8] See Section 8(A)(1)(a)(i) of the *Property and Casualty Insurance Guaranty Association Model Act*. Almost all states have some provision requiring payment in full of workers' compensation claims, but some states might have caps or other limitations on coverage.

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9. Net Worth Exclusions

The *Property and Casualty Insurance Guaranty Association Model Act* (#540) contains an optional section with a variety of alternative provisions states can select, excluding coverage for high-net-worth insureds, whether they are individuals or business entities.[9] The base version sets the threshold at $50 million, while one of the alternatives sets the threshold at $25 million. Many states have enacted some version of this clause or some comparable net worth exclusion.

The impact on workers' compensation coverage depends on how the exclusion is structured. In states with provisions substantially similar to any of the three alternatives under the Model #540, coverage is excluded completely for first-party claims by high-net-worth insureds, but workers' compensation claims against high-net-worth policyholders are administered by the guaranty association on a "pay-and-recover" basis; that is, the guaranty association has the obligation to pay the claim in the first instance and the right to be reimbursed by the policyholder.[10] Thus, claimants are fully protected, and for large-deductible policies, this mirrors the structure of the policy for claims within the deductible. In states with guaranty association laws similar to Guideline #1980 or the NCIGF Model, this is the same reimbursement right the guaranty association would have as the insurer's successor in the absence of the exclusion.

If the policyholder is cooperative, the guaranty association has the option of negotiating an agreement where the policyholder advances funding for claims within the deductible. However, if the policyholder is not cooperative, guaranty associations have expressed concern that the pay-and-recover framework is burdensome and gives the policyholder too much leverage to avoid or delay paying its obligations in full. If Model #540's Alternative 2 is modified to treat workers' compensation claims the same as other third-party claims, then the guaranty association has no obligation unless the formerly high-net-worth policyholder has become insolvent.[11] Otherwise, the claimant's only recourse is against the policyholder or the insured's estate. As stated above, the injured worker should be protected by some means in these cases.

When a guaranty association net worth exclusion and a large deductible both come in to play on the same claim, it is imperative that the receiver and guaranty association stay in close communication in order to avoid any confusion regarding which entity is responsible for the collection. In Section 712 of IRMA, Guideline #1980, and the NCIGF Model, the guaranty fund is entitled to collect net worth reimbursements. Coordination of these collections with receiver efforts to collect on high deductible will do much to avoid duplication of billings and potential resulting collection delays.

10. Deductible Exclusions

Model #540 does not contain any explicit deductible exclusion. Instead, it simply provides that: "In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises."[12] However, some states have enacted explicit language further clarifying that there is no guaranty association coverage

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[9] Section 13 of Model #540.

[10] Alternative 1 applies the pay-and-recover obligation to all third-party claims. Alternative 2 excludes most third-party claims as well as all first-party claims, but requires the guaranty association to pay workers' compensation claims, statutory automobile insurance claims, and other claims for ongoing medical payments. Alternative 3 excludes only first-party claims and claims by out-of-state claimants that are subject to a net worth exclusion in the claimant's home state. This alternative does not create any statutory right of recovery when the guaranty association is obligated to pay a third-party claim.

[11] Section 13(B)(2) Alternative 2 of Model #540.

[12] Section 8(A)(1)(b) of Model #540. Compare Section 3(B)(2)(a) of the *Life and Health Insurance Guaranty Association Model Act* (#520), expressly excluding from life and health guaranty association coverage: "A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner."

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for amounts within a policy's deductible or self-insured retention.[13] For example, Minnesota law excludes "any claims under a policy written by an insolvent insurer with a deductible or self-insured retention of $300,000 or more, nor that portion of a claim that is within an insured's deductible or self-insured retention" from coverage by the P/C guaranty association.[14]

A Minnesota employer entered into an employee leasing arrangement with a PEO, which obtained a workers' compensation policy with a $1 million deductible. Both the PEO and the insurer became insolvent, and the Minnesota Court of Appeals held that there was no guaranty association coverage for workers' compensation claims against the client employer because of the statutory deductible exclusion.[15] The court observed that the legislature deliberately chose to protect the guaranty association from unlimited exposure, without mentioning that the legislature also deliberately created an exception making the cap on coverage inapplicable to workers' compensation claims, which strongly suggests that the statute in question, which is tied to the statutory $300,000 cap on coverage, was not written with workers' compensation in mind.[16] Likewise, the court took for granted that the statute's undefined term "deductible" included the contract provision at issue in the case, even though the insurer had assumed the unconditional liability to pay all claims in full. The opinion did not consider the possibility that the legislature's intent was simply to clarify that the guaranty association has no obligation to drop down and pay claims from the first dollar if the insurer would have had no obligation to pay those claims.

Therefore, if states determine that there is a need to include express provisions addressing deductibles and self-insured retentions in their guaranty association laws, it is essential to avoid unintended consequences. In particular, the key terms should not be left undefined. For this reason, IRMA coined the term "loss reimbursement policy" in its section addressing these types of policies to distinguish them from true deductibles, where the insurer has no obligation to pay anything except the portion of the loss that exceeds the deductible.[17]

This is the crucial difference between a large-deductible workers' compensation policy and an excess policy. Although large-deductible policies transfer a significant amount of risk back to the policyholder, they do not extinguish the insurer's liability. That is why large-deductible policies, in states that allow them, are accepted as a mechanism for satisfying the policyholder's compulsory coverage obligations, while excess policies generally are not. Usually, excess workers' compensation policies may only be issued to self-insurers that have been approved by the state. It is the approved self-insurance program, not the excess policy, that satisfies the employer's compulsory coverage obligation, and the insurer has no liability for any portion of a claim that falls within the employer's self-insured retention.[18] Thus, despite the terminology that is commonly used, it is the excess policy, not the large-deductible policy, that functions as a "deductible" in the traditional sense of the term.

It is worth noting, however, that commercial self-insured retention and large-deductible policies can vary widely in policy terms and sometimes "side agreements" supplement the policies. Arrangements can contain aggregate limits, can vary on the obligation for defense cost and expenses, and, in some

[13] Currently, the only states with language specifically excluding claims within policy "deductibles" are Iowa, Louisiana, Minnesota, Missouri, and Nevada. Louisiana's exclusion applies only to policies issued to group self-insurance funds, and Missouri's does not apply to workers' compensation claims.
[14] Minn. Stat. § 60C.09(2)(4).
[15] *Terminal Transport v. Minnesota Ins. Guar. Ass'n,* 862 N.W.2d 487 (Minn. App. 2015), *review denied* June 30, 2015.
[16] Minn. Stat. § 60C.09(3).
[17] For example, if a consumer has an auto policy with a collision deductible of $1,000, and the repair costs $5,000, the insurer's liability is limited to $4,000. "Self-insured retentions" (SIRs) in commercial excess policies are designed to function the same way on a larger scale. If a business is found liable (or a third-party claim is settled) for $500,000, and its liability policy has an SIR of $300,000, the insurer is never responsible for more than the remaining $200,000, even if the policyholder is bankrupt.
[18] In many states, a separate self-insurance guaranty fund protects claimants if a self-insured employer becomes insolvent. Those funds typically operate entirely under the state's workers' compensation laws, not the state's insurance receivership or insurance guaranty fund laws.

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cases, permit the insured to "self-fund" its claims with an account in the possession of the TPA that is handling the claims. Because of these complexities, policy terms and any related endorsements and side agreements should be carefully reviewed. Whether such side agreements are legally enforceable requires a thorough case-by-case analysis in light of applicable state laws.

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I. INTRODUCTION

This chapter provides an overview of the operation of state Property and Casualty Insurance Guaranty Funds and the Life and Health Insurance Guaranty Associations and their relationship to a receivership. All 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands[1] have a guaranty mechanism[2] in place for the payment of covered claims arising from the insolvency of insurers licensed in their state. In the case of life/health insurance, the guaranty mechanism also provides for the continuation of eligible contracts that would otherwise terminate because of the insolvency. Before the creation of guaranty association systems, a typical claimant might wait years for payment of a claim and then receive only a small percentage of what was due under the policy or contract. Guaranty associations, subject to statutory limitations, alleviate these problems. Section II of this chapter will discuss in greater detail the operation of property/casualty guaranty funds. Section III is devoted entirely to life/health guaranty associations.

Insurance guaranty mechanisms obtain the funds necessary to pay claims from remaining estate assets, in some cases from statutory deposits collected by states and by assessing member insurers. Assessments are limited by state law to a certain percentage of the members' written premium. In the case of property casualty guaranty funds, the members may be permitted by statute to recoup the assessments through premium increases, premium tax offsets or policy surcharges. As for the life/health guaranty associations, recoupment of assessments through premium increases or policy surcharges is typically not feasible because many life/health contracts are issued on a level premium basis.[3] The burden of the assessments on solvent insurers is mitigated in the majority of states, by statutes that allow insurers to offset a portion of the insurer's assessments, over a period of years, against the insurer's premium tax liability. Section 13 of the NAIC's *Life and Health Insurance Guaranty Association Model Act* (#520) (Life Model Act), some version of which has been adopted in most states, permits offsets against premium, franchise or income taxes over a five-year period for amounts paid by life/health insurers to meet their assessment obligations. In addition, Section 9G of the Life Model Act allows life/health insurers to consider the amount reasonably necessary to meet their assessment obligations in the determination of the premiums they charge.

Guaranty associations, both life/health and property/casualty, in most states are overseen by a board of directors, largely composed of representatives of member insurers. Some guaranty association boards also include public members. A minority of guaranty associations also have representatives of state departments of insurance or legislative representatives sitting on the guaranty association's board. The guaranty associations typically employ a Manager, Administrator or Executive Director to oversee daily operations.

Before a claim against an insolvent insurer can be considered a "covered claim" and eligible for guaranty association coverage, the guaranty association must be "triggered" with respect to the particular insolvency. Guaranty associations generally are triggered by the issuance of a court order of liquidation with a finding of insolvency. Some guaranty associations may be triggered under other circumstances. In the event of a multi-state insolvency, it is important that the receiver communicate and coordinate with National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), or National Conference of Insurance Guaranty Funds (NCIGF) as appropriate. Before preparing an order of rehabilitation or liquidation. This will ensure that guaranty associations are triggered as intended and are not triggered prematurely or inadvertently. NOLHGA and NCIGF have the ability to help with coordination and communication to affected GAs.

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[1] U.S. Virgin Islands has one guaranty fund that covers life/health and property/casualty. Oct. 6, 2019, Act No. 8211 was signed into law, and amended 22 V.I.C. § 232 (Scope) to provide that this "chapter shall apply to all kinds of direct insurance, except title, surety, credit, mortgage guaranty and ocean marine insurance."

[2] The term "guaranty fund" typically refers to a property and casualty insurance guaranty fund. The term "guaranty association" typically refers to a life and health insurance guaranty association. However, in various places throughout this handbook, the terms "guaranty fund" and "guaranty association" are often used synonymously, particularly when referring to both types of guaranty mechanisms. Efforts have been made in this chapter to specify property and casualty or life and health when referring specifically to one or the other type of guaranty mechanism or insurer insolvency proceeding.

[3] A few states do permit policy surcharges to recoup assessments for health insurance insolvencies.

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The guaranty associations and the receiver both have statutory duties to protect policyholders of the insolvent insurer. The duties of the guaranty associations to protect policyholders are limited to covered policies or claims, as set forth in state guaranty association statutes. The guaranty associations can be very helpful, if not critical, to the receivership process. In a life/health insolvency, for example, the guaranty associations may, in some cases, be able to arrange for and facilitate transfer of covered obligations to a solvent insurer upon entry of an order for liquidation with a finding of insolvency, provided there has been sufficient pre-liquidation planning and coordination.[4] Maintaining open communication and cooperation between the guaranty associations and the receiver, subject to appropriate confidentiality agreements, during pre-receivership planning and throughout the course of the proceedings will enable both the guaranty associations and the receiver to function more efficiently for the benefit of those whose interests they are obligated to serve.

II. PROPERTY AND CASUALTY GUARANTY FUNDS

A. Introduction

Most property/casualty guaranty fund enabling acts are based on the NAIC *Property and Liability Insurance Guaranty Association Model Act* (540) (P/C Model Act). Although the P/C Model Act is useful for a better understanding of how guaranty funds operate, the law in each state should be consulted, as most states have modified provisions of the P/C Model Act.

The property and casualty guaranty funds have formed an organization known as the National Conference of Insurance Guaranty Funds (NCIGF). Its address is:

National Conference of Insurance Guaranty Funds
300 North Meridian Street
Suite 1020
Indianapolis, IN 46204
Phone: (317) 464-8199
Facsimile: (317) 464-8180
Web site: http://www.ncigf.org

NCIGF can be a useful source of information to receivers when a new property/casualty insolvency occurs. It can help disseminate information to triggered guaranty funds, schedule initial meetings between the receiver and guaranty funds, and establish a coordinating committee to work with the receiver to resolve issues that may arise during the receivership. This organization can also provide names and addresses of guaranty fund contacts and assistance in establishing data reporting to and from the guaranty funds. The Secure Uniform Data Standards (SUDS) is managed by the NCIGF and has become the standard mechanism to transfer data in a secure manner. (See Chapter 2 for more information on UDS and SUDS.)

The NCIGF Web site (See at http://www.ncigf.org) has tables that summarize the key provisions contained in each state's property/casualty guaranty fund enabling act, including lines of insurance covered, whether coverage is provided for unearned premium, whether the guaranty fund has net worth limitations or a claims bar date and the per claim limit and deductible that applies to each claim. The tables are intended to provide a general summary of the guaranty fund laws. The applicable state statute should be reviewed to determine coverage for a specific claim.

[4] In some instances, it is possible to arrange for the transfer to close as of the effective date of the liquidation order.

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B. Triggering Fund Liability

See Chapter 1 Section II.G.4

1. General Statutory Activation Requirements

Previously, the P/C Model Act defined insolvent insurer as "(a) an insurer authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and (b) determined to be insolvent by a court of competent jurisdiction." Due to a variety of triggering related issues that could not be readily resolved by such a general, simplistic definition, amendments to the P/C Model Act expanded the definition of "insolvent insurer" to read as follows:

> "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued 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 amended language makes it clear that guaranty fund resources are only to be used in situations where any doubt pertaining to the insurer's insolvent status has been fully considered and resolved by a judicial proceeding. It must be noted, however, that there are a number of variations found within enacted guaranty fund statutes around the country. While many jurisdictions have either adopted or moved toward the current P/C Model Act triggering test, there are numerous others that fall at various points along the spectrum between the current version and the original 1969 version. It is imperative that the statutes be carefully reviewed in each jurisdiction where activation is anticipated.

2. Regulatory Status of Company

In addition to being declared insolvent, an insurer must have been "licensed," either at the time the policy was issued or when the loss occurred, to be eligible for guaranty fund coverage.[5]

New Jersey has a separate statutory mechanism for the payment of covered claims arising in connection with coverages issued by eligible surplus lines insurers. This mechanism exists in addition to the guaranty fund for insolvent licensed property and casualty insurers. Even in New Jersey, however, there is no statutory protection for ineligible surplus lines insurers.

The initial triggering inquiry must not be limited to whether the insurer in question was licensed at the time of the finding of insolvency.[6] Many, probably most, guaranty fund acts contain language that is sufficiently broad to include claims against an insurer whose license has been surrendered or revoked prior to the declaration of insolvency, so long as the insurer was licensed at the time the policy was issued or when the insured event occurred. When this situation arises, the receiver should contact the relevant guaranty fund as it will be most familiar with its enabling statute and local court decisions interpreting the statute.

3. Court of Competent Jurisdiction

The requirement of a finding of insolvency can only be satisfied by a judicial declaration. The rationale for this requirement is that activation triggers numerous consequences, many of which are irreversible

[5] In this context, "Licensed" means holding a Certificate of Authority, which authorizes an insurer to do business in a state. Such insurers are also referred to as "admitted insurers." Insurers doing business on a surplus lines or other non-admitted basis are not authorized.

[6] At the time of publication of this Handbook, the NAIC is considering "restructuring mechanisms" permitted under the laws of some states (i.e., insurance business transfers and corporate divisions). Whether claims of an assuming or resulting insurer in one of these transactions would be considered "covered claims" eligible for guaranty fund coverage in the event of its liquidation is a question of state law. NCIGF is working with the NAIC to address this issue and provide clarity going forward.

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once put in motion. Judicial review is perceived to be an effective safeguard against arbitrariness and ambiguity.

The current version of the P/C Model Act gives exclusive competent status to the court that is within the insurer's state of domicile. Although it is theoretically possible for a court in another jurisdiction to be viewed as competent for the purpose of triggering guaranty fund obligations, the P/C Model Act's current version does not confer jurisdiction on these courts.

4. Liquidation Order

Were a court of competent jurisdiction to issue a declaration of insolvency that is later modified or reversed on appeal, after guaranty funds have been triggered and claim payments have been initiated, problems can arise. To remedy such consequent dilemmas, both the P/C Model Act and many state legislatures have modified the triggering test, requiring that the judicial declaration of insolvency be final. In other words, activation of guaranty funds in such jurisdictions can be deferred, and perhaps avoided, depending upon the pursuit or exhaustion of stays or appellate remedies.

Nonetheless, although the P/C Model Act drafters clearly contemplated that activation of the guaranty funds would occur only where liquidation had been ordered, the wording of the initial triggering clause left open the possibility that companies placed in rehabilitation could trigger guaranty fund benefits. The more current view, which has also been incorporated in the P/C Model Act, is to require not only a final determination of insolvency, but rather an actual order of liquidation with a finding of insolvency. This limiting language precludes the use of guaranty fund resources as bail-out funds to be used in an attempt to rehabilitate—rather than liquidate—the company. There are a few guaranty funds, however, which still trigger with a finding of insolvency without an order of liquidation. Because of the complexity and variation from state to state of the trigger, it is important to seek legal assistance and to work with the NCIGF when drafting the orders of liquidation or rehabilitation to ensure the appropriate activation of the guaranty funds. (See the Laws and Laws Summaries under Resources on the NCIGF Web site at http://www.ncigf.org).

C. Scope of Coverage

Guaranty funds that have been properly triggered by a liquidation order are obligated to pay "covered claims," that is, claims that are defined as covered under the applicable guaranty fund act(s). Generally speaking, unpaid loss and unearned premium claims under specified property/casualty lines of business written by an insolvent insurer are covered claims, but only to the extent of the lesser of either (1) the applicable policy limits; or (2) the statutory guaranty fund limits on covered claim payments. Residency is usually determined at the time of the insured event. In addition, in order for claims to be covered, the various acts typically require that: the claim be incurred either prior to the entry of the liquidation order or within 30 days of the entry of the order, or before the policy expires or the insured replaces the policy if either of the latter occurs within 30 days of the entry of the liquidation order. Claims of an affiliate of the insolvent insurer typically are not covered, even if such claims otherwise meet the definition of covered claims.

Property/casualty lines of business usually not covered by a guaranty fund include: mortgage guaranty; financial guaranty; fidelity and surety; credit insurance; insurance of warranties or service contracts; title insurance; ocean marine insurance; and any insurance provided by or guaranteed by government. Only direct insurance (not reinsurance) is covered. The receiver should consult with the affected guaranty fund(s) to determine which lines are covered and which lines are excluded.

Usually, the guaranty fund of the state of the insured's residence has primary responsibility for a claim, and the guaranty fund of the state of the claimant's residence has secondary responsibility. One exception to this rule involves workers' compensation claims. The guaranty fund of the state of residence of the claimant has primary responsibility for these claims. With respect to claims involving property with a permanent location, the guaranty fund of the state where the property is located has primary responsibility. Guaranty funds are usually entitled to take credit for amounts paid by other guaranty funds on the same claim.

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Some guaranty fund statutes provide for a per claim deductible. A majority of guaranty association statutes provide that coverage is limited to $300,000 per covered claim, except for workers' compensation claims, which are covered to the extent of benefits provided by state law.

Most guaranty fund statutes require a claimant to first exhaust all other sources of recovery, including other insurance. The guaranty association's obligation is reduced by any amounts recovered from other sources.

The majority of the property casualty guaranty funds' enabling acts contain "net worth" limitations. These net worth limitations either exclude high net worth insureds, and in a few cases, third party claimants, from coverage in the first instance or permit the guaranty fund to recover from the high net worth insured amounts paid on their behalf.

Most of the guaranty funds' enabling acts also require the claim to be timely filed either with the liquidator or the guaranty association. Bar date restrictions vary from state to state and specific state law should be reviewed on this matter. See Section D (3) for more information regarding bar dates.

D. Notice and Proof of Claims

1. Notice

a. Notice to Claimants

Most state receivership statutes give the receiver the primary responsibility for issuing notice to all persons known or reasonably expected to have claims against the insolvent insurer. The guaranty funds have a secondary responsibility in this regard under the P/C Model Act. Because of the extensive interrelationship between the receiver and the guaranty funds regarding claims resolution, the receiver should coordinate the drafting of the receivership claims notice with the guaranty funds so that accurate information concerning the following is included:

- Brief general explanation of the guaranty fund system: the policyholder protection it offers, its anticipated role in the receivership and any delay that will be necessary while the receiver assembles and forwards the files to the guaranty funds.

- Receivership bar date and its legal significance: the fact that many guaranty funds will have no obligation regarding claims filed after the receivership bar date, recommendation to check with the appropriate guaranty fund immediately in order to ascertain whether the guaranty fund has a separate bar date in addition to the receivership bar date.

- Receivership proof of claim form: information, if available, about whether a separate guaranty fund proof of claim form may be required by certain participating guaranty funds; information concerning the address to which proof of claim forms must be sent.

- Clarification that questions regarding the claims determination process should be directed to the appropriate guaranty fund; include here any comments deemed necessary regarding the determination process for claims which are in excess of the statutory maximum coverage of the guaranty funds.

Insolvencies involving long-tail business present notice challenges to liquidators. Company records may not exist to provide addresses for occurrence-based policyholders that were in force from 5 to 25 years ago. Public policy considerations confront the receiver.

A supplemental notice may also be used in situations where additional relevant information becomes available after the first notice has been sent.

b. Notice to the Guaranty Funds

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The receiver must notify the guaranty funds that may become obligated as a result of the receivership as soon as possible. Even if such notice is not a statutory requirement, the receiver should notify all interested guaranty funds as a matter of courtesy. That notice should include a copy of the claimants' notice issued by the receiver, along with copies of the receivership order and any domiciliary injunction which has been entered. The regulator, receiver, and guaranty funds should coordinate and share information well before the liquidation order is rendered. See Section E below for more information in this regard.

2. Proof of Claim

   a. Claims Determination Framework

Nowhere is the interrelationship between the receiver and the guaranty associations more prominent than in the area of claims determination. This relationship is defined in the P/C Model Act that provides that the receiver shall be bound by settlements of covered claims by the guaranty funds. However, Section 703 A of the *Insurer Receivership Model Act* (#555, commonly known as "IRMA") and many state receivership statutes contain provisions that prohibit the receiver from accepting any claim for an amount in excess of or contrary to the terms of the policy.

There has been uncertainty between guaranty associations and receivers as to who determines whether a claim is covered under the policy terms. The receiver and the guaranty funds should discuss questionable coverage issues as they arise in order to prevent subsequent problems.

   b. Forms of Proof

The information to be contained in the proof of claim form is usually established under the receivership statutes in the insolvent insurer's state of domicile. However, some guaranty associations require that each claimant submits a separate proof of claim form, the contents of which will be dictated by the law and practice of the guaranty association's state. This is because statutes creating the guaranty funds contain a series of specific eligibility requirements and limitations on allowability, each of which may require additional information in order to establish the fund's obligation. For this reason, the receiver should coordinate with the guaranty fund prior to any notification to potential claimants regarding the proof of claim form.

   c. Protective Filings via Proof of Claim Forms

Many guaranty funds are not permitted to recognize general proofs of claim, intended as a protective filing for claims that are unknown to the insured at the time of filing, as sufficient notice. These guaranty funds require that specific claim information about known claims must be provided in the proof, including the date and other particulars relating to the insured event.

3. Late-Filed Claims

   a. Rationale

Most receivership statutes contain a provision that requires claims to be filed by the claims filing date established by the liquidation court. See IRMA Section 701. If a claim is filed after that date, it is usually not allowed or is subordinated to a lower distribution priority. In addition, many guaranty funds are not permitted to pay claims filed after the earlier of the claims filing date or a bar date established pursuant to the guaranty fund's enabling act.

The receiver may have the ability to allow policyholders to file "omnibus" or "policyholder protection" claims to meet the bar date requirements, but guaranty fund statutes may not allow coverage of such claims.

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b. Extensions

Once a receivership's bar date has been established, guaranty funds generally take the position that the receiver should not extend the bar date, as such an extension may result in guaranty fund coverage issues.

c. Excused Lateness

Some receivership statutes provide a procedure for allowance of late-filed claims which authorizes the receiver to allow such claims under certain circumstances. (See IRMA Section 701). The receiver should consider claimant requests on a case-by-case basis, through the specific mechanism established in the receivership statutes. The receiver should also consider giving notice to those guaranty funds that may be affected prior to allowing a late-filed claim in order to provide those guaranty funds the opportunity to address how allowance of the claim would impact them.

E. Claim Files Information

1. Information Needed by Guaranty Funds

The key to the successful handling of filed claims is cooperation between the receiver and the guaranty funds throughout the claim process. Receivers should keep in mind that the guaranty funds require reasonable access to those insurer's records which are necessary for them to carry out their statutory obligations.

Recent experience has shown that pre-liquidation coordination and information exchange are essential for the smooth transition of claims servicing responsibilities to the guaranty funds without disrupting ongoing benefit payments. Regulators, receivers and guaranty associations should coordinate and communicate, even if liquidation of the company is not a certainty. A "two-track" approach is recommended. While efforts continue to revitalize the company, the receiver and the guaranty funds should also be taking steps to ensure a smooth transition to liquidation if liquidation becomes necessary.

The receiver's cooperation in providing information and making files available to the guaranty funds is essential to minimize claim interruption. More specifically, the receiver should locate and forward to the involved guaranty funds the following information (See IRMA Section 405):

- A general description of the business written or assumed by the insurer
- Information concerning licensure of the insurer
- Claim counts and policy counts by state and line of business
- Claim and policy reserves
- Unpaid claims and amounts
- Sample policies and endorsements
- Listing of locations of claim files
- Listing of third party administrators, description of contractual arrangements and copies of pertinent executed contracts
- Listing of claims in litigation or dispute and assigned defense counsel
- Such other information as may be needed by the guaranty funds

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Please note, loss adjustment expenses incurred prior to the liquidation order are not covered by guaranty funds, and therefore, should not be sent to the guaranty funds for payment.

2. Claim Files

To facilitate the protection of policyholders and claimants; regulators, receivers and guaranty funds should coordinate transition of claim files well before the company is liquidated. The receiver should forward claim files as soon as possible to the appropriate guaranty funds. Some guaranty funds may require access to or copies of the filed proof of claims forms. Receivers and guaranty funds should consider entering into agreements as to ownership, return of files, auditing rights, inventory controls and reporting.

Most company claim records are held in electronic format. It is essential to address data conversion to Uniform Data Standards (UDS) well before the guaranty funds are triggered. (See Chapter 2 of this handbook.) If there are non-electronic claims records, UDS records will need to be prepared.

Priority should be given to identifying and forwarding all active workers' compensation files and all active files where major litigation or settlement is imminent.

Determination of which guaranty fund should be the recipient of a particular file will depend on a series of factors. Generally, the receiver should deliver the file to the guaranty fund of the insured's place of residence. However, if it is a first-party claim for damage to property with a permanent location, the receiver should deliver the file to the guaranty fund where the property is located. In most instances, if it is a worker's compensation claim, the receiver should deliver the file to the guaranty fund of the state with jurisdiction over the claim.

Claim files sometimes are delivered to the wrong guaranty fund. In this situation, the preferable course of action is for the guaranty fund that received the file to secure from the appropriate guaranty fund their concurrence. After that, either fund will ask the receiver to resend the UDS record to the appropriate guaranty fund or will notify the receiver if the receiver does not make the actual UDS records transfer. The receiver will let the parties know if it prefers the original fund to close the file or to report the transfer with UDS "C" record with transaction code "080". See the UDS Manual[1] for additional information. NCIGF can assist in cases where a high volume of files need to be transferred.

In multi-state insolvencies receivers and guaranty funds should work together on protocols for transmitting files to the appropriate guaranty fund.

F. Unearned Premium Claims

Although most guaranty funds cover unearned premium claims, some do not (see the NCIGF Web site at http://www.ncigf.org at the Guaranty Fund Laws tab for unearned premium coverage by state). For those states where unearned premium is covered, the receiver should prepare and disseminate the necessary calculations as soon as possible. This will allow guaranty funds to make timely refunds to enable the insureds to make arrangements for replacement coverage.

To make payments possible, guaranty funds will need the following information for each potential claimant: policy identification, insured name and address, policy periods and expiration dates, cancellation date, current payment status, and the amount of the unearned premium. If possible, this information should be provided by the receiver by UDS B Record. The initial B Record may not have the calculation but will advise of the "potential" claimants. A subsequent B Record would provide the calculation/audit. In addition, the receiver should forward to the guaranty funds a general explanation clearly showing how the unearned premium was calculated. The calculations should be on a pro rata basis rather than short-rated. The information should be as accurate as possible, given the state of the insurer's records, and should be accompanied by the receiver's initial evaluation of the information's reliability.

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The receiver should be prepared to provide a sampling of the insurer's records and the receiver's calculations to demonstrate the reliability of the unearned premium figures to guaranty funds. Where agents have advanced unearned premium to the insureds in exchange for valid legal assignments, the receiver and guaranty fund should coordinate their positions on acceptability.

It should be kept in mind that where the insured's return premium claim is based on a premium audit or retrospective rating plan, it may not be covered by some guaranty funds. Additionally, net worth limitations embodied in a number of guaranty fund acts may preclude payment of unearned premium claims to certain high net worth insureds.

Premium financing arrangements often create special problems for the affected guaranty funds in processing return premium claims. If the receiver has information concerning premium financing arrangements, the receiver should provide that information to the guaranty funds to facilitate payment of returned premium to the appropriate person or entity.

G. Claim Reporting

How guaranty funds report claims and expense payments, outstanding reserves and administrative expenses to a receiver is an item of concern in every insolvency. This reporting is not only important for the guaranty funds as a creditor, but it also assists the receiver in gathering what is usually the major asset in most receiverships—reinsurance recoverables.

The NAIC in December 1993, adopted the UDS to be used for the reporting of policy and claim information between guaranty funds and receivers. UDS was the result of a joint effort of a number of receivers and guaranty funds to facilitate (1) reporting between receivers and guaranty funds, and (2) reporting to reinsurers by the receiver. The use of UDS file formats to transmit information at the policy or claim level will provide both receivers and guaranty funds with needed information in a uniform, easily usable format. Currently, most guaranty funds and receiverships are able to send and receive information in the UDS format. The NAIC endorsed the use of UDS by receivers and guaranty funds effective March 31, 1995. Most insolvencies instituted prior to that date did not use UDS, nor did they later convert to UDS. It is very important to note that an Operations Manual exists and should be reviewed and used by receivers and guaranty funds for understanding UDS. Version 2 of the UDS was adopted by the NAIC for implementation on Jan. 1, 2005. Version 2 includes many improvements and revisions based upon the collective experience of receivers and guaranty funds with the original version over several years and insurer insolvencies. In 2006, the NAIC adopted the Standardized Financial Report (D Record) for addition to the Uniform Data Standards. A copy of the updated UDS Manual and file formats are at the NCIGF Web site at https://www.ncigf.org/resources/uds/.

It is important to remember that the earlier the receiver determines what information is needed, and communicates those needs to the guaranty funds, the better and more efficient the reporting process will be. UDS, through the implementation of several lettered record formats, has simplified the aforementioned receivers' requirements. The formats were designed by the UDS Technical Support Group (UDSTSD) a group comprised of members of the receiver and guaranty fund communities and approved by the NAIC.

As stated above, almost all claims data for the insolvent insurer will be in electronic format. Security concerns are paramount. The NCIGF addresses the security concerns with a system called the UDS Data Mapper. Using the Mapper, the receivers can map raw data to, or fully created UDS files to UDS record fields in a database. The Mapper will then create new UDS files to be placed in the guaranty associations' SUDS directories. This process has the dual benefit of ensuring UDS compliance and scrubbing the data of any unknown malicious code. This service is available at no charge to the receiver.

Recent estates with significant reinsurance recoveries have found it useful to also develop claims protocols setting out additional information that is needed for reinsurance recovery purposes and dealing with other matters such as new and reopened claims and closed files. Needed information often extends beyond that which can currently be provided by UDS data feeds. Some guaranty funds have agreed to give receivers

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limited, read-only access to their claims database. Assistance from the UDSTSG can also be found by submitting a help request to help@udstsg.org.

H. Claims Exceeding Guaranty Fund Limits and Aggregate Claims

1. Claims Exceeding Guaranty Fund Limits or Claims Excluded from Guaranty Fund Coverage

Under the P/C Model Act and state enabling acts, guaranty funds have per claim limits, or "caps," that can limit the guaranty fund's obligation to an amount less than the insolvent insurer's policy limits. For example, the amount paid in satisfaction of a covered claim (either non-workers' compensation or unearned premium) under the P/C Model Act may not exceed $500,000 per claimant, even if the actual policy limits are greater. The caps vary among the states and the receiver must review applicable state guaranty fund acts. Here, the interrelationship between the guaranty fund and the receiver becomes critical (i.e., both act to pay or determine claims made against the insolvent insurer arising under the same policy and are eventually allowed against the insolvent insurer's estate).

The guaranty fund has a claim against the insolvent insurer's assets for the amounts paid as indemnity and the expenses and costs of handling the claims it pays. Furthermore, anyone with a claim over the guaranty fund's cap, subject to a guaranty fund deductible or subject to a statutory net worth exclusion has a claim against the estate for that portion of the claim not covered by the guaranty fund. From this perspective, the role of the guaranty fund and the receiver are not easily distinguishable. The guaranty fund is concerned with determining and paying its covered claims obligations under its statute while the receiver is determining how much of the claim should be allowed as a claim in the receivership. As a result, whenever a covered claim is filed in excess of the cap, it gives rise to a situation where extra effort and cooperation between the guaranty fund and the receiver will be necessary.

It should be noted here that, in some states, the guaranty fund will not settle a claim without a complete release, which may require participation by the receiver prior to any settlement. In some cases, however, the guaranty fund may pay the claim up to its statutory limit, leaving the excess to be paid by the insured, who will then retain a claim against the estate for the excess amount. Where the insured is unwilling or unable to pay the excess, the claimant may have a direct claim against the estate for the unpaid amount. In either instance, there is a portion of the claim above the cap that is left unsatisfied by the guaranty fund's payment. After approval by the receiver, the "over-cap" claim, as other allowed claims, will be paid as part of a distribution, pursuant to the applicable priority statute.

There may be other situations where the guaranty fund and the receiver will both have an interest in handling a claim. For example, where a claim includes allegations of bad faith or seeks punitive damages, the claim would not be covered by the guaranty fund but may be a claim in the estate.

The successful handling of over-cap claims is dependent upon early communication between the guaranty fund and the receiver. To prevent, or at least minimize, potential conflicts between the guaranty fund and the receiver regarding the payment of over-cap claims, full disclosure, communication and cooperation between the guaranty fund, the insured and the receiver's claims department must begin as soon as it is determined that an over-cap claim may exist. Prior agreement with the receiver should be obtained, where possible, on the amount of the over-cap claim. The guaranty fund has no authority to settle the claim in excess of its limit, and without the consent of the receiver, the claimant or insured (if paid by the insured) is taking a risk that all or a portion of the over-cap claim may be denied by the receiver. In fact, arranging to have the over-cap claims allowed as a claim in the estate may provide the needed leverage to settle the claim.

Receivers and guaranty funds have found it useful to develop specific procedures for dealing with claims where the cap will be exceeded and including such procedures in the claim protocols described above.

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2. Aggregate Claims

Certain types of policies are often written on an aggregate basis. Aggregate policies may be in terms of a policy aggregate, a coverage aggregate, or both. In a policy aggregate, all claims are accumulated until the maximum limit of liability is reached. A coverage aggregate is one where claims against a specific coverage, such as products liability, are accumulated until the maximum coverage limit is reached. When an insurer is solvent, it monitors the erosion of all of its outstanding policies—in other words, the insurer keeps track of how much of a policy's aggregate limit is left as various claims under it are satisfied.

When an insurer is declared insolvent, and one or more guaranty funds begin to satisfy claims against such aggregate policies, problems can arise. The most obvious problem occurs when a guaranty fund paying claims under a policy is not aware that the policy has an aggregate limit. The receiver should take special care to advise the guaranty funds which policies are subject to an aggregate limit. The receiver should not assume the guaranty funds will discover this information on their own.

It is equally important that the receiver and the affected guaranty funds work together to monitor the erosion of aggregate limits. The receiver should advise the affected guaranty funds of claims that have been paid under the policy by the insurer before insolvency and track payments made by the guaranty funds after insolvency. Similarly, guaranty associations should not pay a claim under an aggregate policy prior to coordinating with the receiver. When the aggregate limits are close to being exhausted, the receiver should alert the guaranty funds and require that they obtain prior approval on any payment against such policy. (See IRMA Section 706 D).

The following example should help illustrate the problem. Assume that there is a products liability policy with an aggregate limit of $2,000,000. Assume further that there are 10 claimants filing claims under the policy with 10 separate guaranty funds. If each guaranty fund has a cap of $300,000, but is unaware of the other claims, then potentially, payments totaling $3 million could be made, thereby exceeding the aggregate limit. In this situation, regardless of the original extent of an individual guaranty fund's knowledge of a policy's aggregate nature, it cannot independently keep track of the policy's erosion. In situations like this, it is critical that the receiver monitor each guaranty fund's activity closely and keep all affected guaranty funds apprised of the situation as it develops.

When adequate safeguards are not in place, payments may be made in excess of a policy's aggregate limit and conflicts will arise between the receiver and the guaranty fund. Although the guaranty fund may have made the payment in good faith and within its statutory guidelines, the receiver may feel compelled to deny reimbursing the guaranty fund for that portion of the claim in excess of the aggregate limit. These problems are sometimes not discovered until long after the guaranty fund has settled all of its claims. To avoid such problems, the guaranty funds should not pay a claim covered by an aggregate policy without first consulting the receiver. State liquidation acts vary on the handling of estate distributions for amounts paid in excess of aggregate caps. These laws should be carefully reviewed in dealing with these matters. IRMA Section 706 D addresses policies with aggregate limits and provides that the liquidator may apportion the policy limits ratably among timely filed allowed claims or notify the insured, third party claimants and affected guaranty associations of the erosion of the aggregate limit.

In summary, upon taking control of the estate, it is recommended that the receiver institute the following procedures:

- Determine which policies have aggregate limits;
- Determine policy erosion and continue to monitor aggregate accumulations resulting from payments made by guaranty funds;

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- Advise guaranty funds of these policies and keep them apprised of any pre- and post-insolvency erosion;
- Require guaranty funds to determine how much of the aggregate limit remains available before making any settlements under these policies;
- As soon as it appears that the aggregate limit is about to be reached, notify the guaranty funds immediately that all future settlements should be cleared with the receiver;
- Require guaranty funds to immediately report to the receiver any paid or settled claims that affect aggregate limits; and
- Initiate a system that can earmark pending settlements. One of the benefits of the UDS is that it facilitates the tracking of policies subject to aggregate limits (See the Publications tab of the NCIGF Web site at http://www.ncigf.org).

I. Early Access

Most state receivership statutes contain a provision that requires the receiver to submit to the court a proposal to disburse general assets to guaranty funds. Such proposals are commonly referred to as "early access plans," and apply equally to life and health and to property and casualty insolvencies. The statutes typically contain provisions specific to both.

The purpose of an early access plan is to distribute funds from the estate to the guaranty funds as soon as possible and in the maximum amount possible in order to reduce the assessment burdens on member companies. Early access distributions are essential to the guaranty funds' continued ability to fulfill their statutory duties. (See IRMA Section 803.)

1. Timing

The standard early access provision requires that the receiver submit an early access plan within 120 days of entry of the liquidation order. IRMA requires that the receiver apply to the receivership court for approval to make early access distributions, or report that the receiver has determined that there are not sufficient distributable assets to make any distribution to the guaranty funds at that time, within 120 days of entry of the liquidation order, and at least annually thereafter. (See IRMA Section 803 B). In practice, in order for the receiver to make the calculations necessary to demonstrate to the court that there are insufficient assets at that time to make any distribution, receivers should formulate an early access plan and file the form of the plan within the 120-day period for approval by the court. This procedure will fulfill the receiver's statutory obligation for filing a plan and will ensure that a plan is in place to make distributions when assets become available.

2. Reserves

Most early access provisions in state receivership statutes require an early access plan to include, at a minimum, reserve amounts for the expenses of administration and the payment of the higher priority claims. (See also IRMA Section 803 A(2)). The reserve for expenses should take into account all administrative expenses anticipated to be incurred during the duration of the receivership proceeding. (See specific state statutes to determine if guaranty fund administrative expenses are Class I or Class II; see also IRMA Section 801 A & B.) The reserve for receivership expenses and for other claims that are at a higher priority than the guaranty funds' claim payments need not, however, be reserved 100% out of current liquid assets of the estate, as long as there are sufficient non-liquid assets that will be liquidated during the course of the receivership proceedings to cover those claims. The receiver should reserve a portion of the liquid assets to cover receivership expenses that will become due in the near term and prior to the liquidation of other non-liquid assets.

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It may be difficult for the receiver of some estates to accurately determine the amount of policyholder claims not covered by the guaranty funds. An absolute determination of the amount is not necessary for purposes of the plan, however, as an estimate for calculation purposes is all that is needed. This estimate will be updated from time to time, and any overpayment to guaranty funds must be returned to the receiver. This "claw back" requirement is mandated by IRMA Section 803 F and should be included in any written agreement between the receiver and the guaranty funds.

3. Liquid or Distributable Assets

Most early access agreements provide for payments from distributable assets, which generally means cash and cash equivalents, less reserves for Classes I and II. In developing early access plans, it is anticipated that the receiver will liquidate non-liquid assets as soon as economically prudent.

The receiver, however, is not required to increase liquid assets for purposes of the plan by making forced or quick sales of non-liquid assets that result in obtaining less than market value. In other words, receivers are not expected to hold "fire sales" in order to generate liquid assets for distribution as early access. It is in the interest of all creditors, including the guaranty funds, for the receiver to attempt to obtain full value for the estate's assets. On the other hand, where an asset can be sold at a fair market price, the receiver should consider liquidating the asset in order to generate early access funds and thereby reduce the assessment burden on solvent insurers and their policyholders. The public policy behind maximizing the value of estate assets and reducing assessment burdens on guaranty funds through early access distributions sometimes conflict and special understanding and cooperation between the receiver and the guaranty funds is necessary to resolve this conflict amicably.

Liquid assets do not include real estate, the book value of a subsidiary, assets pledged as security, special or general deposits held by other states that are unavailable to the receiver, or any assets over which the receiver does not have complete control.

4. Early Access Agreements

Any payment to be made under the provisions of an early access plan typically is conditioned upon the guaranty fund executing and returning an early access agreement to the receiver., IRMA obviates the need for an agreement by incorporating the key provisions of a typical agreement in the statute; however, currently, only a small minority of states have adopted this IRMA provision Such agreements include provisions requiring the guaranty funds to:

- Submit to the exclusive jurisdiction of the receivership court, but only for the purpose of the early access plan;
- Return to the receiver any previously disbursed assets, plus interest if applicable, that are required to pay claims that are of an equal or higher priority; no bond shall be required of any guaranty fund. See IRMA Section 803 F;
- Periodically report to the receiver: all amounts paid by the guaranty fund on claims to date; the amount of expenses entitled to priority that have been paid by the guaranty fund; the reserves established by the guaranty fund on open claims; the amounts collected by the guaranty fund as salvage or subrogation recoveries; the amounts collected by the guaranty fund from any state deposit; and other information needed by the receiver. See IRMA Section 803 B; UDS is the platform commonly utilized for the transfer of this data. See Chapter 2 for a broader discussion of UDS.

Calculations and distributions by the receiver should be done at least annually; however, in instances where the guaranty funds are reporting on a quarterly or more frequent basis and sufficient assets are available to make distributions, the receiver may consider making distributions on a more frequent basis.

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5. Expenses

Early access plans typically contemplate that the guaranty funds should receive prompt reimbursement of their administrative expenses. The calculation of liquid assets available for distribution as early access should be made after payment of all incurred receivership and guaranty fund administrative expenses.

Certain categories of guaranty fund expenses may or may not be included in the administrative expense priority class. Therefore, it is necessary to consult the applicable statute to determine appropriate treatment.

In a case where there is disagreement between the receiver and guaranty associations concerning the priority of particular guaranty association expenses, it may make sense to make administrative expense distributions under a reservation of rights, clearly specifying that the priority of certain expenses was a matter of dispute and that such payment does not preclude the receiver from later challenging the priority of particular expenses. Dealing with the issue in this manner ensures that the guaranty associations receive maximum distributions early in the proceeding—when the need for cash can often be critical. Resolution of expense classification issues, which may involve protracted discussions or even litigation, can be conducted while the funds have the necessary cash to pay claims.

6. Basis of Distribution

Most early access statutes provide that distributions to guaranty funds will be based on claims paid and to be paid by the guaranty funds. Some states, however, have based distributions solely on paid claims. In states that follow the reserve language, early access should be based on both paid claims and reserves. This permits a more equitable distribution of assets among the guaranty funds instead of benefiting guaranty funds that make claim payments at an early stage of the receivership proceeding (e.g., a state that has mostly workers' compensation claims). See IRMA Section 803 A(2)(c).

7. Special Deposits

Early access plans typically take into account state deposits by excluding such assets from the calculation of liquid assets available. Similarly, the plans typically take into account payment to guaranty funds from general or special state deposits by essentially treating such payments as prior early access distributions, thereby reducing the early access distribution to those guaranty funds receiving state deposits. If after receiving early access distributions, a guaranty fund receives payment from a special state deposit, then the guaranty fund may be required to return all or part of the early access distribution. Most early access plans do not allow the receiver to take credit for a special or statutory deposit that has not been paid to or is unavailable to the guaranty fund. See IRMA Section 803 G.

8. Salvage/Subrogation

Historically, the majority of receivers have taken the position that salvage or subrogation recoveries collected by a guaranty fund, based on payments made by the guaranty fund, are the property of the guaranty fund. The recoveries are applied to reduce the net guaranty fund payment total that is the ultimate claim of the guaranty fund against the insolvent estate. These receivers accept reimbursement on a pro rata basis in instances where a guaranty fund has made a recovery that includes consideration of both pre-liquidation payment by the insurer and subsequent payment by the guaranty fund. Early access agreements will not be affected when receivers take this position.

A minority point of view is that salvage or subrogation recoveries by a guaranty fund become general assets of the liquidation estate, regardless of whether the payment on which the recovery is based was made by the insurer or the guaranty fund. Specific language to address concerns may be needed in early access agreements when a receiver adopts this view.

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J. Large Deductible Policies

In 2016, the NAIC adopted a white paper titled *Workers' Compensation Large Deductible* Study. The paper revisits and reconsiders issues raised in an earlier 2006 *Workers' Compensation Large Deductible Study.* The 2016 study provides valuable information about how large deductible policies work and special issues that can arise with their use.

As used in workers' compensation coverages, large deductible policies allow employers to retain a certain amount of claims risk, thereby reducing the cost of their workers' compensation coverage. Typically, these policies are administered by the insurer or a third-party administrator paying claims within the deductible and obtaining reimbursement from the insured employer. In the receivership context, where guaranty funds pay claims within the deductible, there is an issue as to the handling of the insured employer's reimbursement of payments within the deductible. That is, should the reimbursement be paid to the guaranty fund outside the receivership distribution scheme, or should the reimbursement be treated as an asset of the receivership estate subject to the claims of all creditors? Several states have provisions in place in their respective receivership statutes which provided that large deductible reimbursements should be paid directly to the guaranty fund outside the receivership distribution scheme.

Where the insolvent insurer wrote large deductible policies, the receiver should be mindful of this issue and should consult with the affected guaranty funds as soon as possible. The receiver should also review those states' guaranty fund statutes where the claims will be processed to determine whether claims within large deductibles are "covered claims" as defined in the appropriate guaranty fund act. Typically, claims under workers compensation policies will be covered. However, claims under policies for other lines of business may not be covered. The availability of guaranty fund coverage is to some extent dependent upon the specific language of the policy involved.

IRMA provides for a different treatment of large deductible collections. Under IRMA Section 712, payments of such monies to the guaranty funds are treated as early access.

Under the *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) deductible recoveries are paid to the guaranty fund to the extent of their claim payments and are not considered early access distributions. Subsection B of this Guideline states, "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.

K. Coordination among Regulators, Receivers and Guaranty Funds

In 2005, the NAIC adopted a white paper titled *Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System*. The white paper addresses the various issues relating to communication and coordination among regulators, receivers and guaranty associations, and how the parties might better work together to protect consumers.[7]

III. LIFE AND HEALTH GUARANTY ASSOCIATIONS

A. Introduction

In 1970, the NAIC adopted the *Life and Health Insurance Guaranty Association Model Act* (#520) (Life Model Act). Since 1970, the Life Model Act has undergone several major revisions. The most recent

[7] A copy of this White Paper may be obtained from the NAIC at: http://www.naic.org/store_home.htm
Phone: 816.783.8300; Fax: 816.460.7593; E-mail: prodserv@naic.org

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revisions to the Life Model Act were made in 2017.[8] All 50 states, the District of Columbia and Puerto Rico have enacted guaranty association laws based on some version of the Life Model Act. (For summaries of the provisions in each state's guaranty association laws see the NOLHGA Web site at:

https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

The Life and Health Insurance Guaranty Associations were created to protect certain policy, contract and certificate holders (and their beneficiaries, assignees and payees) from loss due to the insolvency or impairment of a member insurer. Life/health insurance guaranty associations pay benefits and continue coverage, subject to statutory limitations, either directly or through a third-party administrator. With early communication, information sharing and coordination between guaranty associations and receivers, the guaranty associations can work with receivers to help develop and put in place the infrastructure and solutions that may be able to provide for a seamless transition into liquidation, thereby avoiding unnecessary delays and disruptions, and maximizing protections for policyholders. Early coordination between the receiver and the guaranty associations will also help minimize confusion, avoid duplication of effort and lead to greater administrative efficiency and lower costs for both the receiver and the guaranty associations.

NOLHGA is a vital resource for receivers in multistate life/health insolvencies. NOLHGA, whose members are the life/health guaranty associations of all the states and the District of Columbia and Puerto Rico, collects and distributes information for its members and receivers. It performs analyses of various alternatives by which guaranty associations can fulfill their statutory obligation to protect policyholders and serves as the guaranty associations' national coordinating mechanism for resolving issues. Through its Members Participation Council, NOLHGA works with its affected member guaranty associations and the receiver to develop and implement plans for the disposition of covered claims and contractual obligations through, for example, assumption reinsurance or claims administration.

Ideally, the receiver and NOLHGA, on behalf of the guaranty associations, should commence planning and coordination efforts at the earliest practicable opportunity. As discussed in the NAIC's 2004 whitepaper on Communication and Coordination Among Regulators, Receivers and Guaranty Associations, cited in Chapter 1 of this handbook, coordination and communication with guaranty associations should begin "no later than when a company is placed into rehabilitation, and in many cases, involvement even earlier will enhance consumers' protection and decrease costs of the insolvency to all stakeholders" subject to entering into a confidentiality agreement as appropriate. NOLHGA can be reached at:

National Organization of Life and Health
Insurance Guaranty Associations
13873 Park Center Rd., Suite 505
Herndon, VA 20171
Phone: (703) 481-5206
Web Site: https://www.nolhga.com

[8] All references in this chapter to the "Life Model Act" are to the 2017 version, unless otherwise specified. As of this writing, a majority of states had adopted or substantially adopted the 2017 amendments, and further legislation is expected in additional states. It is always important, however, to check individual state statutes for variations from the Life Model Act in actual cases.

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B. Triggering Guaranty Associations

1. "Insolvent" Insurers

Under the Life Model Act, guaranty associations are triggered when a member insurer is determined to be an "insolvent insurer," as defined therein, i.e., it has been placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency. A member insurer is defined in the Life Model Act as "an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn…."[9] Certain types of insurers are excluded from the Life Model Act definition, such as fraternal and mutual assessment companies. Moreover, while a majority of states now include Health Maintenance Organizations ("HMOs") as member insurers, not all states do. State guaranty association laws will govern whether HMOs are member insurers for purposes of guaranty association coverage in a given state.

2. "Impaired" Insurers

Under the Life Model Act, a guaranty association may act in its discretion if a member insurer is "impaired," subject to certain conditions and limitations. An insurer is an "impaired insurer" as defined in the Life Model Act, if it has not been declared insolvent but is under a court order of rehabilitation or conservation. In such situations, the Life Model Act provides that the guaranty association may, in its discretion and subject to any conditions imposed by the guaranty association that do not impair the contractual obligations of the impaired insurer, and that are approved by the Commissioner, take certain actions to provide protections to policyholders of the impaired insurer. The primary purpose of the guaranty associations is to protect policyholders, however, not to bail out impaired or insolvent insurers so that they can continue as going concerns. Guaranty associations, therefore, have traditionally been extremely reluctant to provide coverage before liquidation.

There are subtle variations among some state guaranty association triggering provisions which could potentially impact uniform triggering of guaranty associations in affected states. Coordination with guaranty association representatives and NOLHGA (if a multistate insolvency), as early as possible subject to appropriately executed confidentiality agreements before a petition for receivership is filed will help to reduce the risk of complications in regard to guaranty association triggering. or individual state provisions, see the NOLHGA Web site:

(https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

C. Scope of Coverage

1. Covered Policies and Limits of Coverage

Guaranty associations were created to provide a limited, but substantial safety net to protect policyholders from loss as a result of the impairment or insolvency of a member insurer. e Under the Life Model Act, the following coverages are provided:[10]

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[9] HMOs were added to the definition of "Member Insurer" as part of the 2017 package of amendments to the Life Model Act. As of this writing, those amendments had been largely adopted in 36 states. However, at least one of those states has continued to exclude HMOs from the definition of Member Insurer.

[10] While there are a few exceptions, these coverage limits have been fairly uniformly adopted in most states. For individual state limits, see the NOLHGA website (https://www.NOLHGA.com/factsandfigures/main.cfm/location/statinfo) or consult the applicable state guaranty association.

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- Life insurance: $300,000 in death benefits, but not more than $100,000 in net cash surrender and withdrawal values, per life. In the case of corporate-owned or bank-owned life insurance, however, overall benefit coverage is capped at $5,000,000 per owner.

- Health insurance: i) $500,000 in benefits for health benefit plans, which are defined to include "any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract", subject to certain enumerated exclusions. The term "health benefit plan" which was introduced in the 2017 amendments to the Life Model Act, replaces the prior reference to basic hospital, medical and surgical insurance and major medical insurance, and includes coverage under health maintenance organization subscriber agreements; ii) $300,000 in benefits for disability income insurance and long-term care insurance; and iii) $100,000 for other health policies not defined as disability income insurance, long-term care insurance or health benefit plans. All limits are applied per life.

- Individual (allocated) annuities: $250,000 in present value of annuity benefits, including net cash surrender and withdrawal values, per life.

- Structured settlement annuities: $250,000 in present value of annuity benefits, per payee or beneficiary. See Chapter 3 for a discussion of structured settlements.

- Unallocated annuities: Coverage for unallocated annuity contracts[11] is typically limited. As of this writing, 28 states provide coverage for limited types of unallocated annuity contracts. The remaining 22 states, plus the District of Columbia and Puerto Rico, do not provide coverage for unallocated annuity contracts. For those states that do provide coverage for unallocated annuity contracts, coverage is typically limited to unallocated annuity contracts issued to or in connection with specific employee benefit plans or government lotteries. Life Model Act Section 3(A)(3). Coverage limits are stated as (i) $5,000,000 per contract owner/plan sponsor for unallocated annuity contracts issued in connection with either governmental lotteries or private employer employee benefit plans that are not protected by the Pension Benefit Guaranty Corporation, and (ii) $250,000 per plan participant for unallocated annuity contracts issued to governmental retirement plans. Life Mode Act Section 3(C)(2)(b) and (e). Unallocated annuity contracts are not covered in every state, and the Appendix to the Life Model Act includes alternate Section 3 text adopted by several states that do not provide coverage for unallocated annuities.

- Aggregate limits across policy types: Aggregate benefits covered with respect to any one life for life insurance, individual annuities, and health insurance (other than health benefit plans) are capped at $300,000. Aggregate coverage for health benefit plans and other policy types is limited to $500,000 with respect to any one life.

2. Exclusions

Products excluded from coverage, in whole or in part, are described in Life Model Act Section 3(B)(2). Under the Life Model Act, coverage is expressly excluded for policies or portions of policies under which the risk is borne by the policyholder or that are not guaranteed by the insurer, as well as certain interest crediting rates that exceed the limits described therein. Self-funded employer-provided welfare benefit plans are also among the products excluded, as are unallocated annuity contracts issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation. Reinsurance is

[11] For purposes of guaranty association coverage, an unallocated annuity contract is "an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate." Life Model Act §5(Y).

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also specifically excluded unless assumption certificates have been issued. For a more complete listing of products or portions thereof generally excluded from guaranty association coverage, refer to Section 3(B)(2) of the Life Model Act. For specifics concerning coverage exclusions in any particular state, consult with the guaranty association in that state.

In addition to the product exclusions referenced above, the Life Model Act excludes coverage for policies or products issued by entities that are not regulated under the standards applicable to legal reserve carriers, and, are therefore excluded from the definition of Member Insurer under the model, such as insurance exchanges, assessment companies, fraternals, and hospital or medical service corporations. HMOs were added as member insurers under the Model as part of the 2017 amendments. However, these amendments have not yet been adopted in all states. Moreover, a few states may have separate HMO guaranty associations established under state law. Accordingly, it will be important to review state law to determine whether and to what extent a state provides guaranty association coverage for HMO products. Hospital or medical service corporations that are members of the Blue Cross/Blue Shield Association may be required by their franchise to participate in their state's guaranty association if permitted by statute, or to establish some other form of insolvency protection for their participants. Whether these entities are included as member insurers for purposes of guaranty association protection may vary by state and must be considered based on the circumstances in each case.

3. Residency Requirements

Residency is determined on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer, whichever occurs first. Typically, this results in the state of residence being determined on the date an order of liquidation with a finding of insolvency is issued. If there is a gap between the start of the receivership and the date an order of liquidation is issued, policy and contract holders may relocate, which could affect the situs of coverage.

The Life Model Act generally provides for coverage of policyholders and certificate holders under group policies who are residents of the state, as well as their beneficiaries, regardless of where the beneficiaries reside. It also provides coverage for contract owners of unallocated annuities if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in the state. Nonresident policyholders and contract holders may be covered under certain limited circumstances. If the insolvent insurer's domiciliary state follows the Life Model Act, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty association law and the policyholders in that state are not eligible for coverage there because the insurer was not licensed in that state at the time specified in that state's guaranty association law. An example of such a situation might be a a resident of State A, who owns a policy of the XYZ Life Insurance Company, domiciled in State B, and placed in liquidation in state B. If the State A resident policyholder is not eligible for coverage by the State A guaranty association because the company was not licensed in State A (and therefore was not a member insurer of the State A guaranty association), coverage would be provided by the State B life and health insurance guaranty association.

D. Guaranty Association Claims Administration

In the case of a multi-state insolvency, life/health guaranty associations work through NOLHGA's Members' Participation Council (MPC) to develop and implement a plan for providing guaranty association coverage, whether through transfer of the covered policies to a solvent insurer, making arrangements for providing ongoing policy and claims administration, or some combination thereof.

For multi-state insolvencies, NOLHGA appoints a guaranty association task force that includes representatives from the domestic guaranty association and other state guaranty associations affected by the insolvency. The size of the task force depends in large part on the number of affected state guaranty associations and the size of the insolvency.

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1. Information Needs of the Guaranty Associations

For guaranty associations to evaluate and discharge their functions with the least possible duplication and delay, they must have detailed information about the insurer and its business. While information needs may vary from case to case, NOLHGA typically requests this information from the receiver on behalf of its members and, if necessary, will offer to assist the receiver in obtaining and assembling the information. Types of information routinely requested include:

- All administrative and judicial petitions and orders with attachments or exhibits
- The insurer's most recent annual statement
- The insurer's most recent financial statement, audited or unaudited, and department or independent financial audits or reviews, including identification of assets that are hypothecated or not publicly traded and unbooked contingent liabilities
- A list of states that have terminated or suspended the insurer's license
- A breakdown, by state, of the insurers' estimated liabilities/reserves by line of business
- A list of third-party administrators and administrative offices, identifying the policies, claims and group policyholders they served, and copies of all provider/vendor agreements
- Actuarial evaluations of the insurer's business
- Copies of policy and contract forms
- Copies of reinsurance contracts, assuming or ceding
- Drafts of the receiver's notices to policyholders, including any cancellation notices
- A breakdown of assets, by category, at the most recent market value available and other valuations of assets that would be helpful in cash flow analysis
- The names and addresses of policyholders and certificate holders with in-force coverage during the preceding year, broken down by state, indicating the type of coverage each had, the date to which premiums have been paid, cancellation or non-renewal dates for business that was canceled or non-renewed according to policy terms, copies of cancellation notices, and the date to which claims have been paid [12]
- Policy values (face amounts, cash surrender values, policy loans, interest crediting rates, rate crediting history, etc.)
- Premium files (and status indicators, such as Reduced Paid Up, Extended Term, or Waiver of Premium status)
- Claims data/claims history (including plan of care and related information for LTC lines)

[12] Specific policy data needs will depend on the facts and circumstances of each case as well as the types of business involved. Initial, critical data needs will typically include all relevant summary policy and reserve information. If the policy master/eligibility records can be provided, that file may contain sufficient information for preliminary coverage determinations and to consider the potential feasibility of an assumption transfer. Additional information will be needed to coordinate coverage and begin planning for implementation of any administration, transfer or other disposition strategies.

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- Rate files/history
- Information concerning the receiver's marketing contacts and expressions of interest received about the insurer's business

2. Notice to Claimants

Shortly after a receiver is appointed, the receiver should collaborate with NOLHGA to provide notices to policyholders. Several notices may be necessary over the course of the receivership. Because of the special nature of life and health insurance guaranty association obligations, the receiver and the guaranty associations should collaborate closely on the contents of all notices to policyholders that involve guaranty association obligations, and may, in some instances, send joint communications to policyholders. Normally, the notices should:

- Provide notice of proceedings against the company
- Explain the existence of the g guaranty associations and their role in the receivership
- Provide basic information concerning guaranty association continuation of coverage, including general reference to the statutory limitations
- Where applicable, advise regarding the possibility that a portion of the policies or contracts may be assumed or reinsured by another insurer
- Provide instructions on filing claims under their insurance policies and remitting future premiums (during rehabilitation)
- Indicate how the guaranty associations intend to treat cancelable policies
- Provide information about conversion policies in the event of policy terminations
- Provide notice of liens or moratoriums
- Identify any applicable claims bar date
- Describe the receiver's handling of claims in excess of guaranty association statutory maximums
- Describe the receiver's handling of claims that are ineligible for guaranty association coverage

When a company goes into liquidation, the guaranty associations will typically send their own notice to policyholders, sometimes as part of a joint mailing with the receiver. The guaranty association notices will provide information about guaranty association coverage and limits, contact information for the state guaranty association providing coverage for insureds in each state, instructions for continuing to pay premiums and submitting claims, customer service contact numbers, and other relevant details depending on the unique facts and circumstances of the case.

3. Notice to Guaranty Associations

In many states, the receiver is required to provide notice of the receivership to all guaranty associations that may be triggered as a result of the receivership. Even if the notice is not a statutory requirement, the receiver should provide NOLHGA (in the case multi-state receiverships) and all affected guaranty associations as much advance notice of receivership as is reasonably possible under the circumstances subject to appropriate confidentiality agreements in order to facilitate the coordination that will be necessary for a successful receivership, and achieve the best outcomes for policyholders. NOLHGA and the affected guaranty associations should also be provided with an advance copy of all notices

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being issued by the receiver to policyholders, as well as copies of the receivership order and any domiciliary injunctions that may have been entered.

4. Proof of Claim

A proof of claim form is less frequently required in life/health receiverships, due in part to the fact that in many instances the guaranty associations will be continuing coverage. Generally, policyholders are not required to file formal proofs of claim for policy benefits. However, policyholders may assert claims for extra-contractual liability against the insurer, such as claims for bad faith. The receiver should consider requiring a proof of claim where extra-contractual liability is involved. Neither the guaranty associations nor assuming reinsurers accept liability for extra-contractual claims.

Receivers and guaranty associations must have data on the policy deductibles and benefit caps under health insurance policies. If the business is transferred to a new carrier, incurred claims will have to be allocated between pre- and post-assumption date periods. In addition, special provisions in the assumption agreement may require additional information in the proof of claim form.

5. Claim Files

The information needs of the guaranty associations generally are addressed earlier in this section of the Handbook. To ensure secure data transfer, receivers or insurance department personnel typically establish a secure website portal or FTP site to provide NOLHGA and its member associations with secure access to the data needed. Otherwise, NOLHGA, or a designated Third-Party Administrator or consultant, can establish a secure file portal where designated users can upload records. Files and records should be made available at the earliest practical opportunity to allow for the planning and coordination needed for a smooth transition and to avoid any disruption to benefits and claim payments.

6. Premiums

The continued and timely payment of premiums is necessary in order for a policyholder to receive continued coverage from a life/health guaranty association. Under the Life Model Act, "premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association." Receivers should work with NOLHGA and the guaranty associations to ensure smooth transition of premium collection. For premiums collected before the liquidation order but providing coverage for periods after the liquidation order, the Receiver should coordinate with the guaranty association to facilitate appropriate allocation of those funds.

E. Early Access

The guaranty associations' administrative costs, like the receiver's, typically have the highest priority in distribution of funds from the insolvent insurer's estate. In addition, guaranty associations have a statutory claim and right of subrogation, allowing them to recover from the estate to the extent they pay covered benefits. Guaranty association claims for the payment of covered benefits are accorded the same priority as policyholder claims (Class 3 under IRMA Section 801), and are taken into account in the calculation of association benefits as part of a rehabilitation or liquidation plan. The guaranty associations' claims in the aggregate often make the guaranty associations the largest claimants against the estate.[13] In recognition of this fact, most state laws provide for the guaranty associations' "early access" to payments from the estate. See IRMA Section 803. Early access is typically accomplished by specific agreement, which should include a provision that the guaranty associations will return excess funds.

[13] In some cases, the guaranty associations may also present claims against the estate for the insolvent insurer's unpaid guaranty association assessments. These claims have general creditor status ranking below other guaranty association claims and all policyholder claims.

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F. Claim Reporting

Guaranty associations should make timely reports to receivers of their costs for policy transfers, policy administration, including TPA costs, claim payments and administrative expenses. In multi-state insolvencies, NOLHGA will typically collect the necessary data from the affected guaranty associations and report to the receiver on their behalf in the form of an Omnibus Proof of Claim, which may be updated from time to time.

G. Guaranty Association Obligations During the Formulation of a Rehabilitation or Liquidation Plan

The successful creation and implementation of a plan to protect policyholders requires good communication and cooperation between receivers and guaranty associations. To the extent consideration may be given to restructuring of covered policies or contracts, the receiver should coordinate with the guaranty associations early in the development of the plan to consider whether the proposed restructuring is consistent with the guaranty association statutory obligations with respect to those policies or contracts. Any restructuring needs to be carefully considered in light of all applicable statutory requirements.

H. Reinsurance

The guaranty associations may find it advantageous to keep in-force ceded reinsurance treaties that the insolvent insurer had in place on covered blocks of business. Accordingly, the receiver should not cancel ceded reinsurance contracts with reinsurers or stop paying premium to reinsurers without consulting NOLHGA or the affected state guaranty associations. The existence of a ceded reinsurance treaty covering a block of business may make the business more attractive to prospective purchasers. In the case of health insurance, reinsurance recoveries may lessen the impact of catastrophic claims upon the affected guaranty associations. See Section 8 N of the Life Model Act and IRMA Section 612, both of which provide that the guaranty association(s) may elect to succeed to the rights and obligations of the insolvent insurer under ceded indemnity reinsurance agreements.

J. Special Issues

Under the Life Model Act, guaranty associations have the power and discretion to "guarantee, assume or reinsure . . . the policies or contracts of the insolvent [or impaired] insurer." Relying on this authority, guaranty associations have, on more than one occasion, acted collectively to establish an insurance company for purposes of collectively managing assets and assuming or administering guaranty association covered obligations. Whether similar arrangements may be appropriate in future insolvencies depends entirely on the circumstances.

J. Guaranty Association Procedures for Collective Action

Many individual state guaranty associations may be triggered in connection with a multistate insolvency. Simply communicating with each guaranty association individually would be a difficult task for a receiver's staff. The receiver should work closely with NOLHGA, through the MPC's appointed task force, to communicate and coordinate with the affected guaranty associations. Recognizing the need for concerted action when multiple guaranty associations must cover the insurance obligations of an insolvent company, the guaranty associations have developed and institutionalized procedures that, through NOLHGA, enable them collectively to administer continuing policy obligations, pay covered claims and, ultimately, discharge the covered obligations. These procedures provide a valuable mechanism for entering into binding contracts.

[1] UDS Manual link to be included when published from .ncigf wesite

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Highlighted references will be confirmed and updated upon adoption of all chapters.

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I. INTRODUCTION

Reinsurance is often referred to as "insurance for insurance companies," but it is separate and distinct from the insurance relationship existing between a policyholder and its insurer. The direct (i.e., primary, umbrella, or excess) insurer (i.e., reinsured or ceding company) cedes to a reinsurer (i.e., assuming company) a portion of its risk under policies issued to its policyholder (i.e., the original insured) pursuant to a reinsurance agreement. Reinsurance is an agreement of indemnity, whereby the assuming insurer in consideration of premium paid agrees to indemnify the ceding company against all or part of the loss that the ceding company may sustain under the policy or policies it has issued. Generally, absent a cut-through (discussed below in Section 2.A.), the reinsurer has no privity with or obligation to the original insured.

Just as reinsurance is important to the operations of an insurer, it is equally important to a receiver. Reinsurance receivables often represent a significant portion of an insurer's assets. Understanding reinsurance is critical to the efficient collection of this important asset. Generally, ceded reinsurance agreements should be continued. In the context of a life/health company insolvency, IRMA Section 612 provides for ceded reinsurance to be continued or terminated pursuant to the terms of each contract if the ceding insurer is in conservation or rehabilitation proceedings, but further provides that such contracts *shall be continued in liquidation* unless they were terminated in accordance with their terms prior to liquidation or were terminated pursuant to the liquidation order. In addition, both IRMA Section 612 and Section 8(N) of the NAIC's Life GA Model Act, as adopted in state laws, provide the life and health insurance guaranty associations the right to elect to continue and assume the rights and obligations of the ceding insurer with respect to reinsurance contracts that relate to guaranty association covered obligations, subject to the requirements set forth therein. To the extent those guaranty association covered obligations are subsequently transferred to an assuming insurer, the reinsurance continued on those contracts may also be transferred to the assuming insurer.

Reinsurance is a sophisticated international industry involving various types of unique contractual relationships. Reinsurance is utilized by insurers to achieve a variety of purposes and effects. It can increase an insurer's capacity to accept larger risks, provide financial support for an insurer, add stability to an insurer's results, protect against accumulations of losses, and provide the expertise of reinsurers who specialize in a particular area of insurance. Reinsurers may in turn be reinsured by other reinsurers referred to as "retrocessionnaires," who may also be reinsured, and so on. In this fashion, a broad spreading of risk is achieved.

It is important to note the terms used in reinsurance do not necessarily have the same meaning when used in the insurance context. A classic example is date of loss. In insurance it often means the date of the damage, while in reinsurance it can be the date the contract was accepted, terminates or any other meaning agreed by the parties. Some common definitions are:

Acceptance	Agreement by which a reinsurer consents to underwrite risk from a ceding company under specified circumstances.
Bordereau	A list compiled by a ceding insurer that provides the loss and premium histories of risks ceded or proposed to be ceded to a reinsurer.
Cede	To transfer part or all of a risk to a reinsurer.
Cedent	Company that is transferring the risk to a reinsurer. Generally, the term is used when referring to the direct insurance company that is ceding business to the reinsurer.
Ceding Commission	The amount the reinsurer pays (or ceding company retains) when the cedent buys reinsurance. Generally, the amount of the commission is attributable to the cedent's acquisition costs.

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Cession	The portion of the risk that has been ceded to the reinsurer.
Commutation	The manner in which the cedent and the reinsurer will agree to a termination of past and future liabilities under a reinsurance contract.
Cover Note	A document issued by the reinsurance intermediary or the broker, indicating the reinsurance coverage that has been bound.
Cut-through Clause or Endorsement	A guarantee by the reinsurer to a party that is otherwise not in privity with the reinsurance contract (often the insured) that payment will be made by the reinsurer under certain specified conditions, e.g., insolvency of the cedent.
Excess of Loss Reinsurance	Reinsurance that attaches once a loss has exceeded a specific amount.
Facultative Reinsurance	Reinsurance in which the reinsurer retains the "faculty" to underwrite each risk individually.
Inuring Reinsurance	When for the benefit of the reinsurer, it will refer to other reinsurance contracts that will reduce the amount otherwise recoverable under a particular reinsurance cover. When for the benefit of the cedent, it refers to other reinsurance contracts that will not reduce the amount recoverable under a particular reinsurance cover. Sometimes referred to as "common account."
Quota Share Reinsurance	Generally, a reinsurance agreement by a reinsurer to reimburse a cedent in the same percentage in which the reinsurer receives premium from the cedent.
Reinsurer	A person or entity that assumes risk from the cedent.
Retention	The amount of risk retained by the ceding company.
Retrocedent	A reinsurer that transfers risk it has assumed to another reinsurer; e.g., cedent cedes to a reinsurer that in turn retrocedes to a retrocessionnaire.
Retrocession	A transaction whereby a reinsurer transfers risk that it has assumed from the cedent to another reinsurer.
Retrocessionnaire	A reinsurer that assumed risk from the retrocedent.
Surplus Share Reinsurance	A type of reinsurance treaty, similar to quota share reinsurance, which spells out specific amounts to be retained by the cedent.
Treaty	A type of reinsurance contract that differs from a facultative contract because it does not retain the faculty of underwriting the individual risk.
Unauthorized	A reinsurer that is unlicensed to conduct the business of insurance. The reinsurer is said to be "unauthorized" and not to provide security to the cedent which the cedent may reflect in its statutory financial statements either as an asset or a reduction in liabilities.

Additional definitions may be found in the NAIC's *Credit for Reinsurance Model Law* (#785), *Credit for Reinsurance Model Regulation* (#786), *Term and Universal Life Insurance Reserve Financing Model Regulation*

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(#787) *Special Purpose Reinsurance Vehicle Model Act* (#789), *Life and Health Reinsurance Agreement Model Regulation* (#797), and *Assumption Reinsurance Model Act* (#803). Glossaries can be found at various Web sites.

II. REINSURANCE BASICS

A. There are several reinsurance arrangements that one might expect to find in an insurer's reinsurance program. Whether undertaken in property and casualty, or life, accident and health insurance lines, there are numerous provisions that are required to be included in reinsurance agreements pursuant to state law (e.g., an insolvency clause – see Section IV.I.3 below). In addition, all of the terms and conditions of a reinsurance relationship are required to be written as part of the principal agreement; "side" agreements and letters are not permitted.

B. A. Property and Casualty Reinsurance Arrangements

A reinsurance program can be extremely complex and may consist of multiple interacting arrangements, all responsive to the same loss. Furthermore, an insurer's net retention, after applying treaty reinsurance and facultative reinsurance, may be further protected by catastrophe or stop loss reinsurance. Also, overlap between different treaties may cover aspects of the same loss.

Two particular types of reinsurance arrangements bear specific mention – fronting and cut-through arrangements. Both fronting and cut-through arrangements affect the parties to the transaction, but do not change the ultimate economics involved.

Fronting is an arrangement by which an authorized insurer issues policies to cover risks underwritten by unauthorized or inexperienced insurers (or for the benefit of insureds who cannot transact the business of insurance) and then transfers its own liability to such unauthorized insurer by means of reinsurance. Fronting involves two actions: (1) a substantial cession of business; and (2) a delegation of claims and underwriting authority from a licensed to an unlicensed insurer. The fronting insurer remains financially liable to the policyholder for the entire insured amount even though, in reality, the fronting insurer may only bear a small financial liability, if any. While fronting can serve useful purposes, abuses can occur if the fronting company fails to exercise control with respect to underwriting, claims, or the risk to which it exposes its assets. A certain amount of disclosure, however, is required on Schedule F of the Annual Statement. Ceding companies are required to disclose whether they have contracts ceding 75 percent of direct written premiums in Schedule F.

A cut-through is either a clause in or an endorsement to an insurance policy or reinsurance contract which provides that, in the event of the insolvency of the insurance company, the amount of any loss that would have been recovered from the reinsurer by the insurance company (or its statutory receiver) will, instead, be paid by the reinsurer directly to the policyholder, claimant or other payee, as specified by the clause or endorsement. Cut-throughs may provide a competitive advantage among commercial insurers. Some clients require insurers to obtain a cut-through or face the possibility of losing business to another insurance company. Reinsurers usually provide cut-throughs only when requested by the insured and reinsured. If a reinsurer issues a cut-through, it has a contractual obligation to pay the beneficiary of the cut-through rather than the receiver. The cut-through does not change the amount of the reinsurance recoverable, only to whom it is paid. Cut-throughs are common in captive arrangements, particularly where the insured owns, rents, or otherwise participates in the captive.

In general, reinsurance agreements are written as proportional or non-proportional and on either a treaty or facultative basis. Proportional reinsurance is reinsurance that involves the cession by the cedent of a specified share of risk, so that premiums and losses are shared proportionately between the ceding insurer and the reinsurer. Non-proportional reinsurance is a form of reinsurance that, subject to a specified limit, indemnifies the ceding company against the amount of loss in excess of a specified retention. It includes various types of reinsurance, such as catastrophe reinsurance, per risk reinsurance, per occurrence reinsurance and aggregate excess of loss reinsurance. Treaty reinsurance (or obligatory reinsurance) refers

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to an arrangement under which a reinsurer automatically reinsures all the risks of a specific portfolio of the reinsured, without an option to decline specific risks within the portfolio. Facultative reinsurance, on the other hand, refers to the type of risk where the reinsurer has retained the "faculty" to underwrite the individual risk. A facultative contract is generally referred to as a facultative certificate.

- 1. Treaty Reinsurance

Under a treaty, the reinsurer is obligated to accept the cession of a class or certain classes of business written by the ceding insurer in accordance with the definitions, exclusions, terms and conditions of the reinsurance agreement. There are common treaty clauses, but each treaty must be read in its entirety to determine how subject premiums and losses are to be treated and how the treaty is affected by other treaties, i.e., inuring treaties. (See definitions in I. Introduction, above.)

A treaty can cover different types of risks. Some treaties cover one line of business, such as fire, casualty, marine, aviation, directors and officers, or boiler and machinery. Others cover an entire program or all business written by a managing general agent, program administrator or specific underwriting department. There are two principal categories of treaty reinsurance: (i) pro rata or proportional reinsurance, and (ii) non-proportional or excess of loss reinsurance.

Treaties tend to be long documents with many clauses and provisions. There are no "standard" contracts, and no two are alike.

- 2. Facultative Reinsurance

Facultative reinsurance is reinsurance of individual risks by offer and acceptance wherein the reinsurer either retains the "faculty" or ability to accept or reject each risk offered by the ceding company or limits its acceptance to certain risks or lines of business of the cedent.

There are two principal categories of facultative reinsurance: facultative obligatory and semi-automatic facultative.

- Facultative obligatory reinsurance: These contracts are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

- Semi-automatic facultative reinsurance: Semi-automatic facultative reinsurance requires the reinsurer to accept certain defined risks of the reinsured, subject to the right of the reinsurer to reject liability for any of such risks within a stated period after submission. Like facultative obligatory reinsurance, semi-automatic facultative reinsurance is also a hybrid of both treaty and facultative reinsurance.

Unlike treaties, many facultative contracts take the form of "certificates" comprising a Declarations page and a page of "standardized" General Terms and Conditions in order to ensure concurrency of terms within the reinsurance market.

- 3. Pro Rata and Excess of Loss Reinsurance

Pro rata and excess of loss reinsurance are forms of either treaty or facultative reinsurance.

a. Property/Casualty Pro Rata Reinsurance

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3. Pro rata reinsurance, also known as proportional reinsurance, consists of quota share reinsurance and surplus reinsurance. Quota share reinsurance is a cession of a specified portion of the risk up to a certain limit of liability, such as 50 percent of the risk per occurrence up to $1 million.

4. Surplus treaties are pro rata reinsurance that are usually designated by such names as first surplus, second surplus, special surplus, etc., reflecting layers of surplus reinsurance over specified retentions. Several reinsurers may each have a percentage of liability on a surplus treaty in each of these layers. Each reinsurer's liability may be referred to as their "participation." It is called surplus reinsurance because it is reinsuring over a net retention by the cedent or over other layers of reinsurance. A reinsurer's respective participation is designated in a document known as an Interests and Liabilities Statement or agreement (I&L) and is designated as being on either a joint (each insurer is liable for the entire amount reinsured) or several (each reinsurer is liable only for a specified amount or percentage) basis.

b. Excess of Loss Reinsurance

5. Excess of loss reinsurance applies to losses that exceed an agreed dollar amount or percentage of premium. The reinsurance may apply to a single risk, to a number of losses arising out of one event, or to an aggregation of losses. Excess of loss reinsurance written on a per risk basis is most common, sometimes supplemented by aggregate loss limits applied on an annual basis. Because excess of loss reinsurance does not participate in the entire loss, premium and losses are not shared on a proportional basis with the cedent.

6. There are many types of excess of loss reinsurance, such as working excess, layered excess, per-risk reinsurance, aggregate excess of loss, and catastrophe or clash cover. The following are examples of excess of loss reinsurance:

   - Working excess: This form of excess of loss reinsurance focuses on loss frequency, as opposed to loss severity, and is usually written with relatively low indemnity in excess of low retention, e.g., $400,000 indemnity in excess of $100,000 retention. (In reinsurance parlance, this is expressed as $400,000 xs. $100,000.)

   - Layered cover: First excess is usually written over a retention where frequency diminishes and severity of loss is more of a factor. To protect against increased severity, second, third, fourth and higher excess layers may have also been purchased. A single loss may potentially expose any number of these excess covers.

   - Per risk: Reinsurance in which the reinsurance limit and the reinsured's loss retention apply "per risk" rather than per accident, per event, or in the aggregate. With per risk reinsurance, the cedent's insurance policy limits are greater than the reinsurance retention. For example, an insurance company might insure commercial property risks with policy limits up to $10 million and then buy per risk reinsurance of $5 million in excess of $5 million. In this case, a loss of $6 million on that policy will result in the recovery of $1 million from the reinsurer.

   - Catastrophe reinsurance: This cover requires more than one loss resulting from a catastrophe or series of events. For example, if only one insured building was damaged due to an earthquake, catastrophe reinsurance would not cover the claim. If multiple losses resulted, the catastrophe reinsurance might respond, but only after application of other available reinsurance. It is generally very high level, such as xs. $100 million. It is a form of excess of loss reinsurance that, subject to a specific limit, indemnifies the ceding company in excess of a specified retention with respect to an accumulation of losses resulting from an occurrence or series of occurrences arising from one or more disasters. It generally covers multiple books of business. Catastrophe contracts can also be written on

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an aggregate basis, under which protection is afforded for losses over a certain amount for each loss in excess of a second amount in the aggregate for all losses in all catastrophes occurring during a period of time, usually one year. There will be two limits that the receiver will have to track: the catastrophe limits and the individual loss limits.

- Clash cover: Clash cover is a form of casualty excess of loss reinsurance under which a cedent may combine and cede the losses of multiple direct insureds, subject to a single reinsurance retention, when the losses arise from the same event or occurrence.

- Aggregate or stop loss reinsurance: This coverage applies when total losses on a group of risks accumulate to a specified retention, which may be defined as a specific amount or a percentage of premium. Generally, once the retention is reached and the aggregate or stop loss reinsurance kicks in, the reinsurance covers all risks above the designated retention.

B. Life Reinsurance Arrangements

- 1. Types of Reinsurance

There are three distinct types of life reinsurance: yearly renewable term, coinsurance and modified coinsurance.

- Yearly renewable term (YRT): Under yearly renewable term reinsurance, the reinsurer indemnifies only the mortality risk. The mortality risk, but not the permanent plan reserves, is transferred to the reinsurer for a premium that varies each year with the amount at risk and ages of the insureds. While YRT reinsurance allows a ceding company to transfer mortality risk, it leaves the company responsible for establishing reserves. The reinsurer becomes liable for the reinsured portion of the net amount at risk but has no cash surrender value liability. While the precise formula for determining the reinsured portion of the net amount at risk varies from treaty to treaty, in general it equals the death benefit less cash surrender value on the portion reinsured. Thus, as the cash surrender value grows from year to year, the amount of reinsurance decreases.

- Coinsurance: Coinsurance is a broader form of reinsurance, under which the reinsurer indemnifies a proportionate share of all risks under the policy. In return, the reinsurer receives a proportionate share of the cedent's gross premium, less an expense allowance or ceding commission, and is responsible for establishing reserves. Under a coinsurance funds withheld treaty, the cedent retains all or some of the reinsurance premiums as security for the reinsurer's obligations. With a reinsurer that is not authorized for credit for reinsurance purposes ("unauthorized reinsurer"), additional security is often provided by trust accounts and letters of credit for any difference between the liability of the reinsurer and the funds withheld by the cedent.

- Modified coinsurance: Modified coinsurance differs from coinsurance in that the reserves on the reinsured portion of the policy are not held by the reinsurer; instead, the reserves are held by, and are the responsibility of, the cedent. The reinsurer receives its proportionate share of the cedent's gross premium, less expense allowances. Periodically, a reserve adjustment payment is made, which is equal to the reserves at the end of the reporting period less the sum of (i) the reserves at the beginning of the period and (ii) the earnings on the reserves at the beginning of the period. The interest element in this calculation is stated in the treaty. If the result of this calculation is positive, the payment is made to the ceding insurer, and if it is negative, the payment is made to the reinsurer. Generally, as long as new business flowing into the account exceeds lapses, the reserve adjustment will be positive.

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Each of these forms of life reinsurance are documented in agreements having clauses and provisions unique to the business reinsured. Some contracts empower reinsurers to compel cedents to raise premium rates on the underlying business, which present many unique issues for receivers. Obtaining advice of competent legal counsel in such situations is important.

- 2. Types of Acceptance

  - Automatic reinsurance: This is the most common form of life reinsurance. Automatic reinsurance enables the cedent to issue policies in excess of its retention promptly and economically. The maximum amount of reinsurance that may be ceded automatically on a particular life policy is usually a multiple of the ceding insurer's retention. In the past, the most common multiple was four, but in recent years, there has been a tendency toward higher multiples, such as six, eight or ten. Automatic treaty limits may also be expressed as a dollar amount. Reinsurers seek a reasonable relationship between a cedent's exposure and the exposure it can cede automatically to a reinsurer. It is assumed that the proper balance will provide more assurance that the ceding insurer will act prudently in underwriting a risk if it is retaining a meaningful or "material" portion of that risk.

  - Facultative reinsurance: Virtually all automatic treaties also provide facultative facilities for risks that cannot be ceded automatically and for situations where the ceding insurer seeks the underwriting assistance of the reinsurer. A "facility" is an agreement setting out, among other things, the rules under which a reinsurer will reinsure risks ceded by the other party. Unlike automatic reinsurance where the underwriting assessment is made by the cedent, under facultative reinsurance, the reinsurer determines whether it will accept the risk and, if so, at what underwriting classification.

  - Facultative obligatory reinsurance: These treaties are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

  - Second excess reinsurance: These are automatic reinsurance treaties that are excess of an initial layer of automatic reinsurance provided by another reinsurer. For instance, a cedent might have first excess automatic cover of four times its $150,000 retention from one reinsurer plus a second excess automatic facility of two times retention from another reinsurer, permitting the cedent to issue up to $1,050,000 of insurance ($150,000 + 4 x $150,000 + 2 x $150,000) on its own underwriting authority. Second excess facilities are sometimes provided on a "criss-cross" basis by two reinsurers sharing an automatic account. One reinsurer might provide first excess cover on lives of persons whose surnames begin with any letter from A to K and second excess cover for surnames starting with L to Z. The other reinsurer would then provide first excess for L to Z and second for A to K. It is a convenient way of providing higher automatic cover when appropriate, without either reinsurer having too large a risk on any one life.

C. Financial Reinsurance

A reinsurance contract that fully participates in the insurance risk of the underlying policies and literally follows the fortunes of the ceding company, such as a simple quota share reinsurance treaty, is referred to as traditional reinsurance. A reinsurance transaction that does not transfer sufficient insurance risk, sometimes referred to as financial reinsurance or finite reinsurance, should be accounted for separately and not commingled with traditional reinsurance transactions. (See SSAP No. 62R, Property and Casualty Reinsurance and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, for further discussion on deposit accounting for reinsurance that does not transfer sufficient risk.) Thus, reinsurance

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transactions that do not transfer sufficient insurance risk are still a viable tool to achieve economic goals, but must be accounted for and reported separately from traditional insurance or reinsurance transactions. See Chapter 9—Legal Considerations.

Although the authoritative language on transfer of risk is in the Statement of Statutory Accounting Principles—SSAP No. 61R for Life, Deposit-type, Accident and Health and SSAP 62R for P&C—of the NAIC's *Accounting Practices and Procedure Manual*, some jurisdictions have enacted legislation, promulgated insurance regulations, or issued insurance bulletins that address transfer of risk issues. The receiver should consult applicable or governing state laws and regulations on this subject.

D. Loss Portfolio Transfer

Loss portfolio transfers are arrangements under which an existing block of loss reserves from events that have already occurred is transferred to a reinsurer acting as retrocessionnaire, and so without privity to the insured. The loss reserves may include known case reserves, reserves for incurred but not reported (IBNR) losses, and loss adjustment expense reserves. Since the losses on casualty business are not payable until future years, the consideration for the loss portfolio transaction is calculated based on present value concepts, i.e., the time value of money. Thus, the ceding company is transferring ultimate loss reserves at a discounted value, and the transaction will create immediate income and surplus relief to such company. The essential elements in this transaction are the payout stream of the loss reserves and the time value of money. The financial responsibility of the reinsurer may be capped.

E. Pooling Arrangements

Pooling arrangements are utilized among two or more insurers or reinsurers to underwrite a particular risk or type of business. An allocation of a share of premium, loss and expense is made to each member of the pool based on the pooling agreement. Pooling can be used among either affiliated or unaffiliated companies. Pooling is common within insurance holding company systems or groups of affiliated insurers, and must be reported as such.[1]

III. INTERMEDIARIES AND THEIR ROLES

A. Reinsurance Intermediaries and Brokers

If the ceding insurer chooses direct placement, it will handle all negotiations directly with the reinsurer. However, a ceding insurer may have received the assistance of a reinsurance intermediary (also known as a broker) to place reinsurance coverage. The terms "reinsurance intermediary" and "broker" are sometimes used interchangeably. In a number of jurisdictions, the reinsurance intermediary/broker is legally considered to be the agent of the cedent; this can be reversed by the reinsurance contract.

The reinsurance intermediary facilitates the relationship by acting as the liaison between the ceding insurer and the reinsurer. The reinsurance intermediary may be responsible for documenting the activity between the parties and passing through accounts and payments between the ceding insurer and reinsurer. Should the reinsurance intermediary agree that it is to have any of these obligations, the reinsurance contract should contain a reinsurance intermediary clause. The following is a sample:

> Intermediary is hereby recognized as the intermediary negotiating this Agreement for all business hereunder. All communications, including but not limited to notices, statements, premiums, return premiums, commissions, taxes, losses, loss adjustment expense, salvages and loss settlements, relating thereto shall be transmitted to Insurer or Reinsurer through Intermediary. Payments by Insurer to Intermediary shall be deemed to constitute payment to Reinsurer. Payments by Reinsurer

[1] NAIC SSAP No. 63; *see also* Statutory Issue Paper No. 97 (Finalized March 16, 1998)

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to Intermediary shall be deemed to constitute payment to Insurer only to the extent that such payments are actually received by Insurer.[2]

For the cedent, the reinsurance intermediary finds reinsurers willing to accept the risk and helps to negotiate reinsurance agreement terms and produce documentation. For the reinsurer, the reinsurance intermediary brings proposals from cedents and administers the transaction details. The reinsurance intermediary receives a fee (called brokerage or commission), which may be deducted from the premium amounts paid to the reinsurer.

Typically, the reinsurance intermediary will place a cedent's business with one or more reinsurers. When accounts are rendered by the cedent, the reinsurance intermediary will prepare an account for each reinsurer and distribute payments to them or seek reimbursement of amounts due the cedent, as appropriate.

The insolvent cedent, possibly subject to certain limitations, may elect to change the reinsurance intermediary at any time during the treaty and need only notify, in writing, the reinsurance intermediary of its decision and its intended handling of its reinsurance in the future. The receiver should be aware; however, that such change may result in the insolvent cedent incurring an obligation to pay an additional commission. Whether such commission is subject to set-off is an issue to consider with competent legal counsel.

The ceding insurer provides the reinsurance intermediary with a broker of record letter pursuant to which the reinsurance intermediary is granted the authority to solicit reinsurers to subscribe to a program. The reinsurance intermediary then presents a package of information to potential reinsurers, compiled in coordination with the insurer, which documents the program to be written and the insurer it represents. Traditionally the reinsurance contract was rarely signed by all parties prior to the inception date of the coverage. Instead, the reinsurers signed placement slips indicating their percentage participation and containing a summary of the reinsurance coverage—limits, retention, exclusions, standard clauses to be used in the contract, etc. The ceding insurer signed a similar document but referred to it as a cover note. When the reinsurance contract was ultimately circulated for execution, each reinsurer would execute a separate signature page or I&L, binding them to the formal contract. More recently, pursuant to US and international regulations, documentation of the transaction must be executed within nine months. many brokers and direct reinsurers have been moving toward contract at placement or contract certainty, the idea being that the full contract wording is agreed upon prior to the inception date of the coverage. In such a case, there would be no need for a placement slip; rather, the reinsurer would sign the I&L page to the contract.

The reinsurance intermediary then gathers all executed slips and I&Ls and provides them to the ceding insurer, indicating that the placement has been completed and summarizing its terms and conditions. Thereafter, the reinsurance intermediary often has the responsibility to draft a reinsurance treaty based on the agreed terms.

The ceding insurer reports premiums to the reinsurance intermediary, who then prepares the necessary accounts to the reinsurer or correspondent broker, together with appropriate remittances less the reinsurance intermediary fee, which may be netted against such premiums.

The ceding insurer reports losses through the reinsurance intermediary to the reinsurer. The reinsurer pays losses through the reinsurance intermediary to the ceding insurer. In some instances, a reinsurer will make its check payable to the cedent and forward it to the reinsurance intermediary, who will simply mark his records as paid and forward the check to the cedent. In other instances, the check will be drawn in favor of the reinsurance intermediary, who will then be obligated to pay the cedent. Funds so paid are held in a fiduciary capacity. Most current reinsurance intermediary clauses deem payment as having been made only

[2] Note that the last sentence of the intermediary clause reverses the general accepted rule that payment to a disclosed agent is payment to the principal.

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upon actual receipt by the cedent. For an example, see the NAIC *Reinsurance Intermediary Model Act* (#790) and New York Regulation 98.

State law following the NAIC Model requires reinsurance intermediaries to be licensed and to have written agreements with their cedents.

B. Role Upon Insolvency

The reinsurance intermediary should be immediately notified of the receivership of either the cedent or reinsurer. The reinsurance intermediary should be provided with a copy of any legal documents (insurance department letter or court orders). It is then the responsibility of the reinsurance intermediary to notify and advise all reinsurers or cedents of the status of the insolvent insurer. It may also be necessary to obtain underwriting and premium records of the reinsurance intermediary, since they are generally more complete than those of the company in receivership.

The responsibility of the reinsurance intermediary does not terminate when the insurer is placed in receivership. The reinsurance intermediary must continue to act in the best interest of the insolvent insurer, including rendering accounts and assisting in the collection of funds from reinsurers. In turn, the estate should continue to provide the reinsurance intermediary with timely claims and accounting reports that need to be rendered to reinsurers. Nonetheless, given the change in the relationship due to the receivership, the receiver may have to contemplate making a new arrangement if he/she has difficulty receiving service from the reinsurance intermediary. If not, there may be an issue whether the intermediary is entitled to assert set-off in respect of pre-receivership financial obligations that include commission(s). In that event, the receiver will want to seek advice from competent legal counsel.

IV. REINSURANCE ACCOUNTING AND COLLECTION PROCEDURES

The purpose of this section is to describe the accounting and collection responsibilities of the receiver for assumed and ceded reinsurance.

A. Introduction

For accounting purposes, reinsurance treaties are classified as either prospective or retroactive. A prospective treaty is one that covers future insurable events arising on or after the effective date of the contract. A retroactive reinsurance treaty (e.g., loss portfolio, as described above in _) is a treaty that covers past insurable events. A reinsurance treaty, whether prospective or retroactive, must transfer insurance risk. Unless insurance risk is transferred, the treaty must be accounted for as a deposit and not as reinsurance. Deposit accounting postpones recognition of revenues and income until the end of the treaty. Under the "nine-month rule," unless the full treaty wording is signed by the parties within nine months of its effective date, the accounting treatment for the reinsurance treaty must be converted from prospective to retroactive. For statutory accounting, a retroactive treaty must be excluded from the underwriting results of an insurance company and cannot be commingled with a prospective treaty.

SSAP No. 62R requires that, for a transaction to be classified as reinsurance, and to be included in the underwriting accounts of the company, the reinsurance treaty must be prospective, and the transaction must contain both underwriting and timing risk.

1. Underwriting risk is the ultimate amount of net cash flows from premiums, commissions, claims, and claims settlement expenses.
2. Timing risk is the timing of the receipt and payment of such cash flows.

SSAP No. 62R further requires that indemnification of the ceding company against loss or liability relating to insurance risk in reinsurance requires both of the following:

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1. The reinsurer assumes significant insurance risk under the reinsured portions of the underlying insurance contracts.
2. It is reasonably possible that the reinsurer may realize a significant loss from the transaction.

For complex or non-traditional reinsurance contracts, present value cash flow analysis of a transaction is often prudent to determine whether significant risk has been transferred or a loss may be realized. If a transaction does not meet these requirements, then the transaction must be reported in the financial statements as non-reinsurance or as a deposit. The authoritative statutory guidance for deposit accounting is contained in SSAP No. 61R.

The receiver's primary objective should be to examine the reinsurance agreements with a view to what is best for the estate. It is possible that reinsurance agreements may be amended, terminated, rescinded, commuted or continued to meet this objective.

B. Unearned Premium Reserves

There may be unearned premium reserves related to a reinsurance treaty for some time after the termination date of the treaty, as the underlying policies have not yet reached their expiration and premiums have not been fully earned. This situation may be altered by the termination method utilized. Typically, the parties may elect to terminate a treaty on either a "cut -off" or "run-off" basis. In run-off, a reinsurer will remain liable for losses for policies in force at termination, even if the occurrences take place after the termination date. Since cut-off terminates the reinsurer's liability as of a certain date, usually with a return to the cedent of any unearned premium reserves held by the reinsurer, the period for which the reinsurer may be liable for losses may be substantially reduced as compared to a run-off provision.

C. Contractual Adjustments

Reinsurance treaties may be subject to future premium or commission adjustments based upon experience. Common adjustments are retrospective premium rating, deposit premium adjustment and reinstatement premium adjustments. The most common commission adjustments are for contingent (profit) and sliding scale commissions.

A retrospective rated premium adjustment is a calculation of the final reinsurance premium for the treaty based upon the loss experience developed during the term of the treaty. An estimated reinsurance premium, sometimes referred to as a deposit premium, is paid by the cedent until the retrospective premium is determined. The final reinsurance premium is the deposit premium plus or minus the adjustment, often subject to a minimum and maximum dollar limit.

Ceding commission adjustments represent a sharing of profits between the reinsurer and cedent and are usually associated with pro rata reinsurance. A contingent commission, or profit commission, is a sharing of a predetermined amount of the profits, if any, realized by the reinsurer from the reinsurance treaty. A formula is specified in the treaty describing how premium, losses, IBNR, expenses and commissions are calculated for determining profitability. At specified dates, this calculation is made and settlement of accounts is undertaken. No additional premium results from a contingent commission agreement. These arrangements in life reinsurance may be referred to as experience refunds.

A sliding scale commission arrangement is one in which the final ceding commission is determined by calculating the loss ratio and relating this to a predetermined range of commission rates. As the loss ratio increases, the amount of commission decreases, or vice versa, usually subject to stated limitations.

D. Ceded Reinsurance Recoverables

The initial step in establishing control over ceded reinsurance receivables is to gather and update all ceded reinsurance treaties and facultative certificates in order to create working abstracts of these arrangements. Once individual arrangements have been analyzed, a matrix of reinsurance coverages in place, by book of

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business, should be established so that the relationship of various ceded treaties is known. See Exhibits 7-1 and 7-2.

The most current account rendered for each treaty should be reviewed, and any open balances due to or payable from the estate should be reconciled. If the reinsurance was purchased through a reinsurance intermediary, there are likely to be multiple reinsurers. Each reinsurer and its percentage of participation should be identified and accounts verified.

Each treaty should be reviewed to determine:

- Lines of business covered
- Limits of coverage
- Dates of coverage
- Workflow and procedures needed to generate premium, losses, etc.
- Outstanding balances
- The appropriateness and method of cancellation of the coverage
- The method of termination (run-off or cut-off)
- The location and security of records underlying the placement of the treaty

Once all participants have been identified in the treaty review phase, an analysis of each reinsurer should be made to determine its financial strength. Procedures should be established to periodically monitor the solvency of reinsurers. If the financial stability of a reinsurer becomes a concern, possible commutation of the reinsurer's liability should be considered.

Treaties may contain security provisions requiring or permitting the insurer to obtain collateral for the reinsurers' obligations. If a treaty provides for letters of credit to secure the obligations of the reinsurers, the obligations of reinsurers should be reviewed and letters of credit either obtained or updated to reflect appropriate liability.

The initial step in the ceded reinsurance accounting process is to develop procedures that allow the assembly of data to produce reporting in conformity with requirements under the treaty.

Allowed claims in liquidation proceedings constitute the basis for submitting claims to reinsurers. Generally, rehabilitation follows the rules of the contract. Thus, it is important to maintain record-keeping systems that fully support the calculation of total claims reinsured.

1. Premium Processing

   In most property/casualty liquidations, the court order cancels coverage on the insurer's direct in force insurance business within 30 days of the date of the receivership. The cancellation of the underlying business terminates the need for ceded reinsurance for losses occurring after the termination date, but does not terminate the reinsurance under the treaty when the receivership is a liquidation based upon a finding of insolvency. In this event, the first consideration in premium accounting is to calculate any unearned premium reserves that the reinsurers may be holding at the termination date and request that they be returned to the estate. There may, however, be additional premiums or adjustments to be forwarded to the estate for direct business issued and in-force prior to receivership.

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Appropriate calculation of this premium should take into consideration the earned portion due reinsurers. Proportional ceded reinsurance involves a calculation of the gross earned premium that is subject to the agreement and a credit to the reinsurer's account for the appropriate proportion. The gross earned premium is subject to ceding commissions due to the estate and, in most events, may be subject to an offset for paid losses.

2. Reinstatement Premiums

Premium adjustments may become due from the insurer to one or more reinsurers as subject premium is received or loss experience develops on business that was reinsured.

Certain types of excess of loss reinsurance agreements, primarily aggregate excess of loss agreements, may provide for an additional premium to be paid to the reinsurers if the total liability limit under the agreement is exhausted by loss payments. This additional premium is known as a reinstatement premium because its payment reinstates the limit of liability of the reinsurance agreement. Reinstatement may be optional, in which case the liquidator may wish to consider whether it should be paid, or if ultimate liabilities will be reduced due to the termination of the underlying policies.

Losses from direct business may be known sooner by the receiver, and reinstatement calculations, as defined by the treaty, may be prepared more rapidly. Losses from assumed reinsurance, however, usually develop over a period of years. For this reason, appropriate controls in accounting and claims are needed to identify any aggregate losses that may be subject to recovery from reinsurers.

The relative priority of such obligations should be considered in a liquidation, and the potential for preferential transfers should be considered in a rehabilitation. Notwithstanding this, it is important for the receiver to maintain current billing practices.

3. Losses Recoverable

Losses to be recovered from reinsurers may arise from both direct and assumed reinsurance operations. It is desirable for the receiver to coordinate reporting with guaranty funds to ensure complete, accurate and detailed information. Controls over this information are required to meet the data requirements of the reinsurance agreements.

In establishing its reinsurance processing procedures, the insurer should have provided for the capture of loss balances due or owing under each treaty or facultative certificate and for each participating reinsurer. If this information does not exist, it is important for the receiver to analyze each treaty by participation to identify each reinsurer. As a result of closer monitoring, a better control over slow-paying or non-paying reinsurers should be achieved.

In addition to paid losses for which the insurer seeks indemnification, outstanding reserves for losses and expenses (and possibly IBNR calculations) are to be reported to reinsurers. Controls should exist to identify certified and unauthorized reinsurers and to monitor the collateral they should provide, as well as the potential recovery against such collateral.

E. Assumed Reinsurance

Accounts for assumed business usually represent liabilities of the estate, as most premiums, except for premium adjustments, are typically received prior to receivership. Because assumed reinsurance is not covered by guaranty funds (except to a limited extent in NJ for life business), and assumed reinsurance generally falls within the general creditor class of the estate's distribution priorities, its accounting is often not of primary importance in liquidations unless collateral is involved. The existence of collateral account heightens the importance for ongoing accounting and reporting in the underlying business. The insurer, however, may have purchased reinsurance protection on this business and is required to properly record and report these transactions to its reinsurers or retrocessionnaires in order to realize recoveries from them,

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which may be significant. Also, it is common for insurers both to assume and cede reinsurance to the same insurers/reinsurers, so that mutual accounts may need to be completed to collect balances.

The general accounting approach to assumed reinsurance is the same as that for ceded reinsurance. The receiver should obtain and safeguard all original documentation, abstract arrangements for working purposes, establish balances as of the receivership date, review each treaty and facultative certificate, develop experience histories by treaty, and assign maintenance responsibilities.

Controls similar to those used for ceded insurance should exist over assumed reinsurance reporting. If business has been solicited directly from cedents, those cedents should be informed of any reporting requirements. If, however, a reinsurance intermediary is involved, then the receiver should communicate the requirements to the intermediary, who has the continuing obligation to report to the ceding insurers.

Intermediaries often remit a net payment for the balance due, which may cause problems in the identification and allocation of payments to various cedents' balances. This becomes more of a problem in liquidations, due to possible statutory limitations on setoff. The receiver should consult with competent legal counsel and determine whether to notify intermediaries not to use net accounting or multiple treaty or reinsurer setoffs. Unless rigorous control is maintained by the receiver, the cash allocation process may become difficult.

The action plan for assumed reinsurance is:

- Documentation
    - Obtain all treaties and update all documentation
    - Establish how treaties were assumed (direct/broker)
    - Abstract treaties into usable format
    - Update any electronic data processing systems used for assumed reinsurance
    - Prepare a matrix of the reinsurance program
- Accounts
    - Establish latest account position by treaty and cedent
    - Verify balances with broker or cedent, if direct assumption
    - Review experience on each treaty
    - Develop plan to deal with problem accounts
    - Request any missing accounts
    - Establish diary for any adjustments due on accounts
    - Review documentation to ensure proper reporting of catastrophic losses and aggregate accumulations
    - Establish diary control for collection of balances
        - Separate responsibility for pro rata reinsurance and excess of loss reinsurance
        - Set up procedures for evaluating and recording excess of loss claims

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F. Reinsurance Accounting Systems

Reinsurance accounting systems can vary however most systems are web-based. In a few cases, there may be a limited accounting system. The type of system used may depend upon the extent and the diversification of the cedent's reinsurance program.

1. Minimum Accounting System Requirements

The reinsurance accounting system must provide information to record the subject business for reinsurance in a manner readily identifiable for each reinsurance contract. The subject reinsurance premium is computed by application of the treaty rate to the subject premium and is adjusted for premiums paid on other reinsurance treaties that inure to the benefit of the treaty.

Losses that emanate from the subject business should be identified. Once the covered losses are identified, reinsurance recoverable under each treaty is computed. If the cedent reports to a reinsurance intermediary, who in turn reports to individual reinsurers, then one summary report should be prepared and mailed to the reinsurance intermediary. If the cedent insurer reports directly to the reinsurers, then individual reports should be prepared. The ceding insurer often retains a percentage of the risk for its account. This can be accounted for on a net basis or as if the ceding insurer is also a reinsurer.

2. Inventory of Reinsurance Accounting Records

The inventory of reinsurance accounting records should be coordinated with the inventory of records for the primary accounting function. The reinsurance accounting records should include:

- Chart and summary of the reinsurance program
- Correspondence files with intermediaries
- Correspondence files with reinsurers
- Formal reinsurance contract wording
- Reinsurance slips (if a formal treaty has not been finalized)
- Signed I&L forms from each reinsurer
- Letters of credit or other forms of security from reinsurers
- Reinsurance accounting folders

The insurer may have a reinsurance accounting procedure manual available that describes the reinsurance accounting cycle and how the data necessary for the reinsurance accounting is obtained and processed to comply with the reinsurance treaties.

The chart and summary of the reinsurance program should describe the various reinsurance treaties, the business covered, and the relationship between the treaties. An individual chart and summary may be available for each reinsurance accounting year. The chart and summary change from year to year as the reinsurance program changes to meet the insurer's needs, objectives and business reinsured.

Correspondence files with intermediaries may include confirmations of reinsurers' participation, accounting reports sent to the intermediaries, or letters requesting payments or cash advances, disputing amounts recoverable, requesting collateral, etc. The reinsurance intermediary is required under the NAIC *Reinsurance Intermediary Model Act* (#790) to retain documents for 10 years. The receiver should instruct the reinsurance intermediary to retain all documents until notified that the documents

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are no longer needed by the receiver. If the relationship with the reinsurance intermediary is to be terminated, arrangements should be made for the intermediary to deliver all documents in its possession, or copies of the documents, to the receiver.

3. Review of Reinsurance Intermediary Records

The receiver may benefit by reviewing the systems and procedures currently being used by the reinsurance intermediary and evaluating its performance. Where applicable, various reports generated by the insurer should be compared to the reinsurance intermediary's records. When reviewing the records of the reinsurer or of the reinsurance intermediary, consider the following:

- What is the status of the treaty documentation?
- Do the balances developed by underwriting year and by reinsurer conform to the balances generated from the insurer's system?
- Has there been a delay between submission of a request for payment and receipt of the payment? This information may become part of the reinsurer evaluation process. If a reinsurer is habitually late in making payments, the receiver should determine what actions are required. The receiver may wish to have the reinsurance intermediary copy the receiver on all billing transmittals.
- While not customary, the receiver should consider a periodic review of the reinsurance intermediary (every quarter to six months). The purpose of the audit is to verify that the receiver has received complete documentation concerning its reinsurance contracts (e.g., wordings and I&Ls), the reinsurance intermediary has collected all money due from the reinsurer, and all payments received by the reinsurance intermediary have been paid to the appropriate parties.

G. Reinsurance Audits

By custom as well as by contract, reinsurers may have access to the cedents' books and records that pertain to the business reinsured. This section will briefly explain the various types of audits, the purpose of each and the information that one can expect to obtain.

Virtually every reinsurance treaty has an access-to-records clause or an inspection clause, such as, "The reinsurers or their authorized representative shall at all times have access to the books and records of the company, which pertain in any way to the business transacted under this agreement." Most facultative certificates have a similar provision. The same often holds true for agreements with pool managers, managing general agents and reinsurance managers.

Audits typically cover accounting, claims and underwriting. Many reinsurance counterparties conduct separate audits, although it may be more effective to examine all three areas simultaneously. This is especially true in those instances where the audit is being conducted as a result of a dispute or in anticipation of arbitration or litigation. (Note that a "dispute" has statutory accounting consequences, so the prudent receiver will beware declaring a dispute too soon.) The receiver needs to coordinate with the reinsurer and any affected guaranty funds as to how the audit should be conducted and who should be involved in the audit. The prudent receiver also will negotiate a memorandum of understanding or non-disclosure agreement that summarizes the intent, scope and logistics (onsite vs. remote access, hours and location(s)) for any audit, which may include, e.g., provisions governing confidentiality, admissibility in a dispute resolution forum, etc.

7. Except in unusual circumstances, the auditors may be limited to review of records directly related to the business their clients assumed. They are generally allowed to review original records together with the cedent's and receiver's summaries of experience, to the extent those are prepared in the normal course of business. However, auditors should be denied material prepared in anticipation

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of litigation or preparation for trial, and in particular they should be denied access to communications to and from counsel retained in connection with reinsurance collections. These materials should be kept in files separate from the underlying claims and underwriting files. Auditors generally do, however, receive access, under appropriate safeguards to preserve confidentiality, to communications to and from claims counsel.

An important consideration is who needs to be present during an audit, from both the audting and audited sides.

1. Accounting Audit

The primary scope of this review focuses on verification of the periodic reporting (monthly, quarterly accountings) of the cedent. Although the bulk of the audit will be conducted at the cedent's offices, a significant amount of work, such as the following, may be conducted prior to that time.

- Review terms and conditions of reinsurance contracts, such as:
    - coverage (type of reinsurance contract, limits, underwriting restrictions, classes of risk and territory)
    - reinsurance period (including cancellation and termination provisions)
    - reporting and settlement
    - definitions
    - procurement of common account protection
- Review cedent's recent financial information, including:
    - financial statements
    - independent auditor's reports
    - financial reports filed with the Securities and Exchange Commission or similar authorities
    - financial statements filed with insurance regulatory authorities
    - other insurance department regulatory reports

A schedule of accounts and settlements between the assuming company and the cedent, according to the reinsurer's documentation, should be prepared to verify the balance outstanding on the account. This analysis should then be compared to a similar schedule from the cedent's records. The results can be used as a source of further investigation, if necessary.

Copies of the cedent's procedural manuals for accounting, claims, reinsurance, and audit should be obtained, reviewed and stored.

Documentation on hand should include the most recent experience reports on the program. Investigation should be made into significant deviations from normal business custom and practice. If desired, a comparison to similar programs with other cedents may also be made.

Comparison of such data to actual historical information, especially in the areas of premium volume and loss experience, may be performed to help determine the scope of the audit required.

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Prior to inception of the audit, which maybe in person or remote, a list of information and documentation required for the audit should be submitted to the cedent to facilitate its availability. The documentation that may be requested would include digital/electronic, read-only access to document sharing systems, and/or printed copies of:

- Premium and claim registers for originating business (primary or assumed)
- Individual policy and claim files to support registers for originating business
- Premium and claim registers for ceded business
- Individual policy and claim files to support ceded registers
- Accounts and bordereau from the cedent
- Cash receipt and disbursement records (including checks, cash journals, ledgers) applicable to settlement of premiums and losses for originating and ceded business
- All contracts relating to managing general agents, brokers, intermediaries and common account protection for originating and ceded business
- All documentation and support relating to letters of credit, trust accounts and funds withheld

Although generally not specified in the inspection clause, the auditors should have reasonable access to personnel involved in the preparation of any of the cedent's documentation pertinent to the audit procedures.

Having completed review of the pre-audit documentation and assuming the availability of all required information at the cedent's office, the audit may:

- Trace information on originating premium and claim registers through the reports to assuming reinsurers.
- Determine relationship of premium and claim registers for originating business (primary or assumed) to ceded premium and claim registers.
- Verify accuracy of reinsurance accounts and the existing control procedures for preparation of accounts to assuming reinsurers based on review of originating and ceded premium and claim registers.
- Analyze cash records in conjunction with accounts to assuming reinsurers to determine balance due from or to cedents;
- Verify timeliness of reporting and settlement of accounts.
- Sample policy files (reinsurance contract files for assumed business) and claim files from premium and claim registers to verify that:
    - policies are in agreement with treaty terms relative to class of risk, period, limits and other provisions.
    - premium allocations for policies are proper, as are all commissions and other deductions.
    - claims are adequately documented and fall within the policy conditions.

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Irregularities encountered in any of the above may be referred to the appropriate staff member of the cedent for resolution of the problem.

This is a simplified outline designed to establish a pattern for the audit. These general steps may not apply to the same degree in all instances. Individual audit programs should be geared to address the needs of the situation, contingent on the nature and volume of the business, as well as the auditor's evaluation of control systems in place.

2. Claim Audit

The ceding insurer should have adequate control procedures in place to allow the assuming insurer to make a determination on the accuracy and validity of the claim information it receives, as well as to assess the competence of the cedent's claims personnel.

- Claims procedure. Preliminary examinations of claim procedures, as outlined in the cedent's current and any prior claims manual(s), should be performed prior to the on-site review. Prior to the examination, a list of documentation required, including the following, should be requested:
    - Claim staffing, including description of positions
    - List of outside vendors, including adjusters, defense/claim attorneys and others
    - Claim control log
    - Claim registers, including aged listing of outstanding claims and salvage and subrogation registers
    - Claim files and related policy/assumed contract files
    - Cash records applicable to claim and expense payments

Assess the Claim Staff. An analysis of the claim control log, claim register and aged listing of outstanding claims, along with the claim handling and diary system procedures outlined in the cedent's claim manual, should be indicative of the adequacy of staffing levels. Discussion with the appropriate claim personnel and review of the claim manual should indicate procedures used to assign claims to outside adjusters and the follow-up procedures used to keep the status on claims current.

A random sampling of claims from the loss registers should be made to determine files to be examined for the remaining portions of the audit. If specific areas or claims are suspect, these files can be requested and examined in addition to the random sample.

4. Claims review generally will include the following:

    - Determination of adequacy of file documentation, including notice of loss, adjusters' reports, attorneys' reports,[3] litigation releases and proofs of loss (including reinsurance notices)
    - Verification of coverage of originating policy and reinsurance agreements as to term, risk, limits and other provisions

[3] Whether the reinsurer is entitled to these reports is the subject of frequent litigation, and the receiver should seek legal counsel before providing or not providing these reports.

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- Reconciliation of payments (loss and expense) to claim filed documentation
- Determination of third-party recoveries (salvage, subrogation, third-party deductibles and other reinsurance)

Claims accounting may require special attention. The auditor will want to verify the correctness of claim allocation by sampling allocation by claim registers and the cedent's retention. In some instances, a review of the claim registers for originating and ceded business may disclose problems in claim allocation.

5. Underwriting Audit

An underwriting audit conducted by the receiver of an insolvent company may differ from that performed by a reinsurer contemplating a continuing relationship with an insolvent cedent. Some vital areas that may be considered during such audit include verification that:

- Premium volume is within guidelines outlined in the reinsurance agreement, if any.
- Controls are in place to determine effective and complete reporting of premiums.

A sample of policy files may be selected (or the policy files that correspond to those used in the accounting or claims audit should be reviewed) to determine whether:

- Risks written conform to the specifications of the reinsurance agreement relating to class of business, types of coverage, exclusions and other warranties.
- Risks written conform to underwriting guidelines.
- Underwriter's approval has been properly executed in accordance with the reinsurance agreement and any related underlying agreement (e.g., managing general agents, brokers).
- Policy endorsements alter reinsurance obligations.
- Premiums have been properly developed to include reporting forms, business subject to audit and retrospectively rated business.

Auditing counterparties typically prepare summaries of their findings. The receiver will want to request and receive a copy of any such report.

6. Handling Audits of Receiver's Records

Because of the receiver's activity in collection of reinsurance balances claimed due, the receiver frequently receives requests for audit of his or her own records and those of the insolvent company. Allowing an audit is an important step in the ultimate collection of the insurer's reinsurance recoverables, but care should be taken that the audit process neither creates new defenses for reinsurers, disrupts the receiver's own efforts to manage claims and assets, nor violates any applicable statutory confidentiality provisions.

7. Preconditions to Audit

After taking possession of the insurer, the receiver is entitled to adequate time to gain control and understanding of the insurer's affairs and records before being subject to audit by reinsurers. Reinsurers may make preemptory demands for audit well before the receiver can respond. The receiver should assure the reinsurer that it will have an opportunity to audit as soon as the receiver has had sufficient time to become familiar with the records he or she has inherited.

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The receiver should consider developing a standard audit procedure to be followed. Once the receiver in consultation with triggered guaranty funds is prepared to schedule an audit by the reinsurer(s), several dates should be requested from the auditor, so that the receiver and guaranty funds have the opportunity to ensure availability of requested claim files, crucial staff and space, and possibly counsel. The receiver needs a firm commitment from the auditors as to the time required for completion of the audit, especially where the claims requested include claims that are open and ongoing with guaranty funds.

To facilitate the audit and ensure document control, the receiver should request a list from the auditor of all files to be reviewed. The receiver should contact affected guaranty funds and arrange for file shipment. The receiver should send a letter to the auditor outlining the procedures to be used for the audit and identifying the liaison between the auditor and the company. The receiver should also have the auditor and the reinsurer sign a confidentiality agreement before the audit to protect the interests of the estate and the insured

8. Preparations for Audit

The auditor may be asked to designate in advance the records to be reviewed, so that they can be located and retrieved. Someone on the receiver's staff or counsel is usually designated to become familiar, if they are not already, with the history, terms, accounts and major issues arising from the business being audited, and to serve as principal liaison between the auditors and the receiver. Arrangements should be made to provide the auditors with a designated space, ideally a separate room, to which records can be brought as requested. Control over records produced for the auditors is essential. Arrangements should be made to have copies (and/or screen shots of electronic or digitally stored material) made, at the reinsurer's expense, of any records or documents they designate, and the receiver should keep track of what is copied. Pricing and availability of copying services should be discussed with the auditing company.

9. Conduct of the audit and follow up

Members of the receiver's staff not personally involved in the audit should be advised that an audit is being conducted, and reminded that requests for information from auditors should be in writing and referred to the designated liaison to ensure correctness and consistency of the information provided.

The receiver should request, and often will receive, a copy of the auditor's findings at the conclusion of the audit.

H. Managing Assumed Reinsurance

Even though assumed reinsurance claims have a lower payment priority in liquidation, maintaining and processing assumed reinsurance claim activity may be vital for setoff purposes, to develop satisfactory support for any retroceded reinsurance that the insolvent insurer may have purchased, and to ensure that existing funded security is not improperly drawn down. Preparation of a schedule of reporting due dates for each assumed reinsurance treaty is helpful.

Pro rata reinsurance loss activity will be reported in a summary of all losses on individual policies reinsured. This summary report, or bordereau, should be accompanied by individual policy identification and loss data.

Initially, a reconciliation of the proofs of loss submitted by or on behalf of cedents may be undertaken with the physical inventory of pending or unprocessed assumed reinsurance claims. The receiver's staff should establish procedures so claims submitted by cedents conform with the terms of the reinsurance treaty, including dates of loss, coverage impacted such as lines or classes of business, and types of risks reinsured. Questions or problems may be referred to the reinsurance intermediary or cedent as appropriate.

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Next, all assumed claims should be reviewed to ensure that they are being reported to the reinsurer in a manner consistent with the requirements of the reinsurance agreement, including issues of coverage, claim support, and timing of reporting. Each reported loss should also be reviewed to ensure there is an appropriate reserve. The receiver's staff should develop additional case reserves if required and, if appropriate, notify reinsurers and retrocessionnaires. The retrocedent should consider doing the following:

- Review (all) incoming loss advices.
- Match loss advices with treaty or facultative certificates.
- Confirm coverage.
- Create a file and enter data, calculating the appropriate share of paid and outstanding.
- Maintain a diary system, either manual or(preferably) electronic.
- Identify all applicable retrocessional treaties and transmit timely notice based on respective terms and conditions.
- Request updates, pertinent information, and documentation through the intermediaries as needed.
- Establish format for closing and eventual purging and storage, pursuant to applicable law and any litigation holds(s).
- Confirm that catastrophic losses are identified and reported (these should be accumulated with potential retrocessional recoveries in mind).
- Review each loss in detail and post any additional case reserves deemed necessary.
- Inquire as to any inuring reinsurance or common account.
- Monitor cedents' pursuit of subrogation, salvage, and other recoveries.
- A separate file is usually required for each facultative certificate or excess of loss treaty, and a separate claim file for each loss under a certificate or treaty may be desirable.
    - For pro rata reinsurance treaties, a single file encompassing one underwriting period should suffice, provided the bordereaux are informative enough for the technical staff to verify coverage.
- If annual aggregate coverage is involved, a system-produced report is helpful for tracking aggregate exhaustion.
- Develop forms for all the above.

I. Managing Ceded Reinsurance Collections

1. Direct Claims and Guaranty Funds

A primary consideration for the receiver is to prepare for the collection of ceded reinsurance for claims that will eventually be allowed by the liquidation court. To that end, the receiver should:

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- If necessary, in addition to Uniform Data Standards (UDS), develop a reporting system to be used by the guaranty funds that conforms to the requirements of the insurer's reinsurance agreement(s).

- Reconcile the insurer's records to periodic reports from the guaranty funds.

- Promptly and adequately document the handling of direct claims that are not covered by guaranty funds so as to be able to notify and bill reinsurers

- Ensure there is adequate control over any claims settled at an amount in excess of the guaranty funds' statutory limits.

- Ensure that the guaranty associations are handling claims properly. This is generally done by audits of the associations.

2. Reports

Accounts rendered should be on forms mutually agreed upon by the cedent and reinsurer, and payments from the reinsurers should be made within the payment terms required by the treaty, without diminution because of the insolvency of the cedent.

The different forms of reinsurance contracts may have different reporting requirements. Because the reinsurer is not required to pay a loss unless the information to support the cedent's payment has been received, it is prudent that the receiver deliver this information as soon as possible. Developing this information often requires coordination with guaranty funds.

3. Insolvency Clause

A reinsurer is obligated to reimburse its ceding insurer for a covered loss after the cedent pays or becomes liable or responsible for underlying loss. This arrangement functions well in ongoing business; however, historically it raised practical problems when the ceding insurer became insolvent. Given the indemnity nature of a reinsurance contract, the receiver often could not demand the reinsurer pay its portion of covered claims until the receiver had paid the underlying claims. Typically, the receiver of a ceding insurer was not able to pay such claims prior to receiving the reinsurance payments and, therefore, had difficulty recovering reinsurance receivables.

In 1939, the New York legislature passed a law requiring that all reinsurance contracts contain an "insolvency clause" if the cedent desired to receive credit for reinsurance. Following the 1939 law in New York, many states enacted a similar requirement, and all states now require some type of insolvency clause, which comes into effect if the ceding insurer is found by a court to be insolvent in an order of liquidation. The insolvency clause obligates the reinsurer to pay recoveries it owes under the reinsurance contract on the basis of the ceding company's allowed claims, not on the basis of whether the insolvent cedent has actually paid the money it owes its policyholders.

Most courts recognize that the main purpose of the insolvency clause is to ensure that a receiver has the requisite access to reinsurance funds.

There may be unusual instances where the reinsurance contract does not contain an insolvency clause, but the contract provides that its interpretation or enforcement is subject to applicable state law (typically the ceding insurer's state of domicile). Many state insurance laws provide that a reinsurance contract must contain required terms before the ceding insurer may claim reinsurance credit for the reinsurance, and one of the required terms provides that the contract must contain insolvency clause language. Thus, a receiver should also determine if the applicable state law requires that reinsurance be paid without diminution because of the ceding insurer's insolvency, as this state law may allow for

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recovery in situations where an insolvency clause is not otherwise available for the recovery of reinsured claims.

4. Notice to Reinsurers

The insolvency clause usually provides that the reinsurer shall be given notice of the pendency of each claim against the company on the policies insured within a reasonable period of time after such claim is filed in the insolvency proceeding. The clause also provides that the reinsurer has the right to investigate each such claim and to interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defenses which it may deem available to the company or its liquidator.

V. TERMINATION OF REINSURANCE RELATIONSHIP

There are five principal methods for terminating a reinsurance relationship: commutation, cancellation, novation, rescission, and by operation of law. Before a receiver uses any of these methods, careful consideration should be given to whether the financial consequences will benefit the insolvent insurer and, consequently, the creditors. By assessing the potential benefits, a receiver will be able to prioritize efforts.

A. Commutation

A commutation is simply a mutual release from a contract in exchange for consideration. The mechanics of a loss commutation are that the reinsurer, by a cash payment to the cedent, discounted to present value, removes the outstanding reserves and IBNR from its books. The result on the cedent's books is that its surplus decreases by the amount of the difference between the cash received and the undiscounted reinsurance recoverable; the reinsurer's surplus is benefited in the same amount.

Commutation may be viewed as a special type of cancellation or as a means of ending the relationship after cancellation has occurred. Note that the New York Insurance Law requires commutation clauses to be included in life reinsurance agreements.

1. Commutation During Rehabilitation

It may be advantageous for the receiver to commute assumed business of an insurer or reinsurer in rehabilitations. Under certain circumstances, commutation could permit the receiver to expedite billing and collection from its reinsurers and retrocessionnaires. The alternative is to allow claims to remain open for an extended period, increasing the administrative burden and expense for both the receiver and the cedents. Note that the insolvency clause may apply, especially in property/casualty

Likewise, the receiver in rehabilitation may find a benefit in offering to commute outstanding losses with its reinsurers. There may be factors, such as knowledge of the weakened financial condition of a reinsurer, a desire to quantify IBNR relating to long-tail casualty business, or the ability to obtain immediate cash, which need to be considered when commuting with reinsurers and retrocessionnaires.

Early commutation may benefit the estate by bringing in cash and avoiding controversy and delay in collection. The receiver is unlikely to be as concerned as an insurer outside of receivership would be, with the loss of surplus inherent in discounting loss reserves to present value.

2. Commutation During Liquidation

Commutation of assumed business by an insolvent reinsurer is the equivalent of determining creditors' claims but may raise questions of priorities or preferences to creditors in rehabilitation as well as liquidation, because commutation terms may require immediate payment to a creditor class which otherwise may not share in distributed assets until a later date, if at all. Commutation of an insolvent insurer's ceded business should involve consideration of the factors discussed above for the

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commutation of ceded business by an insolvent insurer in rehabilitation. The receiver should consider the advisability or necessity of obtaining receivership court approval of commutation agreements.

The NAIC *Insurer Receivership Model Act* (#550) (IRMA) contains provisions regarding commutation of a reinsurer's liabilities. Sections 614 and 615 of IRMA allow a receiver to commence mandatory arbitration of commutation proposals after a certain amount of claims development or in the case of a reinsurer in financial difficulty (as defined by the state's RBC provisions). Section 614 requires receivership court approval for commutations having a gross consideration in excess of $250,000.

The provisions of IRMA outline the procedures, rights and duties of both receivers and reinsurers in the arbitration process and allow the formation of a reinsurance recoverable trust for the satisfaction of any arbitration award. State law should be consulted to ensure compliance with the specific applicable details.

3. Technical Aspects

a. Data

A successful commutation requires complete, accurate and current data. Therefore, the receiver of a ceding insurer should update loss and premium figures in collaboration with respective state guaranty associations and reinsurance intermediaries before attempting a commutation.

The receiver of a reinsurer is largely dependent on information provided by the ceding insurers and reinsurance intermediaries. As a result, the receiver should consider conducting an on-site review or audit of the cedent's records relative to the program or treaty in question. The purpose of the examination is to ascertain that the reinsurer's accounts accurately reflect the business that was or should have been ceded.

b. Evaluate Future Loss Development

Future loss development is necessary to estimate the cost of the commutation. Actuarial staff should provide the calculation. Three basic steps are involved:

- Project reported outstanding and IBNR losses to ultimate incurred commensurate with the risk reinsured (e.g., auto v. general liability and/or asbestos).
- Project the timing of payment of losses to ultimate incurred.
- Calculate the net present value of ultimate incurred losses based on anticipated payment dates. If the parties can agree on a net present value, that becomes the commutation figure.

B. Cancellation of Reinsurance Treaties

1. Term Treaties

The majority of facultative reinsurance agreements and some reinsurance treaties have a fixed termination date, often an anniversary of the date of inception. Nothing needs to be done to end coverage as of that date; it simply expires. These contracts often may be canceled as of an earlier date with 60 or 90 days written notice to the other party, or as specified within the terms of the reinsurance agreement. Cancellation, however, does not usually end the reinsurance relationship, which continues until all claims are submitted and paid, particularly in respect of business written on an occurrence basis.

Non-life business in force at the date of receivership, including assumed reinsurance, is usually terminated within 31 days of the receivership order. Some categories of reinsurance agreements are

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difficult to terminate midterm (such as aggregate excess of loss and stop loss reinsurance agreements), due to loss accumulation period requirements under the contractual provisions. Under a rehabilitation proceeding, however, the receiver would have the option of continuing in-force reinsurance business during an appropriate run-off period instead of effecting a cut-off or early cancellation date.

2. Continuous Treaties

Most obligatory treaties and some facultative agreements have no fixed termination date and continue until terminated by one of the parties. Often, these agreements may be terminated by written notice 90 or 120 days prior to an anniversary of the inception date, or as defined by the reinsurance agreement.

3. Notice of Cancellation

While the form of the notice of cancellation is usually stated in the reinsurance agreement, there are certain aspects to the cancellation process that are not as obvious. The prudent receiver will consult competent legal counsel on the legality and/or effectiveness of a receivership triggered termination. Reinsurance treaties, both term and continuous, are reviewed annually in what is known as a renewal process. Either party may issue a provisional notice of cancellation while renewal negotiations continue. The provisional notice can be withdrawn once a new agreement is reached. Another means of accomplishing the same purpose is for the parties to agree to a reduced period for notice of cancellation.

4. Cut-off vs. Run-off Cancellation

Facultative reinsurance is generally coterminous with the underlying policy. Treaty reinsurance generally applies to policies incepting during its term, and therefore continues to apply as long as the underlying policies have losses reported the underlying policies are often canceled by a liquidation order, but claims will continue to be reported). This is referred to as "run-off." The receiver may also elect to cancel treaties on a "cut-off" basis, pursuant to which the reinsurer returns any unearned premiums and has no responsibility for losses that occur after the treaty terminates.

C. Novation

1. Definition

In novation, a new insurer is substituted for the existing insurer, and the insured must look to the substituted insurer for performance and must pay premiums to the substituted insurer. In a reinsurance context, the principles remain the same, although it should be a three-party agreement between the cedent, the reinsurer and the original policyholder.

Insurance terminology tends to call a novation "assumption and reinsurance." This term is more descriptive of implementation techniques but is inaccurate even in this limited role. The novation usually takes the form of a reinsurance treaty but one with an unusual feature. Not only does the reinsurer assume 100 percent of the risk, the reinsurer also is substituted for the original insurer. It is the latter feature that distinguishes a novation from a reinsurance transaction.

2. Use of Novation

The principal purpose of a novation is to move an existing book of business from one insurer to another. Novation may be more efficient than having the original carrier not renew the business while the new insurer is soliciting the same insureds. Regulatory limitations on nonrenewal of certain lines of business and consumer protection may be primary reasons for novation.

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3. Practical Difficulties

Traditionally, a novation requires the consent of all parties to the contract, the insured, the original insurer and the reinsurer. (Kansas is a notable exception in respect of financially troubled life insurers.) It may be difficult to obtain the actual consent of thousands of policyholders who may not understand the process and who may not be sufficiently interested. There is considerable debate as to the level of notification and consent necessary for a novation. Some insurance departments have required mass mailings to insureds explaining the transaction and offering the opportunity to object or decline novation. However, in a receivership, a transfer of business can often be arranged under the receivership authority statute and/or the order of the receivership court.

4. Bulk Transfer Distinguished

In general, a bulk transfer is the reinsurance of all or substantially all of a book of business. Often, a bulk transfer requires notice to the cedent's state of domicile. A bulk transfer may or may not involve a novation, and a novation may or may not involve all or substantially all of an insurer's book of business. The difference is whether the prior reinsurer continues to retain any liability or ongoing obligation.

D. Rescission

1. Definition

It is important to distinguish "rescission" from "cancellation." Cancellation means to terminate the unperformed portion of a treaty. Rescission restores the parties to their original position prior to entering into the treaty. Rescission is a remedy available only under limited circumstances.

2. Technical Aspects

Typically, general contract principles apply to reinsurance contracts. Under general contract principles, rescission may be obtained by mutual consent of the parties, by a party that has been injured by acts of the other, or through litigation or arbitration proceedings Generally, reinsurance agreement rescissions occur because a party contends it has been defrauded or damaged. Most disputes arise because the reinsurer believes the cedent has made material misrepresentations respecting the nature, quality or volume of the business ceded. In these cases, a complete accounting or a reconstruction of accounts for the contract period may be required.

E. By Operation of Law

In some states with enabling legislation, insurance business may be transferred by operation of law. Since 2000, reinsurance counterparties in the EU have been able to transfer direct and assumed insurance portfolios with continued coverage for re/insureds and a full release for the transferor without completion of either a novation process or concomitant opt-in/out rights for re/insureds. In the US insurance market, a small number of states offer one or both of the following two alternatives: insurance business division and insurance business transfer. Coordination regarding policyholder rights in other jurisdictions and other state laws is an important aspect that is receiving ongoing study in US Insurance regulators. See meeting materials, exposure drafts, and other documents of the NAIC Restructuring Mechanisms Subgroup[4] for updates in this area.

Business *division* (e.g., in Arizona, Connecticut, Delaware, Georgia, Illinois, Iowa, Michigan, Pennsylvania[5]*)* offers companies the ability to divide business operations into two or more entities upon the approval of the regulator;

[4] https://content.naic.org/cmte_e_res_mech_sg.htm
[5] *See, e.g.,* 215 ILL. COMP. STAT. 5-35B.

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business *transfer* is effected via novation following judicial approval (e.g., in Rhode Island, Vermont and Oklahoma[6]); both mechanisms have regulatory and judicial components.

Oklahoma approved the first transfer in an intra-group transaction and Illinois approved the first US division, also in an intra-group transaction. Each of these is highly specialized, and review of the requirements to effect in, and/or the impact upon, a receivership should be undertaken with the advice of competent legal counsel.

VI. SETOFF

A. Overview

Setoff is a device that permits two contracting parties to net reciprocal debt obligations and pay only the remaining balance. It is an important element of any receivership. Setoff is an area of considerable controversy, and it is important to develop an effective approach for handling the various issues that will arise because of its application. It is important to begin this approach early in the receivership with a careful analysis of the applicable provisions of the governing receivership state law. Note that there are/may be unique issues arising from the organizational structure of counterparties; e.g., policyholder-owned reinsurers, fronting insurers, captives (including "pure," hybrid, and series captives), and special purpose vehicles. For example, "triangular" set-offs are not permitted. Thus, where A owes B, C owes A, and B and C are affiliates, A may not lawfully set off what it owes B against what C owes A.[7]

B. Recoupment and Counterclaims

The concepts of setoff, recoupment and counterclaim are often confused. Although each provides a means by which a debtor may attempt to limit the net amount of a creditor's recovery, it is important that the receiver have a basic understanding of the distinguishing features of each procedure, as well as the central concept of "mutuality" (and potential differences imposed by varying priorities of asset distribution) which are discussed in Chapter 9—Legal Considerations.

C. Procedural Steps in Administering Setoffs

The receiver should review the governing receivership state's current statute relating to setoff, and determine the past practices and procedures that have been utilized within the jurisdiction. It would also be prudent to review any court rulings and decisions relating to setoff to determine their applicability to various issues that may arise. The reinsurance agreement may also have provisions relating to setoff, although they may not override applicable statutes.

Once the receiver has elected a course of action for handling setoff issues, written policy and guidelines should be prepared, and coordinated with and reviewed by counsel. The receiver may file the setoff policy and its guidelines with the receivership court and communicate as soon as practicable to cedents, reinsurers, intermediaries and other interested parties.

It may also be necessary for the receiver to audit or review reinsurance account statements, including payments received and processed earlier by the receiver's internal staff, to ensure that there is a consistent application of the mandated setoff procedures. If it is determined that improper setoffs are being applied, communications to appropriate parties should be initiated, and if the matter cannot thereafter be mutually

[6] *See, e.g.,* OKLA. STAT. tit. 36, § 1681-8
[7] *In re Orexigen Therapeutics, Inc.*, 990 F.3d 748 (3d Cir. 2021).

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resolved, the receiver should consider mediation, partial or total rejection of a proof of claim, or appropriate legal action, including arbitration and litigation.

Some receivers require details about claimed set-offs to be included in proofs of claim.,

D. Setoff Against Insolvent Insurers and Reinsurers

To determine if the receiver has a right of setoff against an insolvent insurer or reinsurer, the insurance law of the state of domicile of the insolvent insurer or reinsurer may be applicable and therefore will need to be reviewed. It will be necessary to determine whether the receiver will be able to assert setoff under the other insolvent's domiciliary state laws. See Chapter 9—Legal Considerations.

VII. ARBITRATION CONTROVERSIES

An insolvent insurer will likely be involved in dispute resolution. There will be looming questions, however, of how the resolutions will occur, how the disputes will be resolved, how long they will take and how much they will cost. These are questions a receiver will face on a regular basis.[8]

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.

Many reinsurance agreements contain clauses that require parties to a reinsurance agreement to resolve their disputes through arbitration. When one of the parties is in receivership, the issue of whether reinsurers may compel arbitration or are required to resolve their disputes in the receivership court is governed by local law.

A majority of reinsurance agreements provide for arbitration as the sole means of resolving conflict. Most courts, including the U.S. Supreme Court, favor enforcing agreements to arbitrate, but a small number of jurisdictions have held otherwise. 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 being a confidential process, having expert triers of fact, offering broad ranges of relief, and other procedural and substantive benefits. However, there is no right of appeal *per se,* and successful challenges to arbitral awards are difficult to mount.

Arbitration rights within reinsurance agreements are enforceable under Section 105E of the NAIC *Insurer Receivership Model Act* (#550). If there is a balance payable to the receiver after offsets are considered by the arbitrator, that balance must be paid in cash. If, alternatively, the balance is in favor of the reinsurer, that balance becomes a claim against the insolvent insurer to be paid pursuant to the priority scheme, pro rata, when the insolvent insurer's assets are distributed.

VIII. LETTERS OF CREDIT

A. Nature of the Letter of Credit in Reinsurance Transactions

In general terms, the letter of credit (LOC) is an undertaking by a bank as issuer to honor a draft drawn upon it by a beneficiary (the cedent) in accordance with the terms of the LOC. The LOC is issued by the bank at the request of a the reinsurer, in furtherance of a separate agreement between the reinsurer and the ceding insurer. Reinsurers may also be beneficiaries of LOCs provided by cedents to collateralize future premium payment obligations and ensure financial statement credit.

The bank is obligated to pay on the LOC when the beneficiary presents a sight draft that complies on its face with the terms of the LOC. In many jurisdictions, compliance with the LOC terms must be exact to

[8] This is a very cursory discussion—please refer to the Legal Chapter for a detailed analysis of this subject.

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trigger the bank's payment obligation. In some jurisdictions, substantial compliance is sufficient to trigger the bank's payment obligation. The bank should not look at whether the underlying reinsurance agreement was properly performed before it pays on the complying sight draft. Any contractual disputes between the account party and the beneficiary involving the reinsurance agreement remain separate from the issuing bank's obligation to pay under the LOC.

In the insurance industry, LOCs are frequently used to enable the reinsurer to secure their obligations to the cedent under reinsurance agreements so that the cedent may take credit for the reinsurance on its financial statement, either as an asset or as a deduction from liability. This is permitted under the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786).

In the event of a failure of the reinsurer to fulfill its obligations under the reinsurance agreement, the cedent may draw down the LOC. The issuing bank must honor such a demand, unless the demand documents are forged or are otherwise tainted by fraud, or there was fraud in the underlying transaction. These exceptions must be distinguished from mere commercial disputes between the parties, which, as noted above, do not impact the bank's obligation to pay on a complying sight draft.

B. Basic Features of the Letter of Credit

The Credit for Reinsurance Model Law and Regulation are an accreditation standard, and as such the provisions for LOCs in each state's laws must be substantially similar. LOCs supporting reinsurance with certified or unauthorized must be "clean" (that is non-"documentary" under which certain evidence may be required), meaning the LOC must be payable on a sight draft without any supporting documents, and the LOC must be irrevocable, meaning it cannot be terminated prior to expiration by the account party without the beneficiary's consent.

Acceptable LOCs are required to contain an evergreen clause, which requires the bank to give specified advance notice (usually 30 days) of non-renewal to the beneficiary/cedent. Failure of the bank to serve notice of non-renewal prevents expiration, resulting in an automatic renewal of the LOC. On the other hand, non-renewal of the LOC while balances remain due to the cedent is grounds for the cedent to draw down the LOC.

In addition to these basic features, the bank issuing the LOC must meet certain standards in accordance with Model #785, Section 4. Other states require that the LOC be issued or confirmed by either a domestic bank, a foreign bank licensed in the United States, which is either on the NAIC Securities Valuation Office (SVO) list.

C. What Should a Receiver Know About LOCs?

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the LOCs and list them in accordance with the treaties collateralized and expiration dates. Any evergreen clauses should be noted on treaties under notice of cancellation.

Counsel should be consulted to confirm that the receiver has the power to draw down the LOCs, or if the receiver does not, this power should be immediately obtained from the supervisory court.

It is recommended that a receiver notify each issuing bank that the cedent is in receivership. The receiver should take whatever steps are necessary to ensure that only the receiver is empowered to draw down the LOCs and that the receiver will receive notices of non-renewal. The receiver should seek to have the LOC amended to change the name of the beneficiary to the estate.

Each reinsurer should be advised by the receiver that it must maintain the outstanding LOCs in accordance with the terms of the specific reinsurance agreement.

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Once the above steps have been taken, the receiver should verify the liabilities secured by the LOCs. If an LOC is about to expire and leave outstanding obligations unsecured, the receiver should notify the reinsurer to renew the expiring LOC. If the reinsurer does not agree to renew, counsel should be consulted on the appropriateness of drawing down the LOC to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify all of the LOCs issued on behalf of the reinsurer and list them in accordance with the contract collateralized and expiration date. If any notices of termination have been issued pursuant to evergreen clauses, these should also be listed. Finally, if any collateral has been posted with an issuing bank to secure the LOC, the receiver should properly identify such collateral.

It is also recommended that a receiver notify each issuing bank that the reinsurer is in receivership, and identify the receiver to confirm that only the receiver is authorized to give the bank instructions with respect to the LOCs, which would normally be given by the account party.

The receiver should also communicate with all cedents in whose favor banks issued LOCs on behalf of reinsurers so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the LOCs will be maintained in accordance with the reinsurance agreement. The receiver should also take whatever steps are necessary to ensure that the LOCs will not be improperly drawn down.

Once the receiver properly identifies all of the outstanding LOCs and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the LOCs in order to protect the reinsurer's position by preserving its collateral. The receiver should ascertain the liabilities secured by the LOCs and guard against wrongful draws by cedents against the outstanding LOCs. A danger also exists that the collateral posted will be wrongfully used by the bank to gain a preference on other, unsecured debts allegedly owed to the bank by the reinsurer. The receiver can also protect the reinsurer's position by depositing any interest earned on collateral into the reinsurer's estate, assuming this power is consistent with the account agreement.

There also may be unique set-off issues.

IX. TRUST FUNDS

A. Nature of the Trust Fund in Reinsurance Transactions

A reinsurance trust fund is an arrangement between the reinsurer (the grantor) and the cedent (the beneficiary), under which assets are deposited with a trustee, pending the performance of certain contractual obligations between the parties. In some instances the cedent may be the grantor and the reinsurer may be the beneficiary. If the beneficiary makes a demand upon the trustee stating that the contractual obligations are unfulfilled, the trustee is obligated to pay in accordance with the terms of the trust. The Credit for Reinsurance Model Regulation (#786) contains minimum standards for how a trust should be established and operated.

In reinsurance, trust funds serve as an alternative to LOCs. Certified and unauthorized reinsurers establish and fund them to secure their obligations to the cedent. Trust funds serve as security for the risk undertaken by the cedent and ceded to the reinsurer, allowing the cedent to take reinsurance credit for the ceded risk. Only certain specified assets are generally permitted to be used to fund the trust, including: cash, certain readily marketable securities such as United States government obligations and nationally traded stocks, and clean, irrevocable letters of credit.

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B. Basic Features of the Trust Fund

The administration of the trust fund is governed by the trust instrument that provides for the term, or duration, of the trust fund. It may also include a provision concerning control of the trust assets. The grantor is often given the power to substitute qualified assets, so long as the value of the corpus remains at the agreed level. The trust instrument may also include a provision concerning the ability to control investment of trust assets.

During the term of the trust fund, the principal will yield interest, and the trust instrument may contain a provision allocating the interest either to the grantor or the trust corpus. The trust instrument may also specify under what circumstances a demand can be made on the trustee, allowing the grantee to obtain trust funds. In the event that the grantor wishes to terminate the trust, the trust instrument will include a provision requiring the grantor to give advance notice to the trustee that the trust will be terminated. Finally, in the event that a trustee should resign or die, a provision may be included that allows for the substitution of trustees.

C. What Should a Receiver Do About Trust Funds

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the trust funds established in the cedent's favor and list them in accordance with the treaty collateralized and expiration dates. If any notices of termination have been issued on the identified trust funds pursuant to their termination provisions, these should also be listed.

The receiver should also ensure that he or she is empowered to remove assets from the trust funds if such removal is necessary to fulfill the reinsurer's obligations under the reinsurance agreements. Counsel should be consulted to confirm that the receiver has the power to remove assets and under what conditions assets can be removed, or if the receiver does not, such power should be immediately obtained from the supervisory court.

It is also recommended that a receiver notify each trustee that the cedent is in receivership, clearly identify the receiver, and take whatever steps are necessary in each case to ensure that only the receiver is empowered to remove assets from the trust funds that might otherwise be removed by the cedent.

The receiver should also communicate with each reinsurer on whose behalf a trustee holds a trust fund with the cedent as grantee so that each is aware that the cedent is in receivership. The receiver should assure each reinsurer that no improper removal of assets will occur. It should also be emphasized to the reinsurer that it must maintain the trust funds in accordance with the terms of the specific reinsurance agreement.

Once the receiver properly identifies all of the established trust funds and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the trust funds in order to protect the cedent's position by preserving its security. The receiver should ascertain the liabilities secured by the trust funds. If a trust fund is about to expire, and may leave outstanding obligations unsecured, the receiver should call upon the reinsurer to continue the expiring trust fund. If the reinsurer refuses to maintain the fund, counsel should be consulted on the appropriateness of removing assets from the trust fund to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify the trust funds established on behalf of the reinsurer as grantor and list them in accordance with the agreements collateralized and expiration dates. If any notices of termination have been issued pursuant to the termination provisions of certain trust instruments, these should also be listed.

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It is also recommended that a receiver notify each trustee that the reinsurer is in receivership, clearly identify the receiver, and confirm that only the receiver is authorized to give the bank instructions with respect to the trust funds, which would ordinarily be given by the reinsurer.

The receiver should also communicate with all cedents in whose favor a trustee holds a trust fund with the reinsurer as grantor so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the trust funds will be maintained in accordance with the reinsurance agreement, although the receiver will probably be unable to comply with the demands for increases in trust funds or LOC balances due to the probability of creating an illegal preference. Occasionally, trust accounts and LOCs are in excess of amounts necessary to secure liabilities, and in cooperation with cedents, the receiver may be able to retrieve those excess amounts. The receiver should also take whatever steps are necessary to ensure that trust fund assets will not be improperly removed.

Once the receiver properly identifies all of the outstanding trust funds and takes the necessary steps to solidify his powers with regard to them, the receiver must then manage the trust funds in order to protect the reinsurer's position by preserving its assets. The receiver should ascertain the liabilities secured by the trust funds and guard against wrongful removal of assets by cedents. The danger that the assets will be wrongfully used to gain a preference on other, unsecured debts, should be addressed. The receiver can also protect the reinsurer's position by depositing any interest earned on the assets into the reinsurer's estate, assuming this power is consistent with the terms of the trust.

X. FUNDS WITHHELD

"Funds withheld" refers to an arrangement wherebythe fact that the cedent does not pay the premiums to the reinsurer; instead, the cedent "withholds" the premiums. Generally, this provision is only used with unauthorized reinsurers. The purpose of these provisions is to allow the cedent to reduce the provisions for unauthorized reinsurance in its statutory statement. The reinsurer's asset, in lieu of cash, is "Funds held by or deposited with reinsured companies." So in other words, the receiver will already have the funds under his exclusive control.

XI. INSOLVENT NON-UNITED STATES LICENSED REINSURERS

The estate may have ceded reinsurance with a non-United States licensed reinsurer[9] that is subject to a rehabilitation or liquidation proceeding in its domiciliary jurisdiction. In addition, that non-United States licensed reinsurer may also be subject to an ancillary proceeding under Chapter 15 of the United States Bankruptcy Code.

A. The Non-U.S. Proceeding

As in the United States, the non-U.S. proceeding may be either a rehabilitation, liquidation or equivalent (e.g., in the UK, there are voluntary arrangements, schemes of arrangement, and winding ups, among other mechanisms). In either event, particularly if ceded reinsurance is involved, the receiver should communicate with the non-U.S. receiver to ensure that the estate receives notice of the proceedings and is identified as a creditor. It will then be necessary to keep current with the proceedings to protect the interests of the estate. The procedures described in this chapter for dealing with ceded reinsurance will generally be applicable to these non-U.S. proceedings.

B. Chapter 15 Proceedings

Insurance receiverships are specifically excluded from the ambit of the U.S. Bankruptcy Code; however, the Code does have an influence on insurance issues in at least one important case: if an insurer purchased reinsurance from a non-U.S. reinsurance company, and that reinsurer has become insolvent.

Chapter 15 permits a representative of a non-U.S. proceeding to petition the United States bankruptcy court for relief and permits the court to: (a) enjoin proceedings against the non-U.S. licensed reinsurer,

[9] Also known as alien reinsurers.

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enforcement of judgments or the commencement or continuation of any action against the debtor; (b) order the delivery of the debtor's property to the representative; and (c) order other appropriate relief. Chapter 15 proceedings are limited in scope, do not commence a full bankruptcy proceeding, and confer broad discretion to the courts. Generally, following the adoption of a plan of rehabilitation or liquidation in the non-U.S. proceeding, the debtor requests the bankruptcy court to give full force and effect to that plan and make it binding and enforceable against all creditors in the United States.

Receivers should consider various approaches when faced with a Chapter 15 proceeding. A receiver should file a notice of appearance and request for service of notice to ensure that it receives copies of the filings made in the proceeding, including periodic status reports. Consideration should be given to participation on the creditors' committee if the amount due to the estate is material, and the expense and time to the estate justify participation. Evaluation of proposed schemes of arrangement may also need to be made to protect the interests of the estate. The estate should also continue to report claims as it did prior to the proceeding and should review and recognize any of its obligations under the existing agreements.

Chapter 15 of the Bankruptcy Code now states that a court may not grant relief under the chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable state insurance law or regulation for the benefit of claim holders in the United States. The purpose of the language is to make certain a bankruptcy court has no power over U.S.-based reinsurance collateral posted for the benefit of U.S. claimants.

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I. INTRODUCTION

In each of the other chapters in this Handbook, the authors make two assumptions: first, that the entity placed into receivership is an "insurance company" and is subject to state statutory receivership procedures; and second, that the receivership is administered in the "insurer's" state of domicile. This chapter addresses receiverships where neither assumption can be made.

Many entities engage in the business of insurance without obtaining the requisite license, and are organized as business corporations rather than insurers—or might not even be properly organized as corporations at all. For example, unlicensed entities transacting health insurance business often claim exemption from state licensure requirements under the Employee Retirement Income Security Act (ERISA).[1] Such unlicensed organizations present special problems to insurance commissioners, insurance consumers and, where state law allows the liquidation of such entities, to receivers. The problems stem from a number of factors, some of which include:

1. The fact that such unauthorized activity is ongoing, and not isolated
2. The potential for criminal activity occurring within the business of insurance. This issue arises by virtue of the fact that the insurance codes of many jurisdictions provide that the unauthorized transaction of insurance within the jurisdiction constitutes a crime[2]
3. The adverse economic impact of such activity upon authorized insurers and other insurance licensees
4. The potential for large volumes of unpaid claims due to the dishonesty of plan sponsors, promoters, and others, and from inherent actuarial unsoundness of the plans
5. The absence of guaranty funds or other mechanisms to cover unpaid claims
6. The adverse economic impact upon health care providers and plan participants resulting from unpaid claims
7. The potential adverse impact on the future insurability of plan participants under statutes mandating guaranteed-issue health coverage
8. The lack of comprehensive federal oversight, including licensure and regulation similar to that found in state insurance codes
9. The inability of federal authorities to act rapidly to investigate and terminate illicit operations, and to quickly discipline the perpetrators. This factor is related, in part, to the relatively limited nature and extent of the Department of Labor's jurisdiction over real and claimed ERISA plans

When considering a potential receivership involving one of these unlicensed entities, it must first be determined whether the entity is risk-bearing, and therefore susceptible to treatment as an insurance company. Section 103 (D) of the Insurer Receivership Model Act (Model #555, commonly known as IRMA) states that the Act covers "all other persons organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state." Most states have provisions similar to this based on prior versions of the NAIC Model.

This chapter begins with a general discussion of the issues involved in making these determinations. If the entity is to be placed into receivership, most of the other provisions of this Handbook are applicable or may be adapted to the circumstances presented. In some instances, however, the nature of the entity may warrant the adoption of

[1] 29 U.S.C. Section 1001, *et seq*.
[2] See, for example, Section 626.902, *Florida Statutes*

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different procedures, and this chapter discusses some of those procedures. Finally, many insurers are licensed to do business, and have assets located, in many states. (See Chapter 9—Legal Considerations of this Handbook, section on Liquidation, Jurisdiction and Ancillary Receiverships.) In such cases, "ancillary" receiverships may be established to administer the assets located in states that are not the insurer's domicile. Ancillary receiverships present their own problems and considerations. Finally, insurers organized under the laws of, or having assets located in, other countries create additional issues for a receiver to deal with. This chapter concludes with a discussion of these multi-national (or "cross-border") receiverships.

II. GENERAL CONSIDERATIONS

The receiver of an entity discussed in this chapter frequently must make a number of determinations at the outset: Is the entity entitled to bankruptcy protection? Where should the receivership be initiated? Are there any assets to distribute? What other remedies are available such as injunctive relief, criminal prosecution, etc. Should other regulatory agencies be contacted or involved in the receivership process? This chapter begins with a discussion of these issues, and then continues with a discussion of particular types of entities that may be involved in special receiverships.

Many states do not have explicit statutory language authorizing receiverships of some of the entities discussed in this chapter. In such instances, counsel may have to analogize statutory provisions and similar receivership proceedings in other jurisdictions for guidance and persuasive authority. Proponents of the receivership often must convince the court in their pleadings and proof that the entity is the functional equivalent of an insurer (or some other kind of risk-bearing entity that is clearly within the ambit of the state's insurance code) and, therefore, is subject to the state receivership statutes. Some states have explicit statutory language that allows the insurance regulator to be appointed as receiver of any "insurer," which is defined broadly to include persons purporting to be, or organized or holding themselves out as organized for the purpose of becoming, insurers. This type of language has been invoked to enable the appointment of receivers of entities that are not domiciled in any state (e.g., an alien excess or surplus lines insurer) and might not be licensed or authorized anywhere they transact the business of insurance. For purposes of the discussion in this chapter, we will employ the licensed/unlicensed (authorized/unauthorized, admitted/non-admitted) distinction, and will use the term "insurer" to describe the person or entity in receivership, notwithstanding the fact that there may be an issue whether the person or entity in fact was organized or authorized as an insurer.

A. Federal Bankruptcy vs. State Receivership

Whether an entity may be placed into bankruptcy or a state receivership depends upon whether the entity is determined to be an insurance company or its equivalent. The reason for this rule lies in Article I, Section 8 of the United States Constitution, which provides that Congress shall have exclusive authority to establish uniform laws on the subject of bankruptcies. The United States Bankruptcy Code, 11 U.S.C. § 101 *et seq*. (the Code), is national legislation applicable in all 50 states, the District of Columbia and the U.S. territories. It provides a comprehensive scheme for the resolution of individual and corporate insolvencies. The Code offers debtors four types of relief, but the three that are most likely to apply to the business of insurance are reorganization under Chapter 11, liquidation under Chapter 7, and injunctions and other relief in aid of a foreign proceeding under law relating to insolvency or adjustment of debt pursuant to Chapter 15.

Congress generally has precluded domestic and foreign insurance companies doing business in the United States from seeking relief under Chapters 7, 9, 11, 12 and 13 of the Code.[3] See 11 U.S.C. § 109(b)(2) and (3). However, foreign insurance companies doing business in the United States may seek relief under Chapter 15 of the Code, which is described in more detail in Chapter 9—Legal Considerations of this Handbook.

[3] Chapters 9, 12 and 13 govern adjustment of debts by composition, extension or discharge for municipalities, certain farmers and fishermen, and certain individuals.

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Determining whether an entity may be eligible to be a debtor under the Code, or whether an entity may be placed into a state insurance receivership, depends, in part, upon whether the entity is, or functions as, a "domestic" or "foreign" insurer. Most regulators distinguish between insurers on the basis of: (i) legal form of ownership (e.g., proprietary, cooperative, pools and associations, governmental and other); (ii) their place of incorporation (i.e., domestic, foreign and alien—see Section III.(C) of this Handbook on Alien Insurers in this chapter); (iii) their licensing status (i.e., licensed/admitted vs. unlicensed/nonadmitted); and (iv) the type of their product and service distribution systems (i.e., independent agency, exclusive agency, direct writer and mail order). See generally, Bernard L. Webb, et al., *Principles of Reinsurance Volume I* (1990).

The courts have not developed clear rules for ascertaining whether an entity is eligible for federal bankruptcy relief as opposed to state receivership proceedings. However, the courts have devised several tests for determining whether an entity is excluded from bankruptcy eligibility because it is an insurance company. See 2 *Collier on Bankruptcy*, § 109.03[3][b] (15th ed. rev.). The first test is the state classification test, which is the test favored by most courts. Under this test, the court looks at how the entity is classified under the law of the state in which it is organized. If the entity is classified as an insurance company under state law, the inquiry typically ends there. If the state law does not clearly classify the entity as an insurance company, the court will attempt to determine whether the entity is the substantive equivalent of an insurance company. In doing so, the court will look at the manner in which the entity is actually operated as well as the degree to which the entity is regulated by state law. The higher the degree of regulation, the more likely the courts are to find that Congress intended to exclude the entity from eligibility for relief under the Code. This approach is based, in part, on the recognition that Congress has codified its policy of leaving the regulation of the "business of insurance" to the states in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. See In re *Estate of Medcare HMO*, 998 F.2d 436 (7th Cir. 1993).

The second test is the independent classification test. Under this second test, courts limit their review to the language of the Code itself and, using traditional techniques of statutory construction, attempt to determine whether the entity is an insurance company that is excluded from being a debtor under the Code. See In re *Cash Currency Exchange, Inc*., 762 F.2d 542, 551-552 (7th Cir. 1985).

A third, less-utilized approach looks to congressional intent and public policy factors to determine whether state law provides an adequate scheme for reorganizing or liquidating the entity. If adequate relief is not available, the court may find that the entity is eligible for bankruptcy relief. See In re *Florida Brethren Homes, Inc*., 88 B.R. 445 (Bankr. S.D.Fla. 1988).

Some entities have sought the protection of a federal bankruptcy court either before or during the course of a state receivership. Under federal bankruptcy laws, the policyholders of the debtor would receive no priority and would be treated the same as other unsecured creditors. Unlike most state insurance insolvency laws, under the Bankruptcy Code many federal and state tax claims are given priority over unsecured creditors, including policyholders. This fact often provides impetus for the initiation by unsecured creditors of an involuntary bankruptcy action against an unlicensed insurer. Some state regulators have successfully challenged the federal bankruptcy proceedings of unlicensed insurers and obtained dismissals on the ground that the states have full jurisdiction over the liquidation of licensed and unlicensed insurance entities, and that the Bankruptcy Code specifically exempts insurance companies. However, a jurisdictional battle may ensue and could delay the receivers' efforts to gain control over the records, accounts and operations of the unlicensed insurer, leaving little or nothing to liquidate by the time the order is granted.

Even if the receiver is unsuccessful in challenging the federal bankruptcy proceeding, the receiver should consider continuing an earlier initiated receivership for the limited purposes of preserving its rights on appeal or enforcing its regulatory powers. Although the filing of a bankruptcy petition typically results in an automatic stay of most other legal action against the entity, there are exceptions to this rule. For example, the commencement of a bankruptcy action does not operate as a stay "of the commencement or

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continuation of an action or proceeding by a governmental unit to enforce such governmental unit's police or regulatory power; [or] … of the enforcement of a judgment, other than a monetary judgment, obtained in an action or proceeding of a governmental unit to enforce such governmental unit's police or regulatory power" (11 U.S.C. § 362(b)(4), (5)). Thus, the receivership may coexist with the bankruptcy estate so long as the receivership falls within these exceptions. The receiver should consult with legal counsel regarding how bankruptcy courts have addressed the circumstances of such situations.

B. Jurisdiction and Venue

Once the decision has been made to place an unlicensed entity into receivership, an appropriate jurisdiction (i.e., state, district or territory) must be chosen. Numerous questions arise: Should the domiciliary receivership be initiated in the state (i) in which most of the insurance policies were issued; (ii) in which most of the insurer's assets are located; (iii) where the company is physically located; or (iv) where the books and records are kept? The jurisdictional choice depends upon the relative weight of the facts discovered, as well as the strength of the statutory and regulatory framework in each of the potential jurisdictions. The potential receiver should determine whether a state's insurance regulatory authority has already taken some type of action against the entity, such as by issuance of an emergency cease and desist order, or some other type of administrative proceeding. If so, there will likely exist factual information gathered in preparation for that action, or during the course of discovery, that will assist in this determination. Another source that should be consulted is the consumer assistance bureau of the state insurance regulatory authority. Of course, a particular insurance regulator will likely not be able to put a company into receivership in any other state, but would be able to coordinate with other state regulators on these issues. Many times the issue is not which state, but whether the particular regulator's state is an appropriate jurisdiction to bring receivership proceedings.

C. No-Asset Estates

It is important to determine as early as possible if there are sufficient assets to operate a receivership. Most states' insurance statutes require that the costs and expenses of receiverships be paid out of the assets of the estates, including seized bank accounts. Generally, the receiver of an unlicensed insurer has to rely on the funds held in bank accounts to fund the receivership. Unlicensed insurers frequently have little or no money with which a receivership may be administered. In that case, some states' permanent receivership departments may absorb the regulatory costs of liquidating such entities through a variety of funding options. Consistent with many state statutes, MODEL #555 Section 116 provides for alternative funding in cases where the insurer does not have sufficient assets to pay expenses, either from funds advanced from an appropriation from the state's insurance department, or from a specific fund created for such a purpose. IRMA Section 804 (Alternative 1) provides a mechanism for using residual assets to fund low- or no-asset estates. In either event, the funds advanced are repayable from available monies of the insurer. In some instances, some special deputies or other consultants (e.g., those who have been contracted by the commissioner as receiver in past or current receivership proceedings) have accepted such no-asset receiverships on a *pro bono* or a contingency basis.

In the event that there are insufficient assets, the regulator may elect to forego receivership proceedings. If a receivership is not financially feasible, then the state may seek an injunction to put the unlicensed entity out of business. Frequently, commissioners or receivers discover that the unlicensed entities have moved money from their accounts to other corporate or personal accounts, and the only thing left for a commissioner or receiver to do is aid in any criminal prosecution.

In situations where the risk-bearing entity appears not to have sufficient assets in the jurisdiction, it may be useful to look to some of the ancillary actors. The investigation should include, for example, agents who sold the entity's plan and real or *de facto* third-party administrators who may be holding, processing or transmitting funds for the entity. Frequently, the unauthorized entity will use many such administrators located in various parts of the country. Just as frequently, the entity may use a succession of them. Once

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again, coordination with the state insurance regulators can be useful, as their investigation may have already determined the identity of some or all of those people and organizations.

D. Injunctive Relief, Criminal Prosecutions and Posting Security

In addition to the injunctive relief to protect assets, most states' insurance laws provide for permanent injunctions against the further transaction of insurance business. These laws often allow for actions to be initiated by state law enforcement agencies, including the attorney general and local prosecuting attorneys. The agencies also may become involved in prosecuting unlicensed insurers in criminal actions. Some states' statutes require that an unlicensed insurer post security for liquidation costs before the insurer may file any pleadings in judicial proceedings. This is an effective tool for a receiver to use to prevent frivolous actions which otherwise might exhaust an estate's limited assets.

E. State-Federal Cooperation

Some receivers have successfully coordinated their receivership activities with the activities of federal agencies. A few states have convinced certain agencies, including the Federal Bureau of Investigation (FBI), the Internal Revenue Service (IRS), the U.S. Postal Inspector, the U.S. Department of Labor and the U.S. Department of Justice, to initiate federal investigations into the activities of unlicensed insurers and suspected looters of insurance company assets. These investigations have resulted in the issuance of federal grand jury subpoenas to protect the integrity of books, records and documents originally seized by the receivers and to freeze assets which a receiver may not be able to seize in a cost-efficient or expeditious manner. Joint state/federal investigations are extremely important in obtaining criminal sanctions, forfeitures and restitution orders for those who operate as unlicensed insurers or who have looted insurance companies. It should be noted, however, that once federal or state law enforcement officials begin investigating potential crimes involving individuals related to the insurance company, they may exert control over a significant portion of the receivership's records.

Establishing a working relationship between the receiver and law enforcement officials early on is essential because the objectives of receivers and law enforcement officials are very different. The focus of law enforcement will be on the crime and conviction of the criminal, while the focus of the receiver will be on the recovery of assets for the benefit of the creditors. Good communication can overcome these divergent goals.

The receiver considering whether to approach or cooperate with law enforcement officials frequently must confront a number of issues. One issue is the effect that a criminal investigation/conviction may have upon the receiver's ability to recover, and the timing of recoveries, against the officers and directors of the insolvent insurer (specifically any directors and officers' liability insurance) and under reinsurance agreements. Criminal activity and fraud are frequently excluded from coverage by the applicable directors and officers' insurance policy that the receiver is attempting to reach, and this exclusion may be invoked to support a reinsurer's action for rescission of the reinsurance agreement.

Another issue is control of the insurer's books and records. Prosecutors frequently acquire such books and records by means of a grand jury subpoena or a search warrant. It may be difficult for the receiver to review or copy books and records obtained by such means. Similarly, a criminal investigation or proceeding may involve several enforcement agencies (Postal Inspector, FBI, IRS, and Department of Labor) and several jurisdictions. To the extent that the records are deemed essential to the receivership proceeding, the receiver should immediately attempt to negotiate an agreement to obtain access to and use of the records before relinquishing control over documents or other materials that the applicable authorities are seeking from the receiver. Unless there are strict controls on access to and removal of documents, the documents may be lost or difficult to retrieve. In such cases, the receiver may wish to negotiate and create and implement a file retrieval system. While it may be cost prohibitive in some instances, a receiver should also consider copying all applicable documents and establishing the appropriate chain of custody. Even if the receiver is successful in negotiating continuing access to

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documents, a receiver may have to address the access issue again if different federal agencies or different U.S. attorney offices become involved. Thus, maintaining a copy of the documents may be the best solution.

Overcoming these obstacles may be worthwhile because there are certain advantages to working with law enforcement officials. For example, one of the impediments to the collection of money judgments against culpable persons in multiple states is the fact that the receiver often must enforce its judgment in a foreign jurisdiction. This burden may be overcome by requesting the U.S. attorney, in conjunction with a criminal prosecution, to move for injunctive relief in a civil proceeding to "freeze" all known bank accounts and other assets of the principals and entities controlled by the principals who are the subject of the prosecution. Additionally, the receiver should consider that the federal authority, if convinced to do so, has the ability to freeze assets in multiple jurisdictions in a very expeditious manner. It could sometimes take a receiver weeks or months to freeze the same assets because they are outside of the receiver's jurisdiction, and the receiver may not have immediate access to the appropriate professionals needed to freeze assets in numerous jurisdictions. Thus, although the receiver may experience delay in ultimately recovering an asset because the federal government is involved, they may be able to secure assets for the benefit of the estate that may have been dissipated by the time the receiver was able to freeze them. In such cases the receiver should attempt to reach a written agreement with the prosecutor(s) that any money recovered as a result of the criminal prosecution, either through forfeiture, cooperation with the criminal or other means, will be transferred to the receiver, with all due credit given to the prosecutor. The receiver should be aware, however, that it may be necessary to go beyond the local U.S. attorney to secure the appropriate agreements for assets seized by the federal authorities. Agreements with a local U.S. attorney to deliver forfeited assets to the receiver may not be enforceable. In some instances, agreements to return forfeited assets must be approved by the appropriate division of the Department of Justice in Washington, D.C.

Even when a U.S. attorney who pursues assets at the behest of a receiver cannot forfeit those assets because the defendant claims that the assets recovered did not derive from the criminal enterprise, it is still of benefit to the receivership. This is true because the assets, once seized, are identified for the receiver and thus facilitate the receiver's assertion of a claim, lien or other legal hold on them, notwithstanding the alleged rights of other claimants. Thus, the receiver may be able to prevent a dissipation of the asset without having an opportunity to make a claim to it, which may not have been possible but for the seizure by the U.S. attorney.

Additionally, given the proliferation of unauthorized health insurers posing as ERISA-exempt plans, an extremely useful resource within the U.S. Department of Labor is the Employee Benefits Security Administration, previously known as the Pension & Welfare Benefits Administration (EBSA). Charged with the general oversight and enforcement of both the benefit and welfare plan provisions of ERISA, the EBSA has regional and local offices across the country.[4] The EBSA also has processes by which advisory opinions concerning multiple employer welfare arrangements (MEWAs)[5] may be requested. Utilizing that process can be of enormous assistance in overcoming jurisdictional objections to the commencement and continuation of a receivership.

[4] Employee Benefits Security Administration, previously known as the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210; www.dol.gov/ebsa/.

[5] Office of Regulations and Interpretations, Employee Benefits Security Administration, U.S. Department of Labor, Room N-5669, 200 Constitution Avenue, NW, Washington, D.C. 20210

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III. HOSPITAL AND MEDICAL SERVICE CORPORATIONS

A. Organization and Regulation

Hospital service corporations (such as traditional Blue Cross plans) and medical service corporations (such as traditional Blue Shield plans) do not fit neatly into any category of insurer (proprietary, cooperative, etc.). In some service areas, Blue Cross and Blue Shield are combined into a single plan, and other types of health plans, notably Delta Dental plans, might also be established under state nonprofit health plan laws. Also, many Blue Cross/Blue Shield plans are now organized as stock or mutual insurers and are fully subject to state insurance codes and are not within the scope of this section. This section addresses nonprofit non-stock corporations, often with charitable status, organized for the purpose of contracting with the public and with duly licensed hospitals, physicians, dentists and other health care providers for the provision of health care services to subscribers under the terms of their contracts with the corporation. Since the early 1940s, hospital service corporations have been joined together through reciprocal agreements to provide benefits for members who find themselves hospitalized away from home, to allow free transfer of membership between plans, and to facilitate enrolling national accounts.

B. Blue Cross/Blue Shield Plans

Each Blue Cross/Blue Shield Plan is independent of other Plans. There is no single Plan that operates on a nationwide basis. They have individual corporate names and have designated geographic areas in which they may conduct their operations. Some are statewide, while other Plans include only certain counties within the state or even a metropolitan area. Each Plan has its plan president and board of directors, frequently consisting of community representatives, hospital administrators, physicians and consumer groups. Under some state laws, a Plan is exempt from the payment of taxes and from the operation of the general insurance laws of the state; however, tax exemption may depend on whether the Plan is considered a nonprofit entity. Regulation is limited to those matters the legislature has deemed necessary for the adequate protection of members who subscribe for the services offered by such corporation. Thus, the great majority of Plans are subject to regulation by the insurance departments of various states to the extent that the state insurance department must approve the rates charged to the subscribers, the benefits, payments to hospitals and other contractual details.

The Blue Cross/Blue Shield Association acts as a national coordinating agency for all of the Plans. Headquartered in Chicago, the Association acts as spokesperson or agent for Plans in matters of national or regional concern. All Plans pay dues to the Association, which promulgates national policies, establishes performance standards and contracts for nationwide programs such as Medicare and the Federal Employees Benefit Program. Through the Association, several Plans have established an inner plan service benefit bank to act as a clearinghouse for administering subscriber benefits.

C. Receivership

The receivership of a hospital or medical service corporation is substantially similar to that of a standard health insurer, with the exception of the highly local nature of the insolvency. In the case of a Blue Cross/Blue Shield Plan, the receiver should be aware that the Blue Cross/Blue Shield Association controls the use of the Blue Cross/Blue Shield name and trademark. In addition to the usual claims-handling issues and lack of guaranty fund involvement[6], the most important considerations in the receivership of a hospital or medical service corporation can be insuring continued coverage and controlling the billing practices of the health service providers.

[6] Model 520 excludes hospital and medical service organization, whether profit or non-profit, as member insurers of guaranty funds.

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IV. UNLICENSED INSURERS

Unlicensed insurers may be separated into two general but distinct categories. The first category consists of insurers or individual risk bearers who, while unlicensed in a state, have complied with that state's surplus lines or excess lines laws and are permitted to insure risks in that state, subject to the provisions of those laws. Such eligible surplus lines insurers may be incorporated or organized either under the laws of another U.S. jurisdiction ("foreign" insurers) or a non-U.S. jurisdiction ("alien" insurers).

The second category includes those entities (domestic, foreign or alien) engaged in the business of insurance or transacting insurance in a state where they are neither licensed nor deemed eligible as excess or surplus lines insurers. This category includes individuals, entities or corporations that may or may not be organized as "insurers" and that may or may not be operating legally. Such entities have included:

- Managing general agents
- Third-party administrators
- Marketing groups
- Servicing organizations
- Intermediaries
- Telemarketing firms
- Trusts
- Benefit funds

Note that some states impose personal liability against agents and other persons who place business with unlicensed insurers.

A. Eligible Surplus Lines Insurers

The terms "authorized" or "admitted" when used in conjunction with an insurer, mean an insurer that is licensed to transact business in the home state of the person, entity or risk to be insured. The terms "unauthorized" or "non-admitted" mean that the insurer is not licensed in the home state of the person, entity or risk to be insured. (For simplicity, "authorized" and "admitted" will both be referred to in this section as "admitted," and "unauthorized" and "non-admitted" will be referred to as "non-admitted.")

"Surplus lines insurance" is a mechanism that allows consumers to buy property-liability insurance from a non-admitted insurer when consumers are not able to obtain the coverage from authorized insurers. Under the surplus lines framework, certain non-admitted insurers are permitted to lawfully offer insurance in the state where the person or risk is located. The surplus lines regulatory framework differs from state to state, so the receiver must become conversant with the rules of the state where the insurer wrote on a surplus lines basis. There are, however, some basic principles that are common to all such frameworks:

1. The purpose is to provide access to insurance that is not readily available from admitted insurers
2. They use specially trained and licensed agents, brokers and surplus lines associations to assist those consumers
3. They establish systems of levying and collecting taxes on the transactions

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4. They authorize the state to establish who may insure risks on a surplus lines basis and the types of insurance they may offer

All surplus lines insurers must be licensed in their home jurisdiction, whether that is within the United States or elsewhere. An "eligible surplus lines insurer" is generally one which, although non-admitted in the state of the insured or the risk, has been determined by that state's regulator to be eligible to write certain categories of insurance in that state.

Surplus lines insurers generally are permitted to write three broad categories of risk that are not readily available in the marketplace: distressed risk, unique risk and high-capacity risk.

Distressed risk consists of exposures that are characterized by unfavorable underwriting characteristics, such as having sustained frequent losses in recent years.

Unique risk consists of unusual types of exposures, including those that do not neatly fit within existing policy forms. Another factor that may make a risk unique is insufficient, or no, loss experience. The latter factor makes it very difficult, and perhaps costly, to price an insurance policy.

High-capacity risk does not relate only to possible or probable claims frequency, but more generally to those sorts of risks that require very high limits, which may be beyond the capacity of the authorized market.[7]

Special rules may govern alien surplus lines insurers. As a condition of eligibility to transact business in a state as a surplus lines insurer, alien insurers are required to execute a trust indenture pursuant to which monies are deposited and maintained with a U.S. trustee bank. The NAIC has a Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers, in which Article 4 of the form governs insolvency proceedings. Most alien insurers have executed the NAIC indenture or similar agreements. A copy of current trust indentures can be obtained from the NAIC website at

https://content.naic.org/sites/default/files/inline-files/IID%20Trust%20Nov%2011%202022%20FINAL.pdf

Eligible surplus lines insurers are subject to the receivership laws of the U.S. jurisdiction in which they are domiciled. The insolvency of an alien insurer is usually triggered by the determination of its domicile regulating agency that it is insolvent. Liquidation proceedings may be commenced if the trust fund falls below a statutory minimum and is not replenished. In general, the insurance regulator in the U.S. jurisdiction in which the trust fund is maintained administers the insolvency proceedings. (Under IRMA, an alien insurer is considered to be domiciled in its "state of entry," and that domicile would undertake its liquidation in the U.S. (See IRMA, Section 104 (H) and 201 (A).)

The domiciliary regulator and the claimants of the company are the only entities to whom the trustee may transfer assets. The duties of the trustee and domiciliary regulator in prioritizing and paying claims are set forth in the indenture. The domiciliary regulator generally will seek a conservation order from a court that will enable the regulator to compel the trustee to pay over the corpus of the trust to the regulator. The domiciliary regulator then will administer the trust corpus for the benefit of those who otherwise would have been beneficiaries of the trust. Any assets remaining in the trust fund after all claims are paid should be transferred to the insurer or to its successor in interest. In some cases where an alien insurer has been placed in receivership in its domicile abroad, the U.S. domiciliary regulator, for reasons of economy, will enter into an agreement with the foreign receiver, whereby the domiciliary regulator will transfer the assets under that regulator's control to the foreign receiver upon being assured that the U.S. trust beneficiaries will receive no less from the foreign receiver than they would have received from the domiciliary regulator. Should the domiciliary regulator decide not to transfer the assets to the foreign

[7] Ibid, pg. 6.

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receiver, the domiciliary regulator will pay all claims in accordance with the priorities set forth in the trust indenture and any governing statute. Any assets remaining after all claims are paid then would be transferred to the foreign receiver.

As of this writing, with the exception of New Jersey, no U.S. jurisdiction has enacted laws providing guaranty fund coverage to policyholders or claimants of eligible surplus lines insurers.

B. MEWAs

A common problem encountered by receivers involves life, accident and health insurance operations ostensibly operating under ERISA as a multiple employer welfare arrangement (MEWA).[8] The purveyors of unauthorized health insurance plans operating as MEWAs routinely invoke ERISA to assert that state insurance codes are inapplicable to their operations, and therefore, that state insurance receiverships cannot be maintained. The receiver's involvement will often arise in the context of plans that claim the exemption, but which, in reality, are MEWAs or other regulated risk-bearing entities subject to state regulation. It is thus vital for the receiver to have a good working understanding of MEWAs and related entities, and how they fit within the context of dual state and federal regulation. Following the adoption of ERISA in 1974 (which had the effect of limiting a state's authority to regulate self-insured employer plans), there was a rapid expansion in the number of self-insured employee benefit plans covering the employees of more than one employer. These plans were then referred to as Multiple Employer Trusts (METs), and claimed exemption from state insurance laws under the preemption provisions of ERISA. State insurance officials viewed these uninsured METs as purely for-profit entities, which were intentionally drafted to fall within the regulatory vacuum created by ERISA. Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, state regulation of the arrangement would have been precluded by ERISA's preemption provisions. However, as a result of the 1983 MEWA amendments to ERISA, states are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan.

State Regulation of MEWAs. The NAIC has adopted the Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation, for the purpose of preventing the operation of illegal health insurers, including illegal MEWAs. In addition, approximately 20 states currently have special licensing laws for self-insured MEWAs that specifically address the solvency concerns of MEWAs. However, these state solvency standards are often weaker than those for traditional insurers. Some state licensing requirements for MEWAs might include:

(1) Surplus and reserve requirements for MEWAs, which are generally much lower than for traditional insurers;

(2) The mandatory purchase of Stop-Loss insurance by MEWAs, in order to protect against unexpectedly large claims or a high frequency of claims;

(3) The requirement that MEWAs file annual financial statements audited by a certified public accountant;

(4) The disclosure by MEWAs to their members that they do not participate in a guaranty association; and

(5) Rate filing requirements.

Even if a MEWA is subject to state licensure, they are exempt from state taxes on premiums and from assessments for state guaranty fund coverage. In addition, some state receivership laws either exclude MEWAs or are vague about the department's authority to assume control over a MEWA in liquidation.

[8] ERISA Section 3(40)(A); 29 USCA Section 1002 (40)(A).

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Without the ability to invoke a receivership, licensed MEWAs may be subject to bankruptcy statutes, which, unlike state receiverships, do not give priority to outstanding health insurance claims. Receivers must initially determine whether state rehabilitation and liquidation laws apply to MEWAs, whether they are specifically licensed or unlicensed. Even if state insolvency laws are not an option, there are informal procedures that state insurance departments can take to assist consumers in such cases. These include:

- Ongoing oversight of the MEWA's financial condition;
- Facilitating discussions with licensed insurance entities to provide coverage for the employees and their dependents; and
- Other strategies to assist employers in finding new coverage and reduce the amount of unpaid medical bills.

Federal Regulation of MEWAs. If an unlicensed entity is attempting to operate as a MEWA under ERISA, in addition to available state remedies, the commissioner should also contact the U.S. Department of Labor (DOL), which has expressed an interest in working with the states to regulate MEWAs. Federal assistance is desirable because a MEWA operating as an unlicensed insurer may also be noncompliant with federal regulations, and federal authorities may have remedies available that provide sources of recovery for the estate.

ERISA does not require MEWAs to be federally licensed, nor does it contain any federal solvency or other consumer protections, similar to those generally found in state insurance law. However, the DOL still may be concerned with the same issues as the state insurance departments. Forms filed with the DOL or the IRS may provide the insurance departments with needed information as to the scope of the operations of the various entities. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established an annual Form M-1 filing requirement for MEWAs. The DOL already may be conducting a review and may be able to provide additional staffing to process some of the necessary paperwork.

Illegal MEWA Schemes. State insurance receiverships of MEWAs, where statutes allow, are becoming more frequent, requiring broadened receiver knowledge and sophistication. Because such schemes can be by their nature unlawful, they are often attended by both manipulation and secreting of assets, thereby making forensic accounting resources increasingly important. The schemes often differ in nomenclature and sophistication, but enough commonality usually exists to permit some generalizations and rules to guide the analysis. For example:

(1) The plans will claim total exemption from state insurance regulation under ERISA.

(2) The only plan structure that is arguably exempt from direct state insurance regulation, including jurisdiction for a receivership, is one that is single-employer based and fully self-insured. That is, the plan can apply only to the employees and their dependents of a single employer, and covered claims must be payable solely from the funds of the employer.

(3) The plans are usually MEWAs, which in a minority of states continue to be referred to as METs. Most state insurance codes define the terms in the following way: *[A]n employee welfare benefit plan or other arrangement that is established or maintained to provide one or more of various insurance benefits (including health insurance) to the employees of two or more employers*.[9] By this definition, a MEWA cannot be a single-employer plan so as to exempt it from state insurance regulation.

(4) Although they may employ terminology such as "single-employer trust" to convey the aura of a single-employer-based plan, the reality is that there is usually an upstream migration and/or

[9] See, for example, Sections 624.436-624.446, Florida Statutes.

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commingling of money, consisting of employer and employee contributions, into the control of an entity that is not authorized in any jurisdiction as an insurer or as a MEWA, and which bears the financial risk of loss of covered claims.

(5) No individual employer, either by employer contribution or by the aggregate of employee contributions, is paying enough to fully self-insure the actuarially expected losses of the group during the period for which the contribution is made. Therefore, if claims are to be paid at all, they will be paid from a pool of funds comprised from the contributions of multiple employers or their employees. Invariably, that "pool" will not be authorized as an insurer or as a MEWA.

(6) ERISA also defines and recognizes MEWAs and has some application to certain kinds of them.[10]

(7) The interplay of (3) and (6) in this section results in concurrent state and federal regulatory authority over most employee benefit plans that are MEWAs.

(8) Special rules of preemption apply to MEWAs that meet the ERISA definition of a MEWA and that are also employee benefit plans:

i. If the plan is fully insured, the MEWA remains subject to state insurance laws that provide standards for the maintenance of specific levels of reserves and contributions so as to ensure the plan's ability to pay benefits when due, and to laws that enforce those standards.

ii. If the plan is not fully insured, the MEWA is subject to all state insurance laws that are not inconsistent with Title I of ERISA, unless it has been exempted from them by other regulations of the U.S. Department of Labor. If the MEWA has been so exempted, it is subject to state insurance regulation in the same manner and to the same extent as a fully insured MEWA.

iii. If the MEWA is not an employee benefit plan (that is, nothing more than a health insurance plan, sold to anyone, but using ERISA terminology), there is no preemption at all, and the plan is subject to complete regulation by the state insurance regulatory authority.

Perhaps the key to addressing issues related to so-called ERISA plans is that unless the plan is both single-employer-based and fully self-insured, it is subject to state insurance regulation either as an insurer or as a MEWA, and therefore is subject to state receivership proceedings. In brief, if the plan purports to provide, or does provide, benefits to two or more unrelated employers and their employees, it is subject to state insurance regulation, including state receivership proceedings. Likewise, if there is pooling of funds (contributions or otherwise) at any level, such that any entity other than a single employer is bearing the risk of loss as to covered claims, the plan is subject to state insurance regulation as an insurer or as a MEWA.

Entities Related to MEWAs. Union Plans are the one significant category of multi-employer plans that are not treated as MEWAs by ERISA and therefore are not subject to state regulation. Collectively bargained multi-employer plans are often confused with METs (multiple employer trusts), which are generally subject to state regulation as MEWAs. As a result, many illegal plans try to pass themselves off as bona fide collectively bargained plans. However, these plans must be recognized by the U.S. Department of Labor under strict standards that have been codified in regulations and, in most—if not all—states, the Department has not recognized any of the plans that have used this defense. The term MET is often used interchangeably with MEWA, along with the term VEBA. However, Voluntary Employee Beneficiary Associations ("VEBAs") are a creature of the Internal Revenue Code and are not an insurance or ERISA concept. Instead, a VEBA is merely a vehicle by which certain employee benefits, including health care benefits, can be funded. It is a tax-exempt (not regulatory-exempt) vehicle that

[10] 29 USCA 1002 (40)(A)

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allows an employer to deduct payments made to the VEBA to fund the payment of employee benefits. VEBAs, however, can be maintained for the employees of more than one employer in certain situations.

Plans maintained by employee leasing firms and Professional Employer Organizations ("PEOs") are generally found to be MEWAs, because the employees are usually determined by the DOL to be the employees of the participating employers, and not the PEO. Finally, to the extent that an insurer, a third-party administrator, or some other licensee of a state department of insurance is involved in or with the plan, the plan remains subject to "indirect" regulation because of the regulator's power over its direct licensee.

C. Alien Insurers

The receivership of unlicensed alien insurers presents special problems not encountered in other receiverships. An alien insurer is an insurer that is incorporated or organized in a jurisdiction that is not a state. See IRMA Section 104 (B) (definition of "alien insurer"). Preliminarily, IRMA provides that an alien insurer is considered to be domiciled in its "state of entry," and therefore that state's regulator would be responsible for insolvency proceedings regarding the insurer. See IRMA Section 104(H) (definition of "domiciliary state"). So while not necessarily admitted, an "unlicensed alien insurer" (meaning one that is not licensed in a particular state and is not eligible to write in that state as a surplus lines carrier) may still be considered "domiciled" in the state in which it initially began transacting business—at least for the purpose of a state's insurance insolvency act.

Often, alien insurers are not subject to adequate financial scrutiny or regulation in their alien jurisdiction, and their certificate of authority may not permit them to transact insurance in that jurisdiction. These facts, coupled with the stringent secrecy laws which prevent access to an alien insurer's corporate and financial information, make offshore locations an ideal haven for alien insurers with thin capitalization or other financial weakness.

When an unlicensed alien insurer is liquidated by its alien regulator for reasons of insolvency, the states in which it was transacting insurance may seek to establish an ancillary receivership. If the alien regulator refuses or fails to place the insurer into receivership, and the insurer is either transacting insurance in violation of a state's insurance laws or a state regulator has sufficient information to determine that the insurer is insolvent or not paying claims, then the state's regulator may petition its receivership court to appoint the regulator as receiver to protect the insureds in that state. Generally, the first state regulator to obtain a receivership order will take the lead in receivership matters over other state regulators that obtain later receivership orders. If a domiciliary receiver has already been appointed over an alien insurer (in the state of the alien insurer's entry), however, IRMA Section 1001(B) provides that another state's regulator may initiate an action against a foreign insurer only with the consent of the domiciliary receiver.

The receiver often encounters difficulty attempting to locate and marshal the unlicensed alien insurer's assets. This affects the receiver's ability to assess the potential to pay claims and administrative expenses. Usually, alien insurers maintain few or no assets in the states where they do business. Prior to placing an unlicensed alien insurer into receivership, the regulator may wish to investigate the insurer's assets, including real property, equipment and bank accounts. It is often difficult to identify and locate assets belonging to such insurers. Therefore, the receiver should immediately identify and locate all banks and financial institutions doing business with the unlicensed alien insurer and should serve the banks and financial institutions with certified copies of the receivership order as soon as possible to freeze the assets. Once the assets are frozen, it is unlikely that the insurer will be successful in attempting to dispose of or send the assets outside of the receiver's jurisdiction. Receivers often are unable to locate and marshal assets sufficient to administer the receivership, let alone to distribute assets to policyholders to pay claims.

Even if an alien insurer has executed the NAIC Standard Form Trust Agreement and purports to be an eligible surplus lines insurer, it may not have legitimate assets in trust for the payment of claims. The

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existence of a trust agreement may lead to a false sense of security for the receiver who really is dealing with an unlicensed insurer. Often, the bank that entered into the agreement did so without understanding the responsibilities it agreed to undertake on behalf of the insureds and upon which the regulators and insureds may have relied. Some unlicensed alien insurers open the requisite accounts in this country but only deposit worthless notes and stocks.

An unlicensed alien insurer's solvency or ability to pay claims may not be the only concern of regulators. Transacting insurance in a state without the proper certificate of authority or approval is often a criminal offense.

D. Unions

1. Organization and Regulation

ERISA preempts most state insurance laws as they relate to bona fide union-sponsored plans. Although such a plan may in fact afford health benefits to the employees and their dependents of multiple, unrelated employers, and hence be a MEWA, it is saved from state insurance regulation under ERISA language pertaining to "multi-employer plans."[11] A union sponsored plan will come within the exclusive jurisdiction of ERISA, however, only if the Secretary of the Department of Labor (Secretary) expressly finds that the plan was established and is maintained pursuant to a bona fide collective bargaining agreement. In the absence of such an express written finding, the plan is subject to state insurance regulation as a MEWA. The Secretary has never made such a finding on any of the union-sponsored plans in existence. Nonetheless, state insurance regulators have not routinely exercised authority over these union arrangements, at least if they are paying benefits exclusively to union members.

In recent years, however, bona fide unions have attempted to expand their membership by marketing health benefits to non-union members through "associate membership" programs. Unscrupulous entrepreneurs have also organized sham unions and marketed health benefits under the rubric of the sham union in an attempt to escape state regulation. Both instances have attracted greater scrutiny on the part of state regulators because participants/members have often been left with unpaid claims.

The DOL has responded by revisiting ERISA's preemption of state regulation in the context of union-sponsored plans. The DOL has issued proposed regulations which define the term "collective bargaining agreement" and limit participation of associate members in union-sponsored plans. The policy thrust of regulation by the DOL is that all arrangements marketing health benefits to the public are presumed subject to state regulation until the party proves that it is a bona fide union-sponsored plan and not a MEWA.

Similarly, many state insurance regulators have actively pursued these schemes. One of the best examples of state-federal partnership occurred in precisely this area. In a closely coordinated effort, the Florida Department of Insurance administratively terminated a Florida-based sham union health plan, and the following day, the Department of Labor obtained a temporary restraining order against the union, the plan, and all operatives, and the appointment of an Independent Fiduciary.

2. Receivership

The presiding U.S. District Court appoints an Independent Fiduciary to perform duties similar to those in an insurance receivership, including management of the entity, marshaling of assets and adjudication of claims. Periodic status reports are required by the court, including information on the actions of the Independent Fiduciary, the current financial position of the entity(ies), and the financial results for the period.

[11] ERISA Section 3(40)(A)(i)

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As there are no surplus requirements, there usually are limited assets available to discharge the obligations of the union and related welfare fund. Guaranty fund coverage is not afforded. ERISA requires specific notification of any amount denied on a claim, the reason for the denial, and the right of appeal by the member. The Department of Labor has historically required strict compliance with ERISA on this claim process. There is no specific language in ERISA that addresses liquidating distributions. Therefore, the required notification and right to appeal applies to liquidations as well as any ongoing claim processing. Liquidating distributions are typically on a pro rata basis for all obligations of the union and related welfare fund. The Independent Fiduciary generally prepares a plan of liquidation with the presiding court which sets forth the proof of claim process and proposed pro rata distribution.

E. Other Unlicensed Entities

The problem encountered by regulators and receivers are further compounded when the entity involved was not organized as an insurer, but is conducting business that is regulated as insurance. For ease of discussion, however, the term "insurer" again is used in this section to identify the entity.

Generally, a regulator faced with such an unlicensed entity must consider the following when deciding how to proceed: (i) will state regulatory action be effective in preventing further violations of state insurance laws; (ii) will receivership action through the courts be necessary to prevent further violations of state insurance laws; and (iii) should the activities of the unlicensed insurer be referred to state or federal law enforcement agencies for further investigation? The advantages of enforcing the receivership law and its provision for *ex parte* conservations may include: (i) the availability of a rapid procedure for injunctive relief and the seizure of records or assets without advance notice; and (ii) available assets may be used to pay policyholders and other creditors in an orderly manner.

Many practical problems arise once an illegal insurer is placed into receivership. Once the insurer has been placed in receivership and the proper financial analysis and accounting groundwork has been laid, the receiver may be able to pursue the personal assets of the principals. There also may be hidden assets or potential causes of action that are not readily apparent at the time a decision must be made with regard to appointing a receiver. The criteria for appointment in that case may be that the entity has enough known assets to fund a search for unknown assets or to prosecute a cause of action against owners, operators or related companies which might have received fraudulent transfers. Often, the search for a list of policyholders or potential claimants will continue after the appointment of a receiver. As discussed in earlier chapters of this handbook, receivers typically do not find a complete policyholder list or indications of potential claims at the entity's office upon takeover.

In cases where an alien insurer has been placed into receivership, it may be appropriate to bring other persons and entities into the receivership net. In some instances, the alien insurer contracted with individuals and entities to facilitate the transaction of insurance statewide. These individuals and entities may include premium finance companies, third-party administrators, managing general agents and management companies. In other instances, the alien insurer may have set up affiliates and other entities which share common control and ownership. These alter egos of the alien insurer often commingle their assets with those of the alien insurer in an attempt to hide assets from U.S. regulators. If the receiver believes that these other entities may have assets belonging to the alien insurer and can demonstrate that the entities appear to be alter egos of the insurer, then these other entities also may be placed into receivership (most likely conservation, to enable the receiver to investigate their books and records). Often, premium dollars are funneled through or remain in the accounts of the insurer's affiliates and alter ego entities; making it necessary to seize their assets as well. Once in receivership, immediate attention should be given to tracking the insurance premiums from the point of sale through these various other entities.

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IV. AGENTS

A. Managing General and Other Agents

1. Organization and Regulation

Managing general agents and other types of insurance producers may be subject to receivership laws because they have begun actually underwriting the business of insurance. In other words, they have begun to actually assume risks instead of merely acting as the agent or producer of business for the insurer. Under some states' laws, agents that have intentionally, or even inadvertently in some cases, begun assuming risks by not forwarding premiums to the actual underwriting insurer may fall within the definition of an "insurer." Accordingly, a commissioner may seek receivership of an agent under the same process as an insurer. The grounds for an agent receivership may be insolvency or some other violation of the insurance laws. The receivership statutes of the state in which the agent does business may apply to the agent in receivership.

2. Receivership

Generally, a commissioner will seek receivership of an agent to enjoin the agent's illegal activity (i.e., unauthorized issuance of policies) and to seize control of the agent's books, records and assets. The agent may have engaged in the unauthorized writing of insurance policies independently or on behalf of an insurer which had terminated his appointment. If the agent had apparent authority and premiums were collected, that insurer may be bound by the policies written by the agent even though the agent was not authorized to write such policies. The agent may also have written policies on illegitimate paper (i.e., a fictional insurer or unauthorized insurer) and collected premiums. The primary goals of an agent receivership are to prevent the continued operation of the agent's unauthorized business, to apply recovered assets to any claims under policies of insurance that are not the responsibility of any legitimate insurer, and, more generally, to protect the public.

If the books and records of the insurer are so commingled with those of the agent that to separate them would result in a hazardous situation to the policyholders, the court may order the agent into receivership simultaneously with the insurer. This may be done by substantively consolidating the estates of the agent and the insurer, or it may be done by merely administratively consolidating the handling of the two separate estates in one proceeding. In either case, this empowers the receiver to seize the records and assets of the agent. There are significant legal issues related to this situation, and these should be considered carefully.

The action of the court in placing an agent in receivership generally results in permanent revocation of the agent's license and a permanent injunction against the individual from engaging in the business of insurance. The receiver should cooperate with other state insurance departments, if requested, to establish accurate and supportable findings as a basis for revoking an agent's license for unauthorized insurance activity.

B. Title Agents

A title agent is a person or a corporation that is authorized to act as an agent of a licensed title insurer to solicit insurance, collect premiums, issue and countersign title insurance policies. In some states, the title agent owns or controls an abstract plant. An abstract plant is a facility that maintains real property records, typically by address as opposed to by grantor/grantee records. In some states, a title agent is also an escrow agent and in some states, a title and escrow agent is called an "underwritten title company." Title agents may be subject to laws and regulations specifically governing their operations.

Title agents typically accept, hold and disburse funds deposited by buyers and sellers, or persons acting on their behalf, in connection with real property transactions. The funds may be held in trust or in an escrow account.

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Under most state laws, a title agent is deemed to be in the business of insurance and is subject to receivership statutes. The purpose of receivership of a title agent is to protect the books and records, trust or escrow accounts, and other assets of the agent for the benefit of the creditors and perhaps especially, the escrow or trust depositors. Under state law, trust or escrow funds are under the control of the receiver, but they are not property of the receivership estate and thus they are not distributed pursuant to the priority statutes that apply to insurer insolvencies. Title agent insolvencies can create an immediate and heavy workload for a receiver because of the need to promptly handle escrowed funds and because of the time sensitivity of the transactions to which the funds pertain.

The grounds for receivership of a title agent typically include insolvency, based upon an examination of the escrow accounts, misappropriation of funds and/or unauthorized activity (e.g., the issuance of policies without appointment).

C. Reinsurance Intermediaries

Reinsurance intermediaries are brokers or agents in reinsurance transactions. In addition to the agency issues discussed above, the insolvency of a reinsurance intermediary raises the issue of who should bear the ultimate cost for the reinsurance intermediary's failure. The determination of this issue turns on a question of the law of agency, which most states have answered by statute, and by the terms of relevant reinsurance agreements in which the reinsurance intermediary is named. Those statutes have placed the risk of the insolvency of the intermediary upon the reinsurer. This is memorialized in the "intermediary clause," now required in every reinsurance contract, with respect to which the reinsured seeks statutory accounting credit.

Equally important is the issue of the proper forum for the liquidation of a reinsurance intermediary. This area of the law is largely undeveloped. The several courts which have addressed this issue suggest that the bankruptcy courts of the U.S. are the proper forum. However, the question becomes unclear when the reinsurance intermediary is a closely held or wholly owned subsidiary of an insurer which itself is in receivership.

D. Third-Party Administrators

1. Organization and Regulation

A third-party administrator (TPA) is any person or entity which receives or collects fees, charges or premiums for—or adjusts or settles claims on behalf of—an insurer. TPAs commonly provide such services to self-insured organizations. Over time, TPAs' services have expanded from claims adjudication and handling to that of full risk management services including cost control, auditing, litigation management and regulatory compliance. Some TPAs have also broadened their focus from health care and workers' compensation to property and casualty and professional liability.

Most states require that TPAs be licensed by the insurance commissioners and be subject to regulation by the states' insurance departments. Although some TPAs may also be subject to ERISA laws and supervision by the U.S. Department of Labor, this federal oversight is often ineffective. State insurance statutes usually require that TPAs apply for licensure, submit to examination by state commissioners, and hold all premiums in a fiduciary capacity separate and apart from their general operating funds.

2. Receivership

Commissioners may initiate receivership action against TPAs as a result of their unlawful insurance activities. TPAs are often found in the fray surrounding unlawful insurance activity. Sometimes the line between being an administrator operating on behalf of an insurer blurs when the TPA is performing the functions of an insurer without proper authorization or licensure. In these instances,

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the commissioner may choose to seize the TPA under the state's receivership laws in order to either stop the unlawful insurance business or to shut the TPA down completely.

Receivers are likely to encounter TPAs operating in conjunction with MEWAs, which may attempt to resist state regulation and/or receivership by asserting that they are only subject to federal ERISA statutes. The receiver may wish to contact the U.S. Department of Labor to determine if, in fact, the TPA or MEWA is in compliance with the federal ERISA laws. If the entity has failed to comply with ERISA statutes, then the states may have jurisdiction over the TPA and/or MEWA to initiate receivership action in the appropriate state court.

V. ALTERNATIVE RISK FINANCING MECHANISMS

A. Captive Insurance Companies

1. Organization and Regulation

An ordinary captive insurance company is a risk-financing method, or a form of self-insurance, involving the establishment of a subsidiary entity or of an association organized to procure insurance. Captive insurance companies are formed to serve the insurance needs of a given entity or organization. The insureds normally have a direct involvement and influence over the company's major operations, including underwriting, claims, management policy and investments, although in practice the company usually is managed by a captive manager or attorney-in-fact. Leaving aside special purpose financial captives[12] used in the issuance of insurance-linked securities, the common types of captive insurance companies are:

a. Pure Captive: An insurance company that insures only the property or risks of its parent and affiliated companies.

b. Association Captive: A captive insurance company established by members of an association to underwrite their own collective risks. An association captive usually only insures members of the sponsoring association.

c. Industrial Insured Captive: A captive insurance company that insures the property or risks of the industrial insureds that compose the industrial insured group, and their affiliated companies. An industrial insured is defined by statute, but commonly is one that has a full-time employee acting as an insurance manager or buyer and whose aggregate annual premiums for insurance on all risks total at least $25,000 and who has at least 25 full-time employees.

d. Rent-a-Captive: a rent-a-captive is an insurance company that, by contract with the participants, provides them the benefits of a captive insurance company without the capitalization requirements, administrative costs and legal ramifications associated with establishing and operating an insurance subsidiary. The contract may provide for return underwriting profits and investment income to a participant.

e. Sponsored Captive: A captive insurance company in which the minimum capital and surplus required by applicable law is provided by one or more sponsors, insures the property or risks of one or more participants, and segregates the assets and liabilities attributable to each insurance arrangement in one or more protected cells, sometimes called segregated accounts or segregated cells.

[12] E.g., S.C. Code § 38-90-410, *et seq.*

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A variety of U.S. jurisdictions, as well as some off-shore jurisdictions (such as Bermuda), allow a captive to form in a protected cell structure. In such a structure, a captive insurance company containing separate units or cells is formed with a general surplus and general assets. However, each cell has its own assets and liabilities and the cells are bankruptcy-remote from one another and from the general account—i.e., the assets of one cell cannot be used to satisfy the liabilities of another cell or of the host company.[13] The captive insurance company must generally report an insolvent cell to the state insurance department, usually within 10 days. Actual state laws are neither uniform nor clear as to whether an individual cell can be treated as a free-standing entity for the purpose of insolvency proceedings; however, the definition of persons subject to receivership should be sufficiently broad in most states as to encompass an insolvent cell. The receiver, however, will be obligated to respect the separate nature of the cells.[14] Consequently, it is possible that a policyholder creditor of a given protected cell could receive a 100% distribution while the creditors of other cells or the general creditors of the captive do not. It is clear that the captive insurance company itself is subject to conventional insolvency proceedings.

2. Receivership

Domestic captives are subject to most states' receivership laws. Arguably, off-shore captives also are subject to state receivership statutes when such companies transact insurance business within the state without being properly licensed or authorized under the applicable insurance laws. However, there presently is no guaranty fund protection for insureds of captive insurance companies.

It is possible that captive insurers that are formed under the laws of a tax haven jurisdiction may be subject to the insolvency proceedings in that jurisdiction. As of this writing, the law regarding whether such proceedings can be recognized in the United States if the insurer lacks operations in the tax haven jurisdiction is open to question.

B. Risk Retention Groups

1. Organization and Regulation

A risk retention group is a company which insures similar companies with similar risks and operates nationally without having to be licensed in each state. Generally, every member or company must be insured by the risk retention group, and every insured must be a member of the group. A risk retention group is sometimes formed as a captive insurer in the domiciliary state. The federal Liability Risk Retention Act of 1986 also allowed for purchasing groups that purchase products liability, or completed operations, liability insurance.

Risk retention groups originally were intended to provide insurance to common groups of professionals (e.g., attorneys, bankers, accountants) nationwide without having to comply with each state's licensing requirements. Risk retention groups now cover a gamut of risks, including taxis, limousines and commercial autos, and other commercial liability types of risk.

Risk-retention groups organized or licensed in one state must register to transact business in other states. The risk retention groups are required to comply with the laws of the domiciliary state and certain laws of other states in which they transact business, including their insolvency laws, to the extent permitted by 15 U.S.C. § 3902(a)(1). The requirements for licensing (obtaining a certificate of authority) a risk retention group are less onerous than those for other domestic insurers. For a full discussion on risk retention groups, the NAIC *Risk Retention and Purchasing Group Handbook* is available from the NAIC Publications Department at www.naic.org.

[13] *Accord* NAIC Protected Cell Company IRLMA § 6.
[14] *Accord* NAIC Protected Cell Company IRLMA § 7.

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2. Receivership

A domestic risk retention group is subject to that state's receivership statutes. If there is a challenge to the state's jurisdiction over a foreign entity, a state receiver may be required to initiate regulatory or receivership action against a foreign risk retention group in federal court. Particular attention should be paid to access to records of the risk retention group and issues that may arise with the captive manager. Finally, insureds of risk retention groups are not protected by guaranty funds and are prohibited by federal law from participating in a guaranty association.

C. Group Workers' Compensation Pools

1. Organization and Regulation

A Group Workers' Compensation Pool (GWCP) or group self-insurer is a risk-bearing entity which is permitted to bear workers' compensation risks without being organized as an insurance company. These entities are allowed in a few states. The GWCP must be sponsored by a trade association in most states and must insure a homogeneous group of workers' compensation insureds. A pool administrator or an attorney-in-fact sets up the GWCP as a trust and administers the entity. Typically, the GWCP provides group self-insurance or coverage through an indemnity agreement supported by joint and several liability of the members. GWCPs must prepare and file financial reports with their domiciliary state insurance commissioner or other regulatory agency and be audited annually by a certified public accountant.

2. Receivership

The receivership of a GWCP often is handled like that of any licensed insurer or unlicensed company. One state currently requires its Industrial Commission to administer a prefunded guaranty fund to protect GWCP insureds, thus evidencing the fact that, at least in that state, the GWCP is subject to the state's receivership laws. Some GWCPs are covered by guaranty funds, but the assessment, capacity and guaranty cover of the funds vary. A guaranty fund may be given the authority by statute to require the assessment by one financially impaired workers' compensation pool of that pool's participating employers. Alternatively, the guaranty fund would have to assess all of the pools in the fund to cover claims of an insolvent pool. This arrangement gives the fund incentive to require member pools to assess their own participants to avoid an insolvency.

D. Service Warranty/Extended Warranties

1. Organization and Regulation

A Service Warranty/Extended Warranty Entity is a risk-bearing entity which provides/ administers service warranties and/or extended warranties. The products can be supported by traditional insurance (Contractual Liability Insurance Policy, or CLIP) or the entity is required in those states providing for regulation to maintain reserves and otherwise file quarterly and annual reports with the department of insurance.

2. Receivership

A Service Warranty/Extended Warranty Entity in a few states, such as Florida, is subject to receivership statutes. Otherwise, bankruptcy or other receivership action may be required. Finally, service warranty/extended warranty products are typically not protected by guaranty funds but may be covered by surety bonds or the coverage provided by CLIPs.

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VI. MULTISTATE RECEIVERSHIPS

While this handbook generally assumes that receiverships are conducted in the insurer's state of domicile, in many to most cases insurers placed into rehabilitation or liquidation will have assets located, and creditors residing, in multiple jurisdictions. Note that the term "cross-border receiverships" generally will reference receiverships with issues in several countries, which will be addressed in the next section.

How the administration of a particular troubled insurance or reinsurance company will be affected by these multistate issues depends upon several factors. These include a) the insurer receivership law where the company is domiciled; b) the insurer receivership law in the states in which the company wrote business, held assets or incurred claims; and c) whether these states required the insurer to post special deposits. Several insurer receivership law models have been created to coordinate issues arising in multistate receiverships.

The earliest of these models is the Uniform Insurer's Liquidation Act (UILA), which was adopted by the NAIC as its insurer receivership model law in the 1930s. Created as a result of many insurers failing during the Great Depression, the UILA was designed for the specific purpose of solving certain problems inherent in multistate receiverships. Chief among these problems was that states would seize any assets found within their borders and apply those assets to the claims of residents of that state only. At that time, very few states had statutory insurer receivership laws, and the matters proceeded as equity receiverships in state courts whose jurisdiction was limited by that state's borders. This resulted in widely disproportionate levels of payment of claims and extravagant administrative expenses. The insurance receivership laws in most if not all states can trace their roots to the UILA.[15] In many states, later insurer receivership models were adopted, but the UILA was not repealed. In many other states these provisions were adopted because they were incorporated in the Interstate Relations sections of the NAIC's Insurers Rehabilitation and Liquidation Model Act (the IRLMA). The IRLMA was first adopted by the NAIC in 1968 and was amended several times prior to being replaced by IRMA in 2005. Most states have enacted receivership laws based upon the IRLMA. These acts define the relative rights and responsibilities of state insurance commissioners in their capacities as both domiciliary and ancillary receivers of insolvent insurers.

A. Uniform Insurer's Liquidation Act (UILA)

Under the UILA, the receivership or insolvency proceeding is referred to as a "delinquency proceeding," and defined as "any proceeding commenced against an insurer for the purpose of liquidating, rehabilitating or conserving" a delinquent insurer. The UILA designates the various states that may be involved in any given delinquency proceeding as follows:

- Domiciliary State—The state in which the insurance company is incorporated or organized. If the insurer is incorporated or organized in a foreign country, then the domiciliary state is deemed to be the state in which the insurance company has, at the beginning of the delinquency proceedings, "the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States." The domiciliary state is deemed to be the primary location for the delinquency proceedings.

- Ancillary State—Any state other than a domiciliary state. Ancillary states are those states where ancillary proceedings (i.e., receivership proceedings parallel to those of the domiciliary state) may be instituted. Generally, an ancillary may be instituted in any state where assets of the insurer are located.

- Reciprocal State—Any state that has enacted provisions which are similar in substance and effect to the provisions of the UILA, which: a) state that only the regulator can be appointed as the receiver of an insurer; b) provide for the treatment of voidable preferential and fraudulent

[15] Note that the UILA was withdrawn from recommendation for enactment by the National Conference of Commissioners on Uniform State Laws in 1981 due to it being obsolete.

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transfers; c) provide for the treatment of ancillary proceedings by the domiciliary state; and d) provide for the treatment of claimants residing in other-than-domiciliary states. [16]

The UILA defines certain types of assets and claims involved in delinquency proceedings. "General assets" are defined as "all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons." Assets located or situated in a state other than the domiciliary state are not exempt from classification as general assets by virtue of their location. Assets held in trust or on deposit in an ancillary state for the benefit of all of the insolvent insurer's policyholders are deemed to be general assets. Similarly, reinsurance proceeds typically are deemed to be general assets.

"Special deposit claims" are defined as any claims that have been secured by a deposit made pursuant to a statute for the security or benefit of a limited class of persons. Most states' statutes are designed to protect state residents against foreign insurance companies, and some states require that an insurance or reinsurance company post funds with the state in the form of a "special" or "statutory deposit" before being allowed to do business in that state. The special or statutory deposits can take the form of bonds, trust accounts, escrow accounts, letters of credit, cash or any other form of security approved or required by the state. The states usually require funds sufficient to cover all potential outstanding policyholder (and in some states, general creditor) claims against the insurance company by the residents of that state. In some states, the amount and form of the deposit depend upon the type of insurer involved and the type of insurance risk underwritten.

The UILA has created a framework for simultaneous receivership proceedings in different states with respect to a single insurer. It outlines procedures for delinquency proceedings for both domiciliary and non-domiciliary insurance companies, as well as the duties and responsibilities of the domiciliary and ancillary receivers. The UILA also sets forth provisions governing the filing and proving of claims, priority of creditors' claims, special deposits, and the attachment and garnishment of assets. Overall, these provisions centralize the delinquency proceedings by vesting power in a single domiciliary receiver.

1. Domiciliary and Ancillary Receivers

Once delinquency proceedings are initiated in the state where an insolvent or delinquent company is domiciled, the UILA provides that the court shall designate that state's commissioner of insurance as the domiciliary receiver. Most states have specific requirements for the appointment of a receiver.

Some courts have held that an ancillary receiver cannot be appointed until after a domiciliary receiver has been appointed unless certain steps are taken. Generally, the commissioner of insurance may petition the court for appointment of an ancillary receiver (i) if there are "sufficient" assets of the company located in the ancillary state to justify the appointment of an ancillary receiver, or (ii) if 10 or more state residents petition the commissioner requesting an ancillary receiver. When appropriate, the court appoints the insurance commissioner of the state as ancillary receiver.

Upon appointment of a domiciliary receiver, the court "directs the receiver to take possession of the insurer's assets and administer them." Most states have statutes outlining the specific powers and duties of the receiver as supervisor, conservator, rehabilitator, or liquidator of the delinquent company. In addition, the UILA vests the domiciliary receiver (and successors) with title to all property, contracts and rights of action of the delinquent company, wherever situated, as of the date of

[16] If each state enacted the uniform law, the National Conference of Commissioners on Uniform State Laws reasoned, past embarrassments could be remedied by the following: (1) provision that the insurance commissioner or an equivalent official shall serve as receiver; (2) authority for domiciliary receivers to proceed in non-domiciliary states so as to prevent dissipation of assets therein; (3) vesting of title to assets in the domiciliary receiver; (4) provision for non-domiciliary creditors to have the option to proceed with claims before local ancillary receivers; (5) uniform application of the laws of the domiciliary state to the allowance of preferences among claims; and (6) prevention of preferences for diligent non-domiciliary creditors with advance information. Prefatory Note, Uniform Insurers Liquidation Act, 13 U.L.A. 322 (1986) (superseded).

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entry of an order giving the receiver possession of the company. Upon taking possession of the assets, the domiciliary receiver must proceed to liquidate, rehabilitate, reorganize or conserve the company. Typically, the domiciliary receiver has sole responsibility to operate the delinquent company, to make policy decisions concerning the conduct of the delinquency proceedings, and to create a plan for administration of the company.

If an ancillary receiver is appointed in a reciprocal state, the UILA provides that the ancillary receiver has the same rights and powers regarding assets located in the ancillary state as the domiciliary state would grant to its own ancillary receivers. In addition, the ancillary receiver is deemed to have the sole right to recover assets of the company located in the ancillary state.

The ancillary receiver appointed under the UILA "as soon as is practicable" liquidates from assets in the receiver's possession those special deposit claims and secured claims which are proven and allowed in the ancillary proceedings. Any and all remaining assets of the company then are to be promptly transferred to the domiciliary receiver.

2. Claims, Special Deposits and Priorities

Once receivers are appointed in the domiciliary and ancillary states, the focus of the UILA shifts to the processing and payment of claims. In particular, the UILA provides for the filing of claims generally, the payment of claims out of specially deposited assets, and the relative priority of claimants in the payment process.

a. Filing Claims

Claimants residing in reciprocal states may bring claims against the delinquent company in either the domiciliary proceeding or in an ancillary proceeding in their own states. If ancillary proceedings have not been commenced, a claim against a company in delinquency proceedings must be presented in the domiciliary proceedings. If the claims are controverted, and the ancillary forum is chosen for resolution of those claims, proper notice of the disputed claims must be given to the domiciliary receiver. If such notice is given, the final judgment as to the controverted claim will be conclusive as to amount and perhaps priority in both the ancillary and domiciliary proceedings.

b. Special Deposits

Under the UILA, claimants of a state are given priority against special deposit funds held for their benefit, according to that state's statutes. If the special deposit claims have not been fully paid after all special deposit funds have been fully exhausted, the special deposit claimants may share in the general assets of the company. However, in order to assure equal treatment of all of the delinquent company's creditors, the special deposit claimants who have received a distribution from special deposit funds cannot share in general assets until "general creditors, and claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit."

c. Priority of Preferred Claims

Pursuant to UILA, the preference or priority scheme of the domiciliary state determines which claims will be deemed preferred, regardless of where claims are brought. The priority provisions of the UILA, however, do not replace other principles generally applicable to the payment of claims.

3. Problems Under the UILA

Certain problems have arisen over the years in applying the UILA to multistate delinquency proceedings. Some of these problems have arisen from disputes over the scope of injunctions or stay orders issued by receivers, proper timing of claims, and enforcement of judgments against the

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delinquent company. Other problems have arisen where a nonreciprocal state—a state which has not enacted the UILA—is involved in the delinquency proceedings. The UILA does not address this problem, and courts have struggled to fashion equitable resolutions for the states involved. Most often, courts have held that UILA states have no duty to apply the principles of the UILA with regard to nonreciprocal states.

The UILA has several other "gaps" that have caused difficulties over the years. The UILA does not address the right of a commissioner in an ancillary state to initiate delinquency proceedings in the ancillary state in the event that delinquency proceedings are not initiated in the domiciliary state. Also, the UILA contains no provision governing a domiciliary receiver's remedies in the event that an ancillary receiver refuses to cooperate with the domiciliary receiver in the collection and distribution of assets.

Some of these problems have been addressed in the IRLMA.

B. The Insurers Rehabilitation and Liquidation Model Act (IRLMA)

The IRLMA contains provisions governing all aspects of insurance company receivership regulation in the United States with regard to conservation, rehabilitation and liquidation, including provisions governing multistate proceedings. With respect to multi-jurisdiction receivership, the goals of the IRLMA are to provide improved methods for the rehabilitation of insurers; to make the liquidation process more efficient and economical; to facilitate interstate cooperation in the rehabilitation and liquidation of insurers; and to protect the interests of policyholders, claimants and creditors.

1. Structure of the IRLMA

Ten sections (54-63) of the IRLMA adopt much of the UILA, as well as its policy objective: centralization of delinquency proceedings in the domiciliary jurisdiction. Unlike the UILA, however, the IRLMA no longer refers to the insolvency proceedings as a "delinquency proceeding." Rather, the IRLMA distinguishes between conservation and "formal proceedings," i.e., rehabilitation and liquidation. States are considered reciprocal under the IRLMA if each has enacted the substance and effect of Sections 5 (Injunctions and Orders), 17 (Rehabilitation Orders), 20 (Liquidation Orders) and six of the "Interstate Relations" sections (i.e., 54-56 and 58-60).

2. Domiciliary and Ancillary Receivers

The grounds for appointment of a domiciliary receiver under the IRLMA parallel those in the UILA, i.e., the same grounds for rehabilitation or liquidation set forth in Section 15 of the IRLMA. The two acts differ, however, as to the grounds for appointment of ancillary receivers. The UILA enables the state commissioner to petition for appointment as an ancillary receiver if there are sufficient assets in the state to warrant such action, or if 10 or more residents with claims against the company petition for the appointment of an ancillary receiver. Under the IRLMA, proceedings may be initiated if: (i) there are sufficient assets in the state to justify the appointment of an ancillary receiver; (ii) "the protection of creditors or policyholders in [the ancillary] state so requires"; or (iii) the domiciliary receiver requests such a filing. The ancillary receiver of an insurer domiciled in a reciprocal state may render only such assistance as the domiciliary receiver requests, and has the same powers and duties as the domiciliary receiver when so requested. The ancillary receiver is entitled to payment of his or her costs or expenses, and may enter into agreements with the domiciliary receiver regarding the payment or advancement of such expenses.

3. Receivers of Foreign and Alien Insurers

The IRLMA distinguishes between foreign (those from any other U.S. state, district or territory) and alien (those from another country) insurers. If grounds exist for the commencement of delinquency proceedings against a foreign or alien insurer (i.e., those set forth in Section 15, as well as official

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sequestration of the insurer's property in its domicile, or revocation of the insurer's certificate of authority while residents of the state have outstanding policies or claims) and no domiciliary receiver has been appointed, the IRLMA enables the state commissioner to petition the designated court for appointment as conservator of the insurer's property found in the conservator's state. Under a state court order, the commissioner, as receiver, may conserve (but not liquidate) the assets of an alien insurer that has not established a domicile in the U.S. (but not those of a foreign insurer) found in the state.

4. Receiver's Control Over Assets

Like the UILA, the appointment of a receiver vests the receiver with title to all of the insurer's assets, by operation of law. Under both the IRLMA and the UILA, a receivership is established in which the domiciliary receiver is directed to administer the insurer's assets under the general supervision of the receivership court. However, the IRLMA requires that the receiver provide periodic accountings to the supervising court.

With respect to assets, the IRLMA distinguishes between a domiciliary liquidator appointed in a reciprocal state and one appointed in a non-reciprocal state. A domiciliary liquidator appointed in a reciprocal state is vested with title to, and has the immediate right to recover, all assets in all reciprocal states—except for special deposits and the security on secured claims—upon the filing of the petition for liquidation. However, when a domiciliary liquidator is appointed in a non-reciprocal state, the commissioner of the non-reciprocal ancillary state is vested with title to all of the assets situated in that state and may petition for a conservation order or for an ancillary receivership or transfer such assets to the domiciliary liquidator after obtaining court approval.

5. Claims

The IRLMA and the UILA treat the filing of claims differently. Under the IRLMA, creditors of an insurer under liquidation in a reciprocal state must file their claims in the domiciliary proceeding, subject to its deadlines. However, while the UILA is silent as to the rights of residents in non-reciprocal states to file claims with an ancillary receiver, the IRLMA specifically allows such claimants to file their claims with either the domiciliary liquidator or the ancillary receiver, if the domiciliary state's law permits. Similarly, under the IRLMA, nonresident creditors of an insurer in liquidation in its domiciliary state must file their claims with the domiciliary receiver, subject to the domiciliary state's deadlines. In some states, the in-state residents, including policyholders and general creditors, have a lien on the deposits. The receiver should review the applicable state statutes under which the deposits were created.

The IRLMA also now differs from the UILA in its treatment of controverted claims. Under the IRLMA, controverted claims must be proved and decided in the domiciliary state unless the claimant notifies the domiciliary liquidator in writing that it elects to proceed in the claimant's respective reciprocal state's ancillary receivership. The ancillary court's determination of such a controverted claim is conclusive as to validity and amount, but priority of distribution shall be determined in the domiciliary proceeding. The claimant also may controvert its claim in the domiciliary proceeding.

Secured claimants may surrender their security and file their claims as general creditors, or they can resort to the security and make a claim for any deficiency on the same basis as unsecured creditors in the same class.

The IRLMA now differs significantly from the UILA in the handling of special or statutory deposit claims. Upon the entry of a final order of liquidation or an order approving a rehabilitation plan of an insurer domiciled in the state or a reciprocal state, all deposits must be delivered to the domiciliary liquidator to be held as a general asset for the benefit of all creditors and distributed in accordance with the domiciliary state's law.

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6. Priority of Distribution

Under the IRLMA, general assets are distributed in accordance with the domiciliary state's priority of distribution scheme. The IRLMA was drafted so that the determination of priority by an ancillary liquidator and court is not binding upon the domiciliary liquidator. The IRLMA encourages interstate cooperation by penalizing claimants residing in states if their ancillary receiver fails to transfer any assets to the domiciliary receiver. The claims filed in the ancillary proceeding other than special deposits or secured claims are subordinated to the next-to-last class of claims under the priority of distribution schedule.[17] The UILA contains no similar penalty provisions.

C. Insurers Receivership Model Act (#555, IRMA)

The *Insurers Receivership Model Act*, (#555), commonly known as IRMA, was adopted by the NAIC in December 2005 to replace the earlier IRLMA. There are several areas of change between IRMA and the IRLMA, but probably the subject of the greatest change was interstate relations. Article X deals with this subject in only two sections as compared to 11 in the 1998 version of the IRLMA. Under IRMA, the authority and responsibility for administering the estate of an insolvent insurer is placed on the domiciliary receiver. If a domiciliary receiver has been appointed, an ancillary receivership may be initiated only with the consent of the domiciliary receiver (IRMA Section 1001B).

Prior to the appointment of a domiciliary receiver, any commissioner in any state may petition to be appointed as conservator of the assets of a foreign insurer that are located in that commissioner's state: 1) on the same grounds as would justify the appointment of a receiver in that state; 2) if any of its assets have been seized by official action in another state; 3) if its certificate of authority in the commissioner's state has been revoked and there are residents with unpaid claims or in-force policies; or 4) if it is necessary to enforce a stay under the state's guaranty association laws (IRMA Section 1001A).

An ancillary conservator may use assets of the insurer to pay the costs of administering the estate (IRMA Section 1001E). Once a domiciliary receiver is appointed, the conservator shall turn over all property of the estate to the receiver (IRMA Section 1001D). An ancillary liquidation order can only be issued for the purpose of liquidating assets to pay the administrative costs of the ancillary receivership or to activate the guaranty association in the ancillary state (IRMA Section 1001F).

With the exception of special or statutory deposits established with the state's guaranty association as the sole beneficiary, IRMA provides that the assets of an insurer belong to the domiciliary receiver. The domiciliary receiver is entitled to take possession of those assets (IRMA Section 1002A). Upon the entry of a liquidation order with a finding of insolvency, those special deposits are to be distributed to the guaranty associations as early access (IRMA Section 1002A). All other deposits are to be returned to the domiciliary receiver, who is obligated to administer them in accordance with the law under which they were created (IRMA Section 1002B). Special deposit claims are to be adjudicated and paid by the domiciliary receiver. If the special deposit is insufficient to pay all special deposit claims in full, special deposit claimants may share with other claimants in their priority class, but only after all others of the same class have been paid a percentage of their claims equal to the percentage that the special deposit claimants have received. (IRMA Section 1002C).

IRMA makes all states reciprocal states to the enacting state and directs that all receivership orders and related orders in another state are to be given full faith and credit by the courts of the enacting state (IRMA Section 1002A). This provision is to ensure that stay orders issued in relation to a receivership are honored by the courts in other states.

Reciprocity can be an issue in IRMA. While IRMA provides that a state adopting it would consider all other states reciprocal to that state, the other states may require allowance of their ancillary proceedings

[17] IRLMA § 58

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(which IRMA would not allow) for these other states to consider the IRMA-adopting state to be reciprocal to them. This may be remedied by a state adopting IRMA if it adds a provision for transitioning on reciprocity. Some suggested wording for this follows: "Notwithstanding any other provision of this Act, only to the extent necessary while other states are in the process of adopting Acts similar to this Act, the receivership court may allow for the treatment of ancillary proceedings reciprocal to the laws of any state providing for ancillary proceedings."

NAIC Guideline for Definition of Reciprocal State in Receivership Laws (#1985)

In 2021, the NAIC adopted the *Guideline for Definition of Reciprocal State in Receivership Laws* (#1985) to provide a statutory definition that may be used by state with a reciprocity requirement to effectuate the purposes of the following provisions, which in may states may only apply if the domiciliary state is a reciprocal state.

- The domiciliary receiver is vested with the title to the insurer's assets in the state.
- Attachments, garnishments or levies against the insurer or its assets are prohibited.
- Actions against the insurer and its insureds are stayed for a specified period of time.

The definition provided in Guideline #1985 states that: "Reciprocal state" means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state's insurance commissioner or comparable insurance regulatory official.

Under this definition, any state meeting the applicable Part A standards of the NAIC Financial Regulation Standards and Accreditation Program for state receivership laws will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws and should prevent unnecessary litigation regarding the recognition of a state as a reciprocal state.

Note that Guideline #1985 was adopted to address concerns with reciprocity under IRMA, as noted above, and is available for states to adopt if not already addressed through state statues or other means.

VII. INTERNATIONAL RECEIVERSHIPS

Due to the continued globalization of the insurance industry, insurance companies often may have assets, creditors and debtors located around the world. Therefore, the receiver of a domestic insurance company may be forced to address numerous legal, strategic, practical and political issues related to cross-border insolvencies.

When the insolvent domestic insurer has assets located in a foreign country, the receiver should consult with his or her professional advisors to determine how to administer those assets. Issues to consider include: (1) whether the domestic insurer can repatriate the assets without incurring unacceptable legal risk or significant expense; (2) whether the insurer (or the domestic receiver as legal representative of the insurer), the insurer's creditors, or a foreign regulator can initiate separate insolvency proceedings to ensure the orderly administration of the assets located in the foreign country; and (3) whether the domestic receiver can be granted relief from a foreign court in aid of the domestic receivership proceeding in the form of injunctions, stays, or other relief to prevent creditors from attaching the assets or commencing litigation against the insolvent insurer in the foreign jurisdiction. Additionally, where the insolvent domestic insurer's assets have been commingled with affiliates incorporated in foreign countries, the receiver should consult with his or her professional advisors to ascertain whether it would be possible and prudent to attempt to substantively consolidate the assets and liabilities of foreign entities into the domestic receivership estate, or other available mechanisms for achieving the same result.

When the estate has a claim against an entity that is the subject of foreign insolvency proceedings (such as a reinsurer, retrocessionaire or policyholder with retrospectively related premium or high deductible obligations), the receiver will be confronted with a different set of considerations with respect to the pursuit of its claim. The

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location of the entity's assets and the nature of the insolvency proceedings will be of significant importance. If all of the entity's assets are located in the foreign country, the receiver will need to consider the degree to which the receiver is willing to commit financial and personnel resources to participating in the foreign insolvency proceeding and the risks associated with submitting to the jurisdiction of the foreign court. Levels of participation can range from merely presenting claims in accordance with the foreign court's procedures to contesting the basis for the insolvency proceedings, and the specifics of the relief sought by the entity in the foreign court. If the entity has assets in the United States, the receiver may consider additional options, such as attaching the assets and contesting any relief sought by the entity in the United States in aid of the foreign proceedings.

Insolvency proceedings in foreign countries come in a variety of flavors. This is intended to be neither a comprehensive list nor comprehensive descriptions of the various proceedings. The Common Law jurisdictions in the English tradition (e.g., Bermuda and the United Kingdom) recognize reorganization of both solvent and insolvent companies. Typically, "solvent schemes of arrangement" allow a solvent company to reorganize its liabilities under general corporate law, often in conjunction with an exit from business and often with limited or no court supervision. There are also schemes involving insolvent companies, using the scheme of arrangement mechanism in conjunction with an insolvency proceeding, often involving an insolvency practitioner acting as the provisional liquidator reporting to a court on a periodic basis. Some common law countries also allow court-supervised reorganizations or "orders of administration" similar to a United States proceeding under Chapter 11 of the Bankruptcy Code. European Union jurisdictions recognize a semi-uniform insolvency regime in which a main proceeding coordinates with ancillary proceedings in other member states. The United Kingdom also recognizes a corporate transaction in which a group of insurance policies may be transferred to another company through Part VII of the Financial Services and Markets Act 2000, which provides "for the transfer to the transferee of the whole or any part of the undertaking concerned and of any property or liabilities of the authorised person concerned." As of this writing, the balance of the European Union countries are expected to institute similar procedures.

There are essentially two ways that the orders of a foreign receiver could be enforced in the United States. A foreign receiver may seek recognition under Chapter 15 of the Bankruptcy Code, 11 U.S.C. §§ 1501-1532, or through the doctrine of comity.

Chapter 15 of the Bankruptcy Code is designed to enable "foreign representatives" acting in "foreign proceedings" to enforce orders from those proceedings in the United States. In effect, Chapter 15 opens the traditional bankruptcy tools to a foreign receiver. Chapter 15 replaces the Code's prior mechanism of granting cooperation with a foreign representative under the former Bankruptcy Code § 304.

Chapter 15 was designed to enact the United Nations model insolvency law in the United States. The House Report on the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 describes how the 2005 legislation "introduces Chapter 15 to the Bankruptcy Code, which is the Model Law on Cross-Border Insolvency ('Model Law') promulgated by the United Nations Commission on International Trade Law ("UNCITRAL")." H.R. Rep. No. 109-31, at 105 (2005). The Model Law commentary states: "The purpose of this Law is to provide effective mechanisms for dealing with cases of cross-border insolvency" (Preamble UNCITRAL Model Law). While courts will frequently analogize to case law under the old § 304 when examining Chapter 15 situations, it should be recognized that Chapter 15, by adopting the UNCITRAL Model Law, has adopted an entirely new regime, not simply modified the old one.

Chapter 15 relief is specifically open to foreign insurance companies. A case under Chapter 15 begins with the filing of a petition for recognition of the foreign proceeding. A court may grant a stay of execution on the debtor's assets upon filing of the petition, and prior to the grant of recognition. Chapter 15 provides direct access to U.S. courts for the foreign representative to sue or be sued and mandates that once a foreign representative is granted recognition, the representative will be granted comity and the cooperation of the U.S. courts. If recognition is not granted, the U.S. court may issue orders preventing the foreign representative from acting in the United States. There is an exception to recognition providing that the decision to seek or not seek recognition will not "affect any right the foreign representative may have to sue in a court in the United States to collect or recover a claim which is the property of the debtor" such as collect accounts receivable within the United States.

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Once recognition is granted, a foreign representative may commence either an involuntary or voluntary case under the Code, opening the door to the entire array of bankruptcy powers. Once recognized, the foreign representative may seek a stay of actions against the debtor's assets, and the court may entrust distribution of the debtor's U.S. assets to the foreign representative. Chapter 15 specifically grants the foreign representative the power to avoid transactions as fraudulent transfers or preferences and use the Code's turnover mechanisms for recovery. Chapter 15 gives foreign creditors the same rights as U.S. creditors. Once a foreign proceeding is recognized as a foreign main proceeding, "sections 361 and 362 apply with respect to the debtor and the property of the debtor that is within the territorial jurisdiction of the United States…" 11 U.S.C. § 1520 (a)(1).

Significantly, Bankruptcy Code § 1501(d) provides that "[t]he court may not grant relief under this chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable State insurance law or regulation for the benefit of claim holders in the United States." Under a plain reading of this provision, claimholders should not be enjoined by the bankruptcy court from seeking recoveries out of statutory deposits. As of the date of this writing, there are no bankruptcy court opinions that have considered the question of whether Bankruptcy Code § 1501(d) precludes the court from enjoining a domestic ceding company from seeking recoveries out of a deposit, escrow, trust fund or any other security provided by an unauthorized alien reinsurer to satisfy credit for reinsurance statutes.

One of the unsettled questions at the early stage of the implementation of Chapter 15 is determining what constitutes a "foreign proceeding." A "foreign proceeding" under the Bankruptcy Code is a proceeding "under a law relating to insolvency or adjustment of debt in which proceeding the [debtor's assets and affairs] are subject to control or supervision by a foreign court for the purpose of reorganization or liquidation." 11 U.S.C. § 101(23). While the pre-Chapter 15 definition of "foreign proceeding" and the revised definition may appear similar, it is clear that Congress intended to fully scrap the prior definition in favor of the UNCITRAL Model Law. In fact, the current definition of "foreign proceeding" in the Bankruptcy Code makes clear that it applies only to proceedings "under a law relating to insolvency or adjustment of debt." Therefore, a receiver should consider whether there is a basis for challenging a Chapter 15 petition on the grounds that the foreign restructuring is merely a corporate reorganization rather than a true insolvency proceeding under a law relating to the adjustment of debt.

Additionally, Chapter 15 contains a specific public policy exception: "Nothing in this chapter prevents the court from refusing to take an action governed by this chapter if the action would be manifestly contrary to the public policy of the United States." 11 U.S.C. § 1506. However, this exception is to be narrowly construed. A receiver should consider whether to oppose the Chapter 15 petition on the basis that the relief being sought by the entity in the foreign proceeding is contrary to public policy, such as applicable state insurance regulations.

It is also possible that a U.S. court may grant assistance to a foreign representative under the doctrine of comity when a case lies outside of those contemplated by Chapter 15. Comity is the recognition that one nation allows within its territory the legislative, executive or judicial acts of another nation, having due regard both to international duty and convenience, and to the rights of its own citizens, or of other persons who are under the protection of its laws. Comity is a flexible doctrine, but the courts are inclined to enforce foreign judgments unless they are contrary to public policy. Comity will not be granted when a foreign proceeding tramples on rights granted by the U.S. Constitution. However, other violations of U.S. law must pass a high threshold to prevent a grant of comity.

In summary, due to the complex nature of cross-border insolvency issues, there may be additional legal, strategic, practical and political issues that a receiver may need to address in order to ensure the orderly administration of the estate and the maximization of recoveries for creditors. Once the estate is confronted with issues related to insolvency proceedings in foreign countries, the receiver should consult with his or her professionals to identify potential problems and solutions.

Internationally Active Insurance Groups and Communication with International Regulators

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U.S. based insurance holding company systems that operate internationally are designated Internationally Active Insurance Groups (IAIGs) if they meet certain criteria, generally based on size and writings, but may include other criteria[18].

For each IAIG, a group-wide supervisor is designated, which may not be a U.S. state regulator. Additionally, for each IAIG, supervisory colleges and crisis management groups are formed to meet periodically to discuss and exchange relevant information about the group. One key benefit to supervisory colleges is establishing routine communication channels with appropriate company personnel and regulators in other jurisdictions.

The NAIC through the state regulators has defined a supervisory college as a regulatory tool that is incorporated into the existing risk-focused surveillance approach when a holding company system contains internationally active legal entities with material levels of activity and is designed to work in conjunction with a regulatory agency's analytical, examination and legal efforts. The supervisory college creates a more unified approach to addressing global financial supervision issues. Supervisory colleges may also be formed for groups with international activity that do not fully meet the definition of an IAIG, at the discretion of the relevant jurisdictions' insurance regulators, often referred to as "regional colleges".

Additionally, the group-wide supervisor will establish a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG.

In the event a U.S. insurance entity within an IAIG becomes financially troubled and/or insolvent, the U.S. domestic state insurance regulator and group-wide supervisor (if not the same) should utilize the communication channels established by the supervisory college and crisis management group when beginning a receivership process.

The group-wide supervisor, in consultation with the CMG, determines whether to require that the IAIG develop a formal recovery plan[19] to establish in advance the options to restore the financial position and viability of the IAIG in a crisis. If a recovery plan is in place, it can be used by the CMG and the IAIG to take actions for recovery if the IAIG comes under severe stress. Regardless of whether a formal recovery plan is required, the Own Risk and Solvency Assessment (ORSA) Summary Report should discuss at a high level the severe stresses that may identify recovery options available and provide information for the state insurance department in the event of severe stress.

Resolution plans[20] are put in place at IAIGs where the group-wide supervisor and/or resolution authority, in consultation with the CMG, deems necessary. If a resolution plan is in place, it should contain information from relevant legal entities and other jurisdictions to aid in the receivership process. There may be in pace coordination agreements that outline roles and responsibilities of members of the CMG and the process for coordination and cooperation, including information sharing, among members of the CMG. Refer to Exhibit 8-1 for a template for development of a resolution plan that describes the U.S. receivership system.

Refer to the NAIC *Financial Analysis Handbook* and the *Troubled Insurance Company Handbook* (regulator only publication) for more details on group-wide supervision, supervisory colleges, CMGs, and recovery and resolution planning.

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[18] A discussion of IAIG criteria and other analysis and regulatory considerations for grup-wide supervision is included in the NAIC *Financial Analysis Handbook* and the *Troubled Insurance Company Handbook* (regulator only publication).

[19] Refer to IAIS Insurance Core Principle (ICP) CF 16.15 and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)

[20] Refer to ICP CF 12.2 and 12.3 and the Application Paper on Resolution Powers and Planning for more background information and possible best practice guidance, including the approach to determining if resolution plans are needed and key elements of a plan (e.g., resolution strategies, financial stability impacts, governance, communication, and impact on guaranty fund systems). (https://www.iaisweb.org/home)

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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 the 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.

[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, commonly 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 commencement of proceedings 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 Section 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, Section 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 Section 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 Section 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 Section 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 accounting to the court by the conservator at intervals specified by the order, no less frequently than semi-annually. See Section 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 Section 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 requesting that the insurer be either released from conservation or placed in rehabilitation or

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liquidation. The motion must be filed within 180 days of the conservation order, unless the court grants a 180-day extension. See IRMA Section 302. The conservator is required to coordinate with guaranty associations to ensure an orderly transition in the event of liquidation. See IRMA Section 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 Section 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 which can be financial such as RBC levels or non-financial grounds. Per Section 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 Section 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, Section 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

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

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rehabilitation. Additionally, the order should be served on all financial institutions where the insurer maintains accounts or has other assets.

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, Section 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; Section 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

[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).

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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]

IRMA Section 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 Section403 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.

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[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. 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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5. Hardship provisions.

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 Section 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

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should work closely with the Department of Insurance to ascertain the viability of the business 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:

- Payment of administrative expenses, including staff salaries,
- Notice to creditors and other interested parties,
- Coordination of data transfer from the insurer's data processing system to the receiver's system,
- 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
- 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. Section 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 their insurer has been placed in receivership, is to withdraw their cash value and purchase insurance from another company at the earliest opportunity.

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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 Section 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 Section 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 Section 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 to attempt to rehabilitate the insurer as a prerequisite to seeking an order of liquidation.[11] In liquidation, the

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

[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).

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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 Section 501. State statutes describe the effect of the order of liquidation upon contracts of the insolvent insurer, IRMA Section 114, Section 209 B and Section 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, Section 502 makes specific provisions and distinctions as to cancellations of property/casualty coverages and continuations of life and health coverages.

[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, Section 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 Section 208 and Section 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, Section 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, Section 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 rights 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 Section 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 Section 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, Section 701B and Section 801. The liquidator may be permitted to request the court to set a date after which no further claims may be filed. See IRMA, Section 701B. Many receivership acts also contain provisions permitting claimants to file unknown, unliquidated or contingent claims. See IRMA, Section 704 and Section 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.

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 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.

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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 Section 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 Section 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. This requirement in effect creates a rebuttable presumption that the liquidator's

[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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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. Section 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 applicable law against the consolidated assets. For example, if there is a substantial federal tax claim

[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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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

[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

[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.

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 Section 504 and to whom notice should be given in Section 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 Section 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

[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 insurers 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 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

[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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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 Health Insurers and HMO plans has added new elements to the overall receivership picture. Medicare and Medicaid Health Insurers and HMOs offer eligible enrollees services similar to those of a conventional Health Insurers and HMO rather than the benefits set out by statute or regulation in the fee-for-service programs. Health Insurers and 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 Health Insurer and 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 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.

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

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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 Health Insurers and 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 Health Insurer or 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 health 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 Health Insurers and 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 Health Insurer and 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 Health Insurer or HMO in receivership will thus be able to move their business to another carrier serving that market without risking loss of coverage or gaps in coverage. The same is generally

[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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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 Health Insurer and 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 Health Insurer or 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 Section 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 Section 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 Section 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 Section 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 must 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 Section 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,

[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]

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[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.

Section 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.

Section 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.

Section 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.

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 coordinated 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.

Section 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 Section 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 Section705 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, Section 39 of the Liquidation Model Act and Section 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

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in the statute. IRMA Section 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.

Section 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 Section 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

[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 Section104 CC, defines "special deposit" as "…a deposit established pursuant to statutes for the security or benefit of a limited class or classes of persons." Section 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 Section 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 Section 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.

[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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Investment Company Act of 1940 ("1940 Act")

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

[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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contracts that is next computed after the insurer receives the purchase, withdrawal, or transfer request in good order.

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.

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- 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)

- 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.

NAIC *Modified Guaranteed Annuity Regulation* (#255)

- 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.

Insurers Rehabilitation and Liquidation Model Act (1999) (IRLMA), Section 3 (K):

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

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(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.

(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

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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.

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.

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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,

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.

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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

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,

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

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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 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.

[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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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 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).
- Determine standards governing the Guaranteed Benefits. 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.

[70] But see footnote 65.

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- Determine the TIC's financial risk not supported by a Separate Account. 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:
        - 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.
- Determine the TIC's financial hedging transactions to support its Guaranteed Benefits and other obligations under its Variable and SEC Registered Products.

c. Evaluate Options

- Are the TIC's hedging programs adequate?
    - 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?
- What administrative systems are in place to match daily the value of the Separate Account to each Variable Product?
    - 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

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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.

 - 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 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?

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- 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) 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 https://www.sec.gov/investment-management.

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

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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 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

[71] See also footnote 64.

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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 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]

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

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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 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.

[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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- 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.
- 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.

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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 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

[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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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.

(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.

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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.

(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

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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. 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.

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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 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

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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).

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.

- Section 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. Section 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.

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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.

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

[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.G of this chapter on Priority of Claims.

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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 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 Section 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

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[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.

[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).

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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.

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 Section 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 Section 47] through the use of equitable remedies," or by Section 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 Agreements[89]

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

[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).

[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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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 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* (#440) (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] 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.[91] 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.[92]

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

[90] See NAIC Insurance Holding Company System Regulatory Act §§5A(1), 5A(4), 5 (A)(6)

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

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

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solvent. However, if the subsidiary is insolvent, generally there is a contrary result.[93] Second, when corporate affiliates are operated as if they constitute a single business enterprise, courts recognize that, in certain circumstances, all affiliates benefit from the synergistic effort of the grouping.[94] 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.[95] 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.[96] 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.[97]

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.[98]

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.

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[93] 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).

[94] 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).

[95] 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).

[96] 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).

[97] 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).

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

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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 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.

ON AUG. 17, 2021, THE NAIC ADOPTED A NEW PROVISION, SECTION 5A(6), OF THE *INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT* (#440), WHICH PROVIDES THAT THE AFFILIATED ENTITY WHOSE SOLE BUSINESS PURPOSE IS TO PROVIDE SERVICES TO THE INSURANCE COMPANY IS SUBJECT TO THE JURISDICTION OF THE RECEIVERSHIP COURT. THIS APPLIES TO AFFILIATES PERFORMING SERVICES FOR THE INSURERS THAT ARE AN INTEGRAL PART OF THE INSURER'S OPERATIONS OR ARE ESSENTIAL TO THE INSURER'S ABILITY TO FULFIL ITS OBLIGATIONS. SEE SECTION VIII.G.5 BELOW FOR ADDITIONAL EXPLANATION OF THE MODEL AMENDMENTS RELATED TO AFFILIATED TRANSACTIONS.[99]**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 associations 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.

[99] The full text of Section 5A(6) of the *Insurance Holding Company System Model Act* (#440) is available at https://content.naic.org/sites/default/files/MO440_0.pdf. The 2021 NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

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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 Sections 5G(1), 5G(2), optional 5G(3) define covered claims, and section 5H definition of insolvent insurer[100], 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

    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. [101]

    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.[102] 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 vary from state to state. Model #540 Section 5H states:

> "Insolvent insurer" means an insurer that is licensed to transact insurance in this state, either at the time the policy was issued , or when the insured event occurred, and against whom a final order of liquidation has

[100] The definitions of covered claims in section 5G and insolvent insurer in section 5H of Model #540 were amended in December 2023. Note the definition of covered claims includes three sections, including one optional section. As these amendments are recent, not all states may have adopted them yet, therefore the receiver should refer to the applicable state's law.

[101] *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).

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

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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."

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 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.[103] 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 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.[104]

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.[105] A finding of insolvency in a rehabilitation order is not

[103] 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).

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

[105] 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).

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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.[106] However, if an order of liquidation is not appealed, it is final on the date issued.[107]

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 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—Section 5G[108]

Section 5G f Model #540 defines a "covered claim" as follows:

d. An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and:

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

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

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

[106] *Id.*

[107] *Id.*

[108] The definitions of covered claims in section 5G and insolvent insurer in section 5H of Model #540 were amended in December 2023. Note the definition of covered claims includes three sections, including one optional section. As these amendments are recent, not all states may have adopted them yet, therefore the receiver should refer to the applicable state's law.

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f. The original member insurer has no remaining obligations on the policy after the transfer;

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

(c) The claim would have been a covered claim, as defined in Section 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and

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

[Optional:

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

g. A merger in which the surviving company was a member insurer immediately after the merger;

(b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or

(c) A transaction entered into pursuant to a plan approved by the member insurer's domiciliary regulator.]

(3) Except as provided elsewhere in this section "covered claim" shall not include;

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

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(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

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

2. Covered Claims

a. Unpaid Claims

i. Under most guaranty association acts, to recover for a claim from a guaranty association the claim must be unpaid.[109] This requirement is primarily to prevent excessive or duplicative claim payments.[110] 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.[111]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.[112] 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.[113]

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.[114] 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.[115] Whether the insured later satisfied the

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[109] 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).

[110] 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).

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

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

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

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

[115] *Id.*

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judgment creditors with the insurance policy proceeds was outside the guaranty association's scope.

b. Within the Coverage

i. All guaranty association acts require that to be covered, a claim must "arise out of and be within the coverage."[116] This provision requires that a claim meet a policy's coverage requirements before it will be paid.[117]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.

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

[117] 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.[118] 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.[119]

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.[120]

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.[121] 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.[122]

Generally, "[a] corporation is an entity separate and distinct from its stockholders and from other corporations with which it may be connected."[123] 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.[124]

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

[119] *Id.* at 38.

[120] *Id.*

[121] 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).

[122] *Id.* at 910.

[123] *Id.*

[124] *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."[125] 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. Michigan is a notable exception where the claim limit of $5 million is tied to a cost of living adjustment (COLA) .[126][It should also be noted that the 2023 amendments to Model #540 add a statutory cap for cybersecurity insurance coverage of $500,000.[127]

d. 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.[128] 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.[129] 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.[130]

e. Unearned Premiums

Most guaranty association acts and the Model #540 specifically allow claims for unearned premiums.[131] 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.

i. Assignments Allowed

In a New Jersey action, a claimant bank had financed insurance premiums.[132] 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

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

[126] 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.

[127] As these 2023 Model #540 amendments are recent, not all states may yet have adopted them, therefore the receiver should refer to the applicable state's law.

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

[129] *Id.*

[130] *Id.* at 528.

[131] Model #540, at § 5H.

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

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claim.[133] While the applicable act distinguished reinsurers' claims from others, it did not distinguish between individual and corporate claimants. Had the legislature intended to differentiate between individuals and commercial assignees, it would have expressly done so.[134]

ii. 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.[135] 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.

iii. 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.[136] 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.[137] 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 571notherr 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.

iv. Location of Property

Guaranty association acts generally require that the property from which the claim arises must be permanently located in the state.[138] 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.[139] Subsequently, the insurer became insolvent and the insured submitted a claim

[133] *Id.*

[134] *Id.* at 986.

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

[136] See Model #540, at § 5H(1)(a).

[137] 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).

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

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

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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.

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.[140]

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. Other than coverages that may be set forth in a cybersecurity insurance policy, 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

[140] See Model #540, at § 5H(2)(c).

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materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

F. Title insurance;

G. Ocean marine insurance;

H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such 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.[141]

Michigan also has a net worth exclusion. The U.S. Court of Appeals has addressed the constitutionality of Michigan's net worth exclusion.[142] 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."[143] 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,"[144] the court upheld the net worth exclusion.

[141] 1990 Ga. Laws Section 33-36-3(2)(g).

[142] 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).

[143] 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.

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

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- 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 claim for the return of unearned insurance premiums on policies canceled due to an insurer's insolvency.[145]

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.[146] 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 Section 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 Section 14B of Model #540 as 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.[147]

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.

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

[146] *Id.* at 337.

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

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

Jurisdictions may vary on specifics of claim notice requirements. The local guaranty association should be consulted.

The 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.[148]

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.[149] 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.[150] 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.

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

[149] 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).

[150] 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).

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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.[151]

- Contingent and Policyholder Protection Claims

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

In an Illinois case,[152] 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.[153]

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.[154] In a Massachusetts action,[155] 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.

[151] *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).

[152] 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).

[153] 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).

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

[155] *Id.*

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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 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.[156]

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.[157]

4. 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, refer to Exhibit 9-1—Guidelines Relating to the Reporting of Loss Information to Reinsurers by Insolvent Property and Casualty Insurers.

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;

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

[157] *Id.*

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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;

Class 6. General creditor claims;[158]

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 of IRMA 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.

[158] 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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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 claims and expenses as well as reduce the necessity for assessments against solvent member insurers. Section 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.[159]

North Carolina has addressed the question of which associations will be subject to the early access statute.[160] 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,[161] 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 Section 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.[162] 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

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

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

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

[162] 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).

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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.[163]

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. [164]

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.[165] 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

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.[166]

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.[167]

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

[164] See NAIC Model 540 at Section 13.

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

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

[167] *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. 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.[168] 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. 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.

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.

D. Triggering of Guaranty Associations

Guaranty associations primarily act after the entry of an order of liquidation with 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 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,

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

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

[170] See Model #520, *supra* note 147, at, Section 2.

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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]

H. 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

[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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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]

I. 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. 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.

J. 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.

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.

K. Other Guaranty Association Topics

Refer to Chapter 6—Guaranty Funds/Associations for other topics such as:

- Eligibility of Insurer

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[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.

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- Exclusions from Coverage
- Benefit Limitations
- Early Access

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).[180] 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 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

[180] 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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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."[181] In Section 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 Section 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 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.

[181] Fed. R. Civ. P. 34(a).

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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. The 2021 amendments to the 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 Holding Company Act is available in Chapter 2, Section IV. The *Financial Condition Examiners Handbook* outlines procedures that address data segregation and convertibility to UDS for troubled companies. [182]

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.

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

[182] NAIC Holding Company Act, See also General Examination Guidance, Chapter 3, General Examination Considerations of the *Financial Condition Examiners Handbook*.

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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 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.

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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 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.

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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 Section 402 and Section 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.[183] 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.[184]

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.[185]

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 action may be found to be personal to the injured creditors and the receiver may not have standing to bring the action.[186]

[183] E.g., *Schacht v. Brown,* 711 F.2d 1343, 1346 n.3, (7th Cir.), *cert. denied,* 464 U.S. 1002 (1983).

[184] 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."

[185] 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).

[186] 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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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. Section 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.

   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

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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.[187]

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 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.

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[187] 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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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.
- 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

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- 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 Section 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 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.

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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.[188]

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 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

[188] See *Wilcox c. CSX Corp*, *70 P.3d 85*, *473* Utah Adv. Rep. 25, 2003 UT 21(2003*).*

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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.

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. Section 605 of IRMA addresses fraudulent transfers.

2. Elements of Fraudulent Transfer

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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 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.

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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. Insurance Holding Company System Regulatory Act (#440)

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 may never pierce its own veil.[189] 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

[189] *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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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.[190]

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 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

[190] E.g., *Omaha Indemnity Company v. Royal American Managers,* 777 F. Supp. 1488 (W.D. Mo. 1991).

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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.

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.

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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.)

5. Transactions Between Affiliates

Sections 5A(1)(g) and (h) of the NAIC Model *Insurance Holding Company Systems Act* (Model #440) and Section 19B(7) of its companion *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (Model #450) were amended in 2021 to clarify the rights of a receiver to the data of an insurer managed or held by an affiliate. The amendments provide that: (i) books and records of an insurer maintained by affiliates are property of the insurer, (ii) that data and records should be identifiable and capable of segregation, (iii) that if a Commissioner deems an insurer to be in a statutorily defined Hazardous Financial Condition, he or she may: require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party's ability to fulfill the contract in the event of a liquidation, (iv) premiums are the property of the insurer with any right of offset subject to receivership law, (v) affiliates are subject to the jurisdiction of the receivership court and the Commissioner may require the affiliate to agree to this in its written agreements with the insurer, (vi) and includes provisions relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate. In the event of a receivership, including supervision and conservatorship, (i) the rights of the insurer extend to the receiver or guaranty fund, (ii) the affiliate will make essential personnel available to the receiver, and must continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work, and (iii) requires affiliates to maintain necessary systems, programs or infrastructure and make them available to the receiver for as long as the affiliate receives timely post-receivership payment unless released by the receiver or receivership court.

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 Atc
- 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

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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.[191] RICO claims against the insurer's attorneys, solicitors, reinsurers, agents, brokers and shareholders have also been sustained.[192]

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)
- 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.[193] 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.[194]

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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[191] 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).

[192] 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).

[193] *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.

[194] 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

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.

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

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policyholders, creditors and claimants.[195] IRMA Section 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.[196]

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 have responded to this defense by attempting to distinguish between conduct that injures the corporation and conduct that benefits it.[197]

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.[198] 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.[199]

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.

[195] 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).

[196] *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).

[197] 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.

[198] E.g., *FDIC. v. Ernst & Young,* 967 F.2d 166 (5th Cir. 1992).

[199] 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.[200]

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.[201]

Preliminarily, it should be noted that an affirmative claim against the receiver may be barred by the liquidation order.[202] There is also a recognized distinction between the regulator and the receiver.[203] 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.[204]

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
- 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[205]

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[200] E.g., *Rollins v. Ellwood,* 141 Ill.2d 244, 565 N.E.2d 1302 (1990).

[201] 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.*

[202] *Id.*

[203] *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.)

[204] *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).

[205] 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. [206]

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.[207]

K. Discovery Issues

1. Receiver's Right to Preliquidation Documents

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.

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).

[206] 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.

[207] 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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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.[208] IRMA Section 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.

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

[208] 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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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.[209] 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.[210]

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 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.

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[209] 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*.

[210] 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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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, ceded and assumed, 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 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.[211] Receivers should be aware of case law regarding the legal effect of providing late notice of claims to reinsurers .[212]A small number of courts 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

[211] See *Christiana General Insurance Co. v. Great American Insurance Co.,* 745 F.Supp. 150, 161 (S.D.N.Y. 1990).

[212] Certain Underwriters at Lloyd's of London v. Home Ins. Co., 783 A.2d 238 (N.H. 2001); Unigard Sec. Ins. Co., Inc. v. North River Ins. Co., 4 F.3d 1049 (2nd Cir. 1993); and North River Ins. Co. v. CIGNA Reinsurance Co., 52 F.3d 1194 (3d Cir. 1995) evaluated whether the ceding insurers' failure to provide notice of the reinsured claims warranted denial of reinsurance coverage for such claims. The courts concluded that if the reinsurer denies reinsurance coverage based on a reinsured's failure to provide timely notice of reinsured claims, the reinsurer must prove that it was prejudiced by the reinsured's lack of notice, or that the ceding insurer acted in bad faith, meaning that the reinsured acted with gross negligence or recklessness in not providing proper notice of the reinsured claims.

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resulting from the breach.[213] 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.[214] 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.

C. Secured Reinsurance

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 may be security (often referred to as "reinsurance collateral") 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.

The United States reinsurance regulatory framework has undergone significant changes in the last decade, first in 2011 when reinsurance collateral requirements were reduced for certified reinsurers

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[213] *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).

[214] *Liberty Mutual Ins. Co. v. Gibbs,* 773 F. 2d 15 (1st Cir. Mass. 1985).

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domiciled in qualified jurisdictions, and then again in 2019 when collateral requirements were eliminated altogether for certain reinsurers that are licensed and have their head offices in reciprocal jurisdictions. If an unauthorized reinsurer is neither a certified reinsurer nor a reciprocal jurisdiction reinsurer, then it must continue to post 100 percent collateral on all U.S. reinsurance assumed. These changes affected the amount of reinsurance collateral readily available with respect to non-U.S. domiciled reinsurers and reduced it from the previous 100 percent requirements for all unauthorized 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

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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 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.[215] 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,

[215] 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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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 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.

D. 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.

E. 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 Section 114 and Section 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 Section612 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.[216]

F. Rescission

1. Rescission Defined

[216] Model #520, at Section 8.N.

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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.

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.[217] 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."[218] 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.

G. 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

[217] 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).

[218] *Id.*

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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.

Section 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.

H. 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

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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;
- 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.

I. 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.[219] 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.[220] 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

[219] See e.g., *Selcke v. New England Ins. Co.* 995 F.2d 688, 689, 690 (7th Cir. 1993).

[220] 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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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 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.

J. 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.[221]

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.[222]

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.[223] 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.[224]

Additionally, some courts have held that arbitrators have broad authority to require pre-hearing security.[225] 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.

K. 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

[221] See e.g., *Morgan v. American Risk Management, Inc.*, 1990 WL 106837 (SDNY July 20, 1990).

[222] *Morgan v. American Risk Management, Inc.,* 1990 WL 106837 (SDNY July 20, 1990);

[223] *John Hancock Property & Casualty Insurance Co. v. Universale Reinsurance Co.,* 1993 U.S. Dist. LEXIS 9411 (SDNY July 12, 1993).

[224] See e.g., *Stephens v. National Distillers and Chemical Corp.,* 69 F.3d 1226 (2d Cir. 1995).

[225] *Pacific Reinsurance Management Corp., v. Ohio Reinsurance Corp.,* 935 F.2d. 1019 (11th Cir. 1991).

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information has been denied on the basis of relevancy since the policyholder had no contractual right to the reinsurance proceeds.[226] Insurers and reinsurers have also contested production on the basis that the information was proprietary and confidential.[227]

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.[228]

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.**L. 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 Section 801 C(1) of IRMA and Section 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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[226] See e.g., *Leski, Inc. v. Federal Ins. Co.,* 129 F.R.D. 99, 106 (D.N.J. 1989).

[227] See e.g., *National Union Fire Ins. Co. v. Stauffer Chemical Co.,* 558 A.2d 1091, 1097 (Del. Super. Ct. 1989).

[228] *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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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—Commencement of the Proceedings. 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 (Model #555, commonly known as 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

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rehabilitator to file a liquidation petition.

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 Internal Revenue Service (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.

[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

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 (e.g., 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 of IRMA) and the shareholders, in their capacity as owners, become creditors of the estate (Section 501 of IRMA). 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

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rather 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 (Section 802 C of IRMA).

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

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:

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- Name and address of claimant, organized by class
- Claim number
- Claim amount and priority classification
- Status
    - Allowed
    - Denied
    - partially allowed
    - determination
- Liquidator's recommendation
- Court determination
- 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 and Chapter 2—Information Systems. 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.

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

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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 Incurred But Not Reported (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;
- 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;

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- 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 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

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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-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

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adjudication processes, tax returns and litigation. Financial reporting requirements are set out in Section 117 of IRMA.

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 (e.g., 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.

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

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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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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

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[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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the 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

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[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] Upon the appointment of the FDIC as receiver over such subsidiary, the subsidiary

[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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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* (#555, commonly known as 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 Act, 12 U.S.C. § 5383(e)(1), explicitly refers to both rehabilitation and liquidation of insurance companies in the insurance company context.

(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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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. See Chapter 1, Section IV(A) of this 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 planning and/or independent grounds prior to a 12 U.S.C. § 5383(b) determination to trigger state regulatory action, including:

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- 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 enterprise risk reporting,[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

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[18] The NAIC *Insurance Holding Company Regulatory Model Act* (#440) requires that annual enterprise risk reports to the regulator identify material risk within the holding company systems that could pose a financial or reputational contagion to the insurer. The NAIC *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) requires the filing of annual reports for certain large insurers and insurance groups on the insurer or insurance group's assessment of risks.

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subsidiary is an insurance company into receivership is made by the Federal Reserve and the director of the 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. See Chapter.1, Section VI(A) of this Handbook. This

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cooperation and advance planning among the Regulator, the receiver and ideally also the company itself is especially 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 Chapter.1, Section VI(A) of this 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 Chapters 8 and 9 of this 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

[19] www.fdic.gov/analysis/quarterly-banking-profile/fdic-quarterly/2011-vol5-2/lehman.pdf

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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 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:

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- 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 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 #555 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 the 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 an 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 the NAIC *Insurance Holding Company System Regulatory Act* 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

[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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authority to transfer a wholly owned subsidiary of an insurer. The subsidiary is an asset of the insurer, not the covered financial 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 the *Insurance Holding Company System Regulatory Model Act* 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

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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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company 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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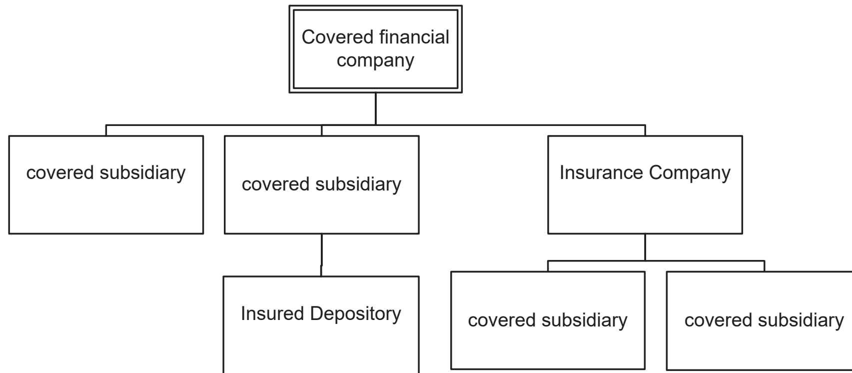

The FDIC adopted Regulation § 380.6[33] regarding its lien authority under § 204(d) as applied to insurance companies and their subsidiaries. The Regulation was amended from its original proposed form, in response to comments by the NAIC, NOLHGA/NCIGF and others, to provide that liens would only be imposed, 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

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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).

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* (#1700) ("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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Exhibits and Checklists from the Receivership Handbook

Chapter 1	**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 **Exhibit 1-4**: P&C Pre-Receivership MOU **Exhibit 1-5**: Comparison of the Uniform Act, IRLMA, and Model #555	**CHECKLIST 1**—Pre-Commencement **CHECKLIST 2**—Commencement **CHECKLIST 3**—Human Resources and Payroll **CHECKLIST 4**—Property, Real Estate, Records and Facilities Control **CHECKLIST 5**—Customer Service **CHECKLIST 6**—Underwriting **CHECKLIST 7**—Information Systems **CHECKLIST 8**—Accounting **CHECKLIST 9**—Tax and Compliance **CHECKLIST 10**—Claims **CHECKLIST 11**—Large Deductible Policies **CHECKLIST 12**—Reinsurance **CHECKLIST 13**—Legal
Chapter 3	**Exhibit 3-1:** Example of Financial Reporting Format **Exhibit 3-2:** Example of Daily Cash Flow **Exhibit 3-3:** Example of Budget-Projected Liquidation Expenses	
Chapter 4	**Exhibit 4-1:** Potential Recovery from Unrelated Third Parties Matrix of Relationships	
Chapter 5	**Exhibit 5-1:** Linear Summary of Claims Administration **Exhibit 5-2:** Claimant Notice via Postcard **Exhibit 5-3:** Assignment of Claims Issues Guidance Exhibit 5-4: Federal Home Loan Bank	
Chapter 7	**Exhibit 7-1:** Treaty Master Abstract **Exhibit 7-2:** Reinsurance Matrix	
Chapter 8	**Exhibit 8-1**: U.S. Template for Resolution Plan	
Chapter 9	**Exhibit 9-1:** NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers **Exhibit 9-2:** Considerations for Separate Accounts – Receivers' Checklist	
Chapter 10	**Exhibit 10-1:** Interim Liquidating Balance Sheet **Exhibit 10-2:** Closing Liquidating Balance Sheet	
Chapter 11	**Exhibit 11-A:** Initiation of Orderly Liquidation of Insurance Company Under Dodd-Frank **Exhibit 11-B:** State Receivership Initiation Process **Exhibit 11-C:** Guideline for Implementation of State Orderly Liquidation Authority	

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The following are two revised pages of the various checklists of the Receiver's Handbook for Insurance Company Insolvencies:

Checklist 1—Pre-Commencement	Project Assigned To	Date Completed	Completed By	Notes
Obtain from the Department of Insurance • Its most recent examination work papers, • The insurer's most recent annual and quarterly statements, • Audited financial statements with auditor's opinion, • Actuarial certifications, • Any SEC filings, • Tax returns and any other financial statements, • Group Profile Summary (i.e., Holding Company Analysis), • Most recent Insurer Profile Summary, • 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 As, Form Ds 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 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: • Cell phones ▪ Laptops and Tablets ▪ Flash drives ▪ Vehicles ▪ Security ▪ Maintenance agreements ▪ Copiers ▪ Office equipment				

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