

# **Receiver's Handbook for Insurance Company Insolvencies**

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**April 2021 Edition**

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NAIC Executive Office  
444 North Capitol Street, NW  
Suite 700  
Washington, DC 20001  
202.471.3990

NAIC Central Office  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106  
816.842.3600

NAIC Capital Markets  
& Investment Analysis Office  
One New York Plaza, Suite 4210  
New York, NY 10004  
212.398.9000

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## ***Forward***

The April 2021 edition of the *Receiver’s Handbook for Insurance Company Insolvencies* has been updated to incorporate updated guidance on large deductible policies in the following chapters.

- *Chapter 5, Section V. Payment of Claims—A. Priority of Distribution in Receivership—5.a. Class 3 and 4 Claims for Policy Benefits*
- *Chapter 5, Section IX. Best Practices for Successful Billing and Collection of Large Deductible Programs in Liquidation*
- *Chapter 6, Section II. Property and Casualty Guaranty Funds—J. Large Deductible Policies*
- *Chapter 9, Section III. Claims— I. Large Deductible Policies*

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## ***Disclaimer***

These materials are designed and intended to provide a general overview of concepts, principles and procedures that the authors and editors believe may be of assistance to a receiver. This is not an instructional manual. These materials are not intended to serve as a definitive statement of the law or procedural requirements of any particular jurisdiction or to establish a standard of conduct or performance. They are not intended and should not be construed as being binding upon a receiver in any jurisdiction, nor should a receiver act solely in reliance on the contents of this Handbook. Materials in this Handbook relate to individual experiences and receiverships and are not necessarily suitable or applicable for use in all situations.

While these materials have been prepared at the request of the National Association of Insurance Commissioners, they do not reflect the formal position of that organization or of any individual or insurance regulatory authority in the states, districts or territories of the United States. Adoption of these materials is solely for the purpose of providing for its publication and distribution to parties who may have an interest in reviewing the material.

The users of these materials should consult the applicable statutory provisions and regulatory authority and experienced or professional personnel prior to adopting or utilizing the information contained in this Handbook.

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## ***Publisher’s Note***

Every reasonable effort is made to ensure that the materials in this Handbook are current. However, because of the committee structure and operational procedures of the National Association of Insurance Commissioners, there may be a lag between the drafting, exposure, adoption and publication of these materials.

The NAIC welcomes the comments and suggestions of the readers of this Handbook. Comments or suggestions should be directed to Financial Regulatory Services, National Association of

Insurance Commissioners, 1100 Walnut Street, Suite 1500, Kansas City, MO, 64106-2197. Comments and suggestions can be sent electronically to NAIC staff listed on the Receivership and Insolvency (E) Task Force page of the NAIC website. [https://content.naic.org/cmte\\_e\\_receivership.htm](https://content.naic.org/cmte_e_receivership.htm)

## OVERVIEW OF INSURER RECEIVERSHIP PROCEEDINGS

Insurance receiverships vary greatly in size and complexity; therefore, there is no one uniform approach to their administration. The receivership process may take a few months or several years to conclude. Insurer insolvency proceedings are conducted in state courts because insurance companies are specifically exempted from the provisions of the Bankruptcy Code (See 11 U.S.C. § 109(b)). State statutes typically provide for the appointment of the insurance commissioner as receiver of an insurer. A receivership proceeding is commenced with the filing by the insurance commissioner of a petition in the appropriate state court, requesting the appointment of the commissioner as receiver of the insurer. Receivership proceedings are generally filed in the state of domicile of the insurer, although in certain circumstances, proceedings may be filed in jurisdictions where the insurer transacted business or assets are located. State laws provide several grounds upon which a receiver may be appointed, but insolvency is the basis for most such proceedings.

In many instances, particularly where fraud or defalcation is suspected, the commissioner will ask the court for a seizure order. A seizure order directs the commissioner to immediately take possession and control of the property, books, accounts, documents and other records of the insurer, and the insurer's physical premises. The order also will contain injunctive provisions prohibiting the officers and directors and any other persons from disposing of property of the insurer, transacting any business of the insurer or otherwise interfering with the receiver. Supervising courts routinely grant such orders to prevent the diversion of funds or destruction of records. In many jurisdictions, these proceedings may be confidential. In order to protect the due process rights of the insurer, a full hearing is scheduled for a later date, at which the court will determine if a permanent order of receivership should be entered.

Upon the entry of a permanent order appointing the insurance commissioner as receiver, the receiver is vested with total control of the insurer and title to all of its property. The authority of the officers and directors is suspended. The injunctive provisions mentioned in the preceding paragraph are usually made permanent. The commissioner typically appoints a special deputy to manage the day-to-day operations of the receivership. The receiver is given a great deal of latitude in exercising his or her authority over the affairs of the insurer. The receiver's actions may only be set aside if the supervising court finds that the receiver has abused his or her discretion. Receivership orders may be appealed by management or owners of the insurer. However, such orders are not often reversed. The standard of review is whether the regulatory authority acted reasonably in an effort to protect policyholders, other creditors and the public.

There are primarily two types of receiverships: rehabilitation and liquidation. In rehabilitation, a plan is devised to correct the difficulties that led to the insurer being placed in receivership and return it to the marketplace. The regulator must determine whether a rehabilitation of the company is likely to be successful, or if its problems are so severe that the appropriate course of action is to liquidate the insurer. In a liquidation, the receiver marshals the assets of the insurer, determines the liabilities of the insurer to policyholders and other creditors, and distributes the assets in satisfaction of such claims in accordance with a priority-of-distribution scheme prescribed by state law. Insurer Receivership Model Act Article III adds a third form of court-supervised receivership—conservation. Conservation allows the receiver a period of time in which to analyze the company and its financial condition and determine whether the policyholders and creditors will be best served by liquidation, rehabilitation or returning the company to private management.

Receivership estates vary greatly in size and complexity; they may involve anywhere from one state to all states and territories. Some insolvent insurers have assets of only a few million dollars, and some recent insolvencies have involved companies with billions of dollars in assets. The receivership process may take a few months, or in many cases, several years to conclude.

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## I. INTRODUCTION

Insurer insolvencies are governed by state law, rather than federal bankruptcy law. However, although the insolvency is governed by the law of the state in which the insurer is domicicated, the laws of the various states in which an insurer conducted business may also be implicated. Consequently, during the takeover and administration of an insolvent insurer, it is important for the receiver to consider the laws of those states.

Most states have enacted statutes that govern the conservation, rehabilitation and liquidation of insurance companies and that are patterned 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 (“Liquidation Model Act”); and the Insurer Receivership Model Act (“IRMA”). In this handbook, the model acts will be referred to collectively as the “NAIC Model Acts.” Because of their widespread influence, the NAIC Model Acts are bases for discussion of issues involved in the takeover and administration of troubled or insolvent insurers. Even so, the laws of the individual states may deviate from the models, in whole or part, and certain types of insurers—typically service provider organizations (e.g., PPOs, HMOs)—may not, in some jurisdictions, be subject to the laws that apply to impaired or insolvent insurers.

Receivership proceedings are usually commenced against insolvent or financially impaired insurer in the insurer’s domiciliary state (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 states 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.

## II. PRE-RECEIVERSHIP TOOLS

### A. Administrative Supervision

Some 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 his or her designee serves as administrative supervisor of the insurer. In states where administrative supervision orders may be issued without formal court proceedings, the orders are subject to administrative review and are usually confidential. Administrative supervision orders are sometimes useful in temporarily stabilizing a deteriorating situation prior to the entry of an order of conservation, 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 over specified spending limitations;
- Close any of its bank accounts;
- Lend any of its funds;
- Invest any of its funds;
- Terminate or cancel reinsurance;

- Transfer any of its property;
- Incur any debt, obligation or liability;
- Merge or consolidate with another insurer;
- Enter into any new reinsurance contract or treaty; and
- 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.

If the insurer fails to comply with the order of administrative supervision or is insolvent, the regulator may petition for a receivership order.

## **B. Seizure Orders**

In a majority of states (IRMA, §201), the regulator may obtain a seizure order from a court of competent jurisdiction. Some statutes enacted prior to IRMA may use different terms for this order, such as a conservation order. In IRMA, this order is referred to as a seizure order; the term conservation order refers to an order entered under §301. Generally, a petition 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. If, as a result of such a petition, 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 or the National Organization of Life and Health Insurance Guaranty Associations (“NOLHGA”) in states where a finding of insolvency is not required to activate guaranty association obligations. A seizure order may be issued by the court *ex parte*—without notice—and without a hearing.

- Contents of the order

Generally, the order directs 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 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.

- Duration

The duration of a seizure order is often an issue. In some cases, the seizure order will specifically prescribe the time period that the order is to remain in effect. In other cases, the order prescribes that it will remain in effect for such time as the receivership court may deem necessary for the regulator to ascertain the insurer’s condition.

- Review

If the insurer wishes to contest a seizure order, it may petition the court for a hearing and review of the order. IRMA, §201(F), provides that the court shall hold such a hearing within 15 days of the request.

Likewise, 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 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.

- Purpose

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 seek an order of conservation, rehabilitation or liquidation.

- Confidentiality

State statutes often require that all records and papers relating to a judicial proceeding or review of seizure be confidential (IRMA, §206(A)). If the regulator determines that he acted in good faith but erred in seizing the insurer, or if the regulator is successful in resolving the insurer's difficulties, he or she 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.

- 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 (IRMA, §1001<sup>1</sup>). 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.

### III. RECEIVERSHIP ACTIONS

IRMA incorporates three distinct receivership actions—conservation, rehabilitation and liquidation (IRMA §207). IRMA lists 22 independent grounds, any one of which suffices for the issuance of any of the three orders. Many of the same grounds support conservation, rehabilitation or liquidation orders in several states. In addition, a number of states authorize supervision, which may be either administratively or judicially ordered. 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.

#### A. Conservation

In some states, a court of competent jurisdiction may enter an order of conservation upon the petition of a regulator (IRMA, §301). 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 a financially impaired 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 (IRMA, §302).

Most state statutory schemes allow the regulator to apply to the court *ex parte* for an order of conservation. In these circumstances, the proceedings are 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

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<sup>1</sup> Under IRMA, the proceeding is referred to as an ancillary conservation, and the commissioner is appointed as conservator.

continued confidentiality of the proceedings allows the receiver to assess the insurer's current status. Confidentiality allows the receiver to discharge the conservation, if appropriate, and return to normal business operations without public knowledge and the resultant harm to the insurer's business.

## **B. Rehabilitation**

A regulator may petition a state court of competent jurisdiction for an order of rehabilitation (IRMA, §401). 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.

### 1. Grounds

The grounds upon which a regulator may petition the court for an order of rehabilitation vary from state to state. The regulator must allege and prove a specific statutory ground that indicates that rehabilitation of the insurer is warranted.

A rehabilitation proceeding is a formal adversary proceeding, commencing with a complaint filed by the regulator. 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.

### 2. Contents of a Rehabilitation Order

An order of rehabilitation appoints the regulator as rehabilitator and directs the rehabilitator to seize the insurer's assets and administer them under general court supervision (IRMA, §401(A)). The rehabilitation order may vest the rehabilitator with title to all of the insurer's assets, books, records, accounts, property and premises, and generally includes an injunction against pending and threatened litigation. The order should be filed with the court clerk or recorder of deeds so that creditors and the public are put on notice of the rehabilitation.

The rehabilitation order usually requires that the rehabilitator file reports and accountings with the court. IRMA, §401(B), provides that the order must require accountings be filed no less frequently than semi-annually, and include a report concerning the likelihood that a rehabilitation plan will be prepared.

The rehabilitator usually has the power to act as necessary or appropriate to reform and revitalize the insurer. The rehabilitation order should suspend the powers of the directors, officers and managers, except as the rehabilitator delegates. The rehabilitator retains all powers not delegated (IRMA, §402).

While most guaranty associations are triggered by a final order of liquidation that contains a finding of insolvency, a number of guaranty associations may be triggered by only a finding of insolvency. Thus, to ensure that guaranty associations are not inadvertently triggered, it is important that a rehabilitation order against an insurer *not* include a finding of insolvency. (See Chapter 6—Guaranty Associations, and [www.ncigf.org](http://www.ncigf.org) or [www.nolhga.com](http://www.nolhga.com) for a more complete discussion of this issue.)

The receiver is charged with implementing the restrictions, limitations and requirements set forth in the order of rehabilitation.

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. The order may also require the insurer to modify or even cancel certain managing general agent ("MGA"), third-party administrator ("TPA") and general agency agreements. The order may also suspend claims payments and halt the transfer of cash or loan values on life insurance contracts.

The order possibly will provide that reinsurance agreements may not be canceled and that the insurer may not obtain any new reinsurance without the approval of the receiver.

The receiver will be empowered under the order to seize 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 receiver 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 authority of the officers and directors of the insurer.

### 3. Coordination with Guaranty Associations

IRMA §405 requires that the rehabilitator works with the guaranty associations that would be triggered by an order of liquidation. This new requirement has been added to ensure that, in the event of a liquidation, the associations can hit the ground running and fulfill their obligations to policyholders as expeditiously as possible. The rehabilitator should provide the associations with the data they will need to satisfy the policy obligations they assume on the date of liquidation, and should arrange to meet with the associations and, if appropriate, their national organizations, to plan for liquidation. IRMA includes a list of the data that might be needed by the associations, but it is preferable for the rehabilitator and the associations to agree on what is needed and what is available. The general rule should be to err on the side of more data rather than less.

### 4. The Rehabilitation Plan

Under IRMA a plan which is fair and equitable to all parties must be filed within one year of the Rehabilitation Order unless the receivership court extends the deadline. Subsection C of § 403 of IRMA 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 *deminimus* amount;
2. Provide adequate means for the plan's implementation;
3. The plan must provide sufficient financial data to allow the claimants and the receivership court to evaluate the potential for success of the plan; and
4. The plan must provide for the disposition of the books and records of the estate.

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

1. Payment of claims. Depending on the sufficiency and liquidity of the estates' assets, the rehabilitator may wish to propose payment of administrative expenses and policy benefit claims on a current basis, while deferring payments to subordinate classes.
2. Transfer of the insolvent insurer's book of business, wholly or in part, to a solvent carrier.
3. Imposition of regulatory market conduct standards on third party administrators or assuming carriers.
4. Engaging a third party administrator or guaranty association to handle claims for the rehabilitator.

5. Periodic audits of third party administrators.
6. Establishing a termination date for the estate's non-policy liabilities.

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

Other considerations when drafting a rehabilitation plan include the following:

1. Whether to retain the insurer's former management or install new individuals in management positions;
2. A business plan;
3. A work-out plan for the insurer's creditors;
4. A marketing plan for the insurer;
5. Hardship provisions;
6. An underwriting plan in the event the insurer is permitted to write new business;
7. Continuation of periodic reporting to the court, and ancillary states in which the insurer is licensed, including updated cash flows and projections to enable the court to determine whether the plan should be modified or terminated, and whether the insurer can ultimately meet its obligations. Under §117 of IRMA, quarterly financial reporting to the court is required unless such reporting is excused for good cause shown. Tax reporting should continue uninterrupted and statutory financial reporting should continue uninterrupted and statutory financial reporting should continue if possible.
8. 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.
9. 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
10. 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.
11. 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 bar date 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.

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

If the regulator determines that the causes and conditions that made the rehabilitation proceedings necessary have been removed, he or she may apply to the court for an order terminating the rehabilitation. Under the NAIC Model Acts, officers and directors may also make such an application. A resulting order may permit the insurer's owners and directors to resume possession and control of the insurer and its business. However, prior to returning possession or control, the receiver must ensure that the guaranty funds are made whole (IRMA §901).

Alternatively, the time may come when the rehabilitation is failing, and further attempts at rehabilitation would substantially increase the risk of loss to policyholders, creditors or the public. At that time, a petition for liquidation is in order. In some states, when policy payment obligations have been suspended for a particular length of time after the rehabilitator's appointment and the rehabilitator has failed to file for court approval of a rehabilitation plan, the rehabilitator must petition the court for an order of liquidation on insolvency grounds.

## C. Considerations Common to Both Conservation and Rehabilitation

### 1. Issues to be Addressed

The receiver's review of the insurer's operations may be made with a view toward identifying its weaknesses. The following is a list of potential areas of concern and priority actions that may need to be addressed:

- 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 needed on business and 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;
- Market conduct studies;
- Unfunded agents' balances or finance notes;
- Management of the insurer's assets and investments;
- Numerous/recent changes in Information Technology 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; and
- 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 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 funds, and prepare the insurer for future business operations, sale or liquidation.

The receiver needs to 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. 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 need to be carefully analyzed by the receiver. In some 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. 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;
- The source of the funds for the acquisition;
- The identity and background of the acquiring party;
- The purchaser/investor's compliance with statutory and regulatory requirements;
- The protection afforded the insurer's policyholders and creditors; and
- The overall effect on the insurer.

## **D. Liquidation**

The regulator may petition the court for an order of liquidation when any of the grounds set forth in §207 of IRMA exist, 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. 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 statute; the immediate delivery of all books, records and assets of the insurer to the liquidator; and enjoinder 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. If it is appropriate to trigger the guaranty associations, it is essential that the order of liquidation includes a finding of insolvency for property and casualty guaranty associations; the finding of insolvency may also be necessary in certain states for life and health guaranty associations. (For further information, see [www.ncigf.org](http://www.ncigf.org) and [www.nolhga.com](http://www.nolhga.com).) See Exhibits 1-1 and 1-2 for suggested language for liquidation orders.

## 2. Effect on Policies

The cancellation of policy obligations raises several legal issues with respect to the obligations of property/casualty 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 the 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;
- 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 funds and associations;
- Coordinating with NCIGF and/or NOLHGA, as necessary; and
- Entering into and canceling contracts.

Most jurisdictions hold that the liquidator generally steps into the shoes of the insolvent insurer and possesses the same rights and obligations as the insurer. 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 act as statutory receiver of the insolvent 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. Causes of Action by Receiver

The receiver should undertake an investigation to identify any cause of the insurer's insolvency that may lead to a financial recovery by the estate. Among the typical causes of insurer insolvency are:

- Undercapitalization;
- Uncollectible or inflated assets;
- Insufficient loss reserves for risks assumed;
- Agents or TPAs who misappropriated or improperly handled money belonging to the insurer;
- Problems involving reinsurance, e.g., insolvency, disputes, collectability, etc.;
- Unprofitable lines of business/negligent underwriting;
- Risky investments;
- Fraudulent transactions;
- Failure to monitor agents; and
- Mismanagement by directors and/or officers.

In examining the insurer's books, records and assets, the receiver should carefully review and analyze the financial transactions with all affiliates.

Because some states have short statutes of limitations, the receiver should promptly determine whether potential causes of action should be filed against former directors, officers and consultants, as well as against certain debtors of the estate. The NAIC and the FBI have developed a questionnaire to be used by the receiver in reporting fraud and other white-collar crimes to the United States Department of Justice for purposes of initiating a criminal investigation. (See Exhibit 1-3.)

#### 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 funds; 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.

## 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 IRMA, the date is not later than 18 months after the entry of the liquidation order, unless extended by the receivership court (IRMA, §701(A)). The liquidator shall permit a claimant to file a late claim under certain circumstances (IRMA, §701(B)). If a claimant does satisfy the criteria for filing a late claim, the claim will be subordinated to a lower distribution priority (IRMA, §801(I)). Some statutes enacted prior to IRMA may provide that such a claim is barred from participating in a distribution.

## 7. Ancillary Proceedings

Liquidation of an insurer is conducted by the receiver in the insurer's state of domicile. Most insurers, however, are licensed to do business in several states. The states in which the insurer is licensed to do business may be authorized to establish an ancillary receivership. Ancillary receiverships may be funded by the insurer's assets that are located in that state. The NAIC Model Acts were 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 Model Acts recognize the central role of the domiciliary liquidator and the role of the ancillary receiver. Under some statutes, a regulator in another 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, including special deposits, to justify the appointment, or if the goal of protecting the creditors or policyholders located in the state mandates establishment of an ancillary receivership. In those states where there are assets of the insurer, the ancillary receiver aids and assists the domiciliary receiver to recover those assets, liquidate special deposit and secured claims, pay necessary expenses, and remit the balance of the insurer's assets to the domiciliary receiver.

Some statutes permit a claimant who resides in a reciprocal state to file a claim in either the domiciliary or ancillary proceeding. 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 owners of special deposit claims against an insolvent insurer receive priority against the deposits. A deficiency in the special deposit may prohibit full discharge of the claims against the special deposit. In this situation, the claimants may share in the general assets after creditors of the same priority have been paid percentages of their claims equal to the percentage from the special deposit.

Priority of payment becomes an issue in receivership proceedings involving one or more reciprocal states. In this situation, all the reciprocal states residents' claims are given equal priority for payment from the general assets, regardless of where the assets are located. Owners of secured claims are also affected when one or more reciprocal states are involved in the receivership. 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.

Under §1001 of IRMA, the need 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.

#### **IV. INTERESTED PERSONS**

##### **A. Guaranty Associations**

Guaranty associations have been established in each state, as well as the District of Columbia and Puerto Rico, to provide a measure of protection to policyholders in the event of the impairment or insolvency of an insurer. As a general rule, both the property/casualty guaranty associations and the life and health guaranty associations require a liquidation order with a finding of insolvency to trigger guaranty association obligations. However, in states that do not include the Model Act language in their guaranty association statutes, guaranty associations may be triggered by other combinations of events. Individual state laws, the guaranty associations and their national organizations should be consulted to assure that the correct language is contained in the court order to achieve the desired result regarding the activation of the guaranty associations. Exhibit 1-3 contains model language for use in orders of liquidation for property/casualty insurers.

NOLHGA and NCIGF have been instrumental in facilitating both the preparation of effective court orders as well as the coordination of efforts between the liquidator and activated guaranty associations by:

- Disseminating information to the triggered guaranty associations.
- Establishing coordinating committees or task forces, consisting of several guaranty association representatives and other technical advisors, to interface with the liquidator in resolving issues that may arise during the liquidation. This streamlines the process by allowing the liquidator to deal with a core group rather than each guaranty association individually.
- Assisting the liquidator with disposal and/or cancellation of the business and hard-to-manage assets.
- Assisting in filing proofs of claim on behalf of member associations.

##### **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 and any agreements between them should be reviewed and analyzed carefully. These may include service agreements, management agreements, pooling agreements (see Chapter 9—Legal), etc. Under certain circumstances, the receiver may want to obtain control of these other entities. This may be accomplished by substantive consolidation (see Chapter 9—Legal). However, all the pros, cons and ramifications of this action need to be very carefully considered, especially the impact consolidation may have on any potential litigation or positions taken or contemplated by the receiver.

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.



## C. Federal Government

In the mid-1980s, federal courts started to consider the impact of certain federal statutes upon state insurance rehabilitation/liquidation proceedings. Receivers have had to be particularly sensitive to the federal superpriority statute 31 U.S.C.A. §3713, in the broader context of the McCarran-Ferguson Act. Those issues are discussed in Chapter 5—Claims and Chapter 9—Legal Considerations.

Receivers should keep the following in mind as they deal with federal/state issues in a particular receivership.

In the 1993 United States Supreme Court decision on *U.S. Department of Treasury v. Fabe*, the Court ruled that the federal priority statute must yield to a conflicting state receivership statute to the extent the state statute furthers policyholders' interests. However, the Court also held that the state statute, to the extent it was designed to further the interest of creditors other than policyholders, was not a law enacted for the purpose of regulating the business of insurance. The Court found that the preference accorded by the state statute at issue, and the expenses of administering the insolvency proceedings, were reasonably necessary to further the goal of protecting policyholders, since liquidation could not commence without the payment of administrative costs. On the other hand, the Court found that the preferences given by the state statute to employees and other general creditors were too indirectly connected to the regulation of insurance, and thus these claims were found to be preempted by the federal statute. The Supreme Court did not decide the issue of the severability of the Ohio statute. On remand, the district court held that the preempted portions of the statute were not severable from the remainder, and declared the Ohio priority of distribution statute invalid in its entirety.

Court decisions since *Fabe* have shed some additional light on specific aspects of receivership administration. For example, courts have ruled that the superpriority statute preempts a liquidation filing deadline and that *Fabe* does not prevent the application of a federal arbitration provision. Nevertheless, federal courts post-*Fabe* have remained focused on the need to preserve the exclusive jurisdiction of the receivership court to deal with all aspects of the insurer's affairs.

## V. RECEIVERSHIP ADMINISTRATION

### A. Planning

The regulator who expects to successfully prosecute a receivership action must become familiar with the insurer's operations and business as soon as possible, as must any potential special deputy and staff. Regulators may benefit from discussions with the department's financial regulatory personnel. 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 important for the intended receiver to meet with the regulator's staff as soon as possible, preferably 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. Information from financial examiners, financial analysts, market conduct examiners and licensing agents might assist the receiver in determining the causes of the insolvency.

It is also important for the receiver 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 takeover site to secure the assets and records. In some circumstances, it may be important to maintain confidentiality about an intended takeover, in which case a meeting with management may not be possible.

During any meetings with management, the receiver should request that all fidelity bonds, directors and officers policies, and errors and omissions policies be identified, segregated and made accessible. Once the takeover begins, one of the receiver's first acts will be to place all insurance carriers on notice to preserve the rights of the estate.

## 2. Identify Key Transitional Elements

The insurer's officers, directors and employees may be willing and able to advise the prospective receiver about the existence of service providers and outside consultants employed by the insurer, including legal counsel, accountants and actuaries. The receiver should obtain, or ensure access to, records and contracts that the insurer has with all consultants and service providers. The receiver will have to determine which, if any, of the various service providers to retain. The receiver should also determine if the insurer is a member of a FHLBank and, if so, identify key individuals at the insurer and at the FHLBank. Additional steps to consider in the pre-takeover phase are in the checklists included in the exhibits at the end of this chapter.

It is also important to maintain meaningful dialogue with the guaranty funds in the states where the insurer was authorized to conduct business, and with NOLHGA or the NCIGF, because the receiver needs to:

- Be aware of any statutory prerequisites to trigger guaranty funds' obligations and plan accordingly;
- Guard against coverage gaps between the guaranty funds' trigger dates and the policy cancellation date, if any, with respect to property/casualty policies and cancelable life or health policies;
- Identify the definitions of "covered claim" or "covered policy" for each state guaranty fund;
- Determine whether a guaranty association or similar association is providing coverage for multi-state health maintenance organizations in other states; and

Arrange early coordination with NOLHGA for life and health insurers, and with NCIGF for property and casualty insurers, to facilitate a seamless transition of coverage and/or payment of benefits.

## 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 customers and the effectiveness of the working business plan. The progress reports includes a view of the whole insurance company—financial and operational, highlights key data about company activities of each division and also identifies 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.

## B. Receivership Order

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. Many receivers use Web sites for this purpose. State insurance departments' Web sites may also be available for that purpose.

The order may be issued because the insurer is impaired (generally, a conservation and rehabilitation) or insolvent (liquidation or, in special circumstances, a rehabilitation). The order 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 MGA or 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;
- Payment of loss and loss adjustment expense, etc.;
- Moratoria on claims, cash surrenders, withdrawals, policy loans, etc.; and
- Hardship Provisions (refer to state statutes, state guaranty associations or to [www.ncigf.org](http://www.ncigf.org) and [www.nolhga.com](http://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.

### **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 IMRA) 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;
- Guaranty associations;
- State insurance departments;
- Third-party claimants;
- NAIC;
- Internal Revenue Service;
- U.S. Department of the Treasury;
- U.S. Department of Justice;
- State and local offices;
- Banks;
- Brokerage or investment banking firms;
- Managing general agents, general agents and all agents of record;
- Reinsurers;
- Intermediaries;
- Creditors, including secured creditors; (including the Federal Home Loan Bank, if applicable)
- Claim adjusters;
- Third-party administrators;
- Premium financiers;
- Vendors;
- Accountants, actuaries, lawyers and other professionals;
- Landlords and tenants;
- Officers and directors;

- Stockholders and other equity holders; and
- Other necessary parties.

Notice may vary depending upon whether the insurer is in rehabilitation or liquidation. Under IRMA, conservation is similar to rehabilitation, and the notice requirement is the same. If the notice is pre-approved by the court, it will avoid potential claims of non-disclosure 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 at the end of this chapter 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 takeover stage 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 in the initial takeover 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 at the end of this chapter. 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 routing of daily cash receipts (create receipt log). With respect to life and health insolvencies, 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 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.

## 2. Administration and Ongoing Asset Management

Once the takeover of the insurer 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 of takeover. The various checklists at the end of this chapter 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 non-traditional 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:

- Reinsurance

With respect to life insolvencies, it is critical that the receiver immediately analyze whether to continue or cancel ceded reinsurance contracts. The Life Guaranty Association Model Act, the life guaranty association statutes in many states and IRMA give the life guaranty associations the authority to continue particular contracts 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 IRMA §612 and NAIC Life and Health Insurance Guaranty Association Model Act §8N.)

- Audit premiums

Certain property/casualty 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, prepare for a possible Phase III tax liability. (See Chapter 3—Accounting and Financial Analysis, Section VIII.)

- Taxes

Value to the estate may be generated through the eventual 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.

- Property/casualty salvage and subrogation

With respect to property/casualty 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.

- 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.

- Deductibles

Many property and casualty 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. 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.

- 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.

- 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 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, state and federal tax, marketing, personnel files, reinsurance files, and administrative files—and how they should be maintained.

Checklists found at the end of this chapter 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 (IRMA §118A). 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 it may also 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 the exhibits at the end of this chapter should be itemized and secured.

## **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 §1001 of IRMA, the need 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.

The NAIC models prior to IRMA permit reciprocal states to establish receiverships ancillary to the domestic state's receivership. State statutes based upon these models 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 funds;
- The need for a receivers' agreement (see discussion below regarding receivers' agreement);
- The need for local counsel in other jurisdictions;
- The status of litigation by the ancillary receiver; and
- 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 e-mail 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.

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.) that is essential for the orderly administration of the estate;
- Coordinating the oversight of the insurer's out-of-state litigation; and
- Synchronizing the use of joint claims forms and the funding and maintenance of joint claims accounts.

#### 1. Claims Handling

When there is no ancillary receivership, citizens of non-reciprocal states should file their claims in the domiciliary state. Some pre-IRMA 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.

It is not unusual that an ancillary receivership is established for purposes unrelated to claims 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.

#### 2. 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 IRMA and, even when no domestic receiver has been appointed, 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.

## **VI. ACCOUNTING**

*Please refer to Chapter 3—Accounting and Financial Analysis and Chapter 4—Investigation and Asset Recovery when reviewing this section.*

In the initial takeover, 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 assert control over them. 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. 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.

### **C. Investigation of Insurer's Financial Statements**

The receiver and consultants retained by 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 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.

## **VII. ELECTRONIC DATA PROCESSING**

### **A. Overview**

This section highlights the activities that should take place for a receiver to understand and take control of the insurer's data processing system. To the extent possible, the receiver should not allow anyone access to the insurer's computer system until a complete backup of what is on the system has been performed. It

is not uncommon for the insurer's computer system to be intertwined with that of its affiliates; therefore, legal consultation is advised prior to taking any action that may impact the affiliates' operations. Areas of concern and/or courses of action may include the following areas:

- Staff;
- Hardware;
- Software;
- Application controls;
- Remote access
- Disaster recovery plan; and
- Data processing removal.

For more detailed discussion, refer to Chapter 2—Information Systems. Detailed tasks are listed in the checklist included in the exhibits at the end of this chapter.

### **B. Liquidating Hardware/Software**

For any hardware/software owned by the insurer, the receiver should determine whether to maintain it or to 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.

### **C. System Shut Down**

The receiver should arrange for the orderly shutdown of the computer system. Prior to shutdown, 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.

## **VIII. CLAIMS**

The receiver should become familiar with the insurer's records and procedures.

### **A. Control the Claim Department's Records**

In initial takeover, the receiver's first responsibility is to rescind all claim payment authority of the insurer's claim department and to identify and control the insurer's records. Original claim documentation may be found in the claim department in either hard copy files or computer files, or at off-site locations such as branch offices or TPA locations.

The receiver needs to become familiar with the computer processing systems for claim files and policy files. Controlling computerized files and systems requires determining whether the information systems are centralized or decentralized. In a decentralized operation, secure data on personal computers and servers, including that stored on all storage media and computer printouts. In a centralized operation, the information systems department should evaluate existing security procedures and revise them if necessary. In addition, obtain the latest reports relating to claim processing.

Obtain copies of the insurer's claim policies and procedures manuals. Review them to determine if the insurer has formal procedures that address the following areas:

- Actual claim processing flow;
- The level of claim file documentation required;
- The coverage confirmation process;
- Claims reserving and settlement philosophy;
- Claims settlement authority;
- Litigated claims;
- Aggregate policy procedures;
- Large Deductible Policy Procedures including collection, collateral and aggregates;
- Reinsurance recovery procedures;
- Theories relevant to property/casualty insurers, such as trigger theories for asbestos and environmental claims; and
- The insurer's relationships with and responsibilities to managing general agents, TPAs, outside claim adjusters, reinsurance intermediaries and other outside parties.

If no manual exists, the receiver should interview claim department personnel to develop an understanding of actual procedures and document them.

### **B. Understand the Claim Department**

The receiver needs to understand the operations of the claim department, including its organization, the nature of the claims and how the department processes claims.

The receiver should obtain or prepare an organization chart that outlines the reporting relationship and authorities of each person in the claim area. For a large department, this chart could also include each person's telephone number and other pertinent information.

The receiver should also determine the number of open claims and outstanding reserves by category of business and prepare a list of the claim files.

### **C. Review Claim Handling**

The receiver needs to review the claim handling process by obtaining or preparing an overview of the typical flow of a claim. This flow chart should include all interactions the claim department has with other departments. If the flow varies significantly by product line, consider preparing a separate flow chart for each product line.

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 computer elements of the system.

With a basic understanding of the claim handling process, the receiver should determine whether there are

any bottlenecks in the process, such as:

- Setup of new claims;
- Correspondence files;
- Claim diaries;
- Indemnity payments;
- Loss adjustment expense payments;
- The handling of insurance department complaints;
- Reinsurer claim inquiry;
- Reporting to reinsurers; or
- Subrogation and salvage recovery.

Investigate the insurer's methods of reserving for claims by reviewing, in detail, its policies and procedure manual and discussing the claim reserve policy with the claim manager.

Because of reinsurer reporting requirements, the receiver needs to determine the procedures to notify reinsurers of individual losses in excess of certain dollar limits. The receiver should determine if the insurer is subject to such requirements, and if so, whether it has developed specific procedures to ensure that it meets the requirements of its reinsurance agreements.

The receiver should confirm that procedures are in place for collection of salvage and subrogation.

#### **D. Review Outside Involvement in Claim Handling**

In addition to third-party administrators, several other types of outside parties may participate in handling claims, e.g., counsel, adjusters, appraisers, investigators, etc. The receiver should review their roles and determine if outside parties are performing work that the estate could handle in-house more cost-effectively. It also needs to be determined if any insurer records are located with the outside vendor.

#### **E. Claims Handling in Conservation/Rehabilitation**

Depending upon the insurer's cash flow and ability to pay all policyholder claims in full, the receiver may impose a moratorium on the continued payment of claims and/or defense of insured—or cash surrenders, policy loans or dividends—with consideration given to hardship exceptions, whereby claims meeting certain established criteria are paid at a pre-determined percentage or amount. In establishing such procedures, the receiver should be fully informed as to coverage issues and how claims will be handled in the future. If the receiver implements a hardship procedure approved by the court, it should be well thought out, carefully documented and should include an appeal process. These procedures must include a complete description of the information that needs to be submitted by the policyholder requesting the hardship payment and the methodology utilized to evaluate that information. In the event the claim payment procedures are modified with court approval, the receiver should ensure that claims staff is provided with written directions for the handling of claimant inquiries.

For detailed information on how to handle claims in a liquidation, see Chapter 5—Claims.

#### **F. Uniform Data Standard**

In December 1993, the NAIC adopted the Uniform Data Standard (UDS), suggested for use in reporting policy and claim information between guaranty funds and receivers for receiverships instituted after March 31, 1995. UDS is a defined series of file formats that allow receivers and guaranty funds to exchange data related to the insolvent company's unearned premium, loss and loss adjustment expense claims in automated media. The UDS Operations Manual provides an explanation of the reporting format. Contact the NCIGF for a free copy of this manual. Please refer to Chapter 2—Information Systems and Chapter 6—Guaranty Funds for further information on UDS.

## **IX. REINSURANCE**

With respect to property/casualty insurers, reinsurance receivables usually represent the largest asset of a property and casualty estate and may be significant in a life and health estate. This asset may be difficult to collect. Understanding reinsurance is critical to the receiver's ability to marshal this asset. (For detailed discussion of reinsurance, please refer to Chapter 7—Reinsurance.) 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 §612 of IRMA and Section 8(N) of the Life and Health Insurance Guaranty Association Model Act.

### **A. Location of Reinsurance Documents**

Before the receiver can begin to marshal reinsurance receivables, it is necessary to understand the reinsurance relationships of the insurer. To accomplish this, the receiver must first locate and categorize the various documents reflecting the reinsurance arrangements of the insurer. Many of the documents are indicated in the checklists included in the exhibits at the end of this chapter.

### **B. Document Control Activities**

Letters of credit (LOC) 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. Typically, the original LOCs must be presented to the issuing financial institution in order to draw against those letters of credit.

The receiver should locate and 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.

### **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 instructed to continue to perform all contractual duties and responsibilities.

However, the duties of the intermediary need to be clarified. The receiver should instruct the intermediary to take the following actions:

- Advise all reinsurers or cedents of the status of the insolvent insurer;
- Turn over all funds in their possession due the insurer;
- Turn over original LOCs;
- Continue to render accounts to receivers and reinsurers;
- Assist in the collection of funds from reinsurers;

- Transmit claims and other notices to the receiver and the reinsurers;
- Establish procedures for the handling of reinsurance inquiries; and
- 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 proper 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.

### **X. PERSONNEL**

#### **A. Open Lines of Communication**

Takeovers are tough on employees. Some employees are not responsible for or even aware of the current difficulties of their employer. Upon takeover, productivity and morale often decline, turnover increases and rumors abound. Meetings with employees to explain the takeover procedures, emphasize current changes in operations, and answer general questions will assist in opening the necessary lines of communication and minimize the spreading of misinformation and undesired turnover. Whenever possible, these informational meeting with employees should take place on the first day of the takeover.

#### **B. Personnel, Payroll and Benefits Functions**

It is important that the receiver takes control of the personnel, payroll and benefit functions with minimal disruption to the ongoing process. The receiver may need to establish a new benefit program and replace trustees on employee pension plans. Payroll-related bank accounts and records, personnel-related files, personnel policies and procedures and benefits information warrant immediate review. Additional records for review and areas of concern are indicated in the checklists included in the exhibits at the end of this chapter.

Frequently, employees are employed by a holding company. Once the subsidiary insurer is placed into receivership, the holding company may no longer be able to finance payroll or benefits due to discontinued management fees. The receiver may wish to identify key employees and offer employment to those employees necessary to administer the receivership.

#### **C. Staffing Plan**

One of the receiver's responsibilities will be to develop a staffing plan that identifies required positions and key staff. Sources for this plan include a current organizational chart, comprehensive job descriptions and personnel files. Since responsibilities/job functions may change throughout the receivership process (conservation, rehabilitation, liquidation), the receiver should periodically update the organizational chart and base additions to staff or layoffs on positions identified.

#### **D. Sources of Staff**

Provided there is adequate supervision by the receiver's staff, reassignment of the insurer's current employees with the appropriate experience or expertise may be the most cost-effective approach to staffing. Often, individuals have performed numerous jobs/tasks while moving up in the company. Interviews with line management may assist in identifying these employees, and verification of credentials and references is suggested. However, cost constraints, as well as the need for specialized



talent, may require that temporary clerical/professional staff and consultants be retained.

Policies and procedures for the use of temporary resources will require designation of billing rates (hourly, daily), travel and expense policies, payment terms and, most importantly, the work product required. The receiver may want to consider developing a standard contract to ensure uniformity as well as facilitating the negotiation process. The receiver may also wish to consider developing a relationship with one temporary staffing agency.

### **E. Staff Incentives**

It's important to remember that resignations and layoffs will be inevitable. The goal is to retain the insurer's employees until their skills and expertise are no longer necessary in the receivership proceedings. Staff incentives may help to achieve this goal as well as restore initiative, motivation and harmony among the work force. Staff incentives may include the following:

- Maintain/increase existing benefit package, including severance;
- Continue/implement performance and salary review processes and procedures;
- Bonus programs for retention and performance;
- Educational/professional opportunities;
- Tuition reimbursement;
- Seminars;
- Training/work experience in other areas;
- Job postings for internal opportunities;
- Job search/interviewing techniques; or
- Providing outplacement services.

### **F. Other Personnel Issues**

The receiver should identify any personnel related litigation and other disputes to include 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.

## **XI. CLOSURE OF THE ESTATE**

The best time to start planning for closure is at the start of the receivership. Since the receivership process may take a number of 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 an 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; and
- Final tax returns have been prepared and filed with the federal government and financial settlements prepared as required.

For a more complete discussion on closing an estate, see Chapter 10—Closing Estates.

### **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. (For a discussion of guaranty associations, see Chapter 6—Guaranty Associations.) Prior to making a final distribution, the liquidator can value guaranty association reserves (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.

### **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. Therefore, once the ancillary receiver has finalized claims filed in the ancillary proceeding and made distributions to any special deposit claimants, excess funds from the special deposit, if any, must be forwarded to the domiciliary receiver.

### **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.)

### **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 of 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. (See Chapter 10—Closing Estates.)

## 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 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 funds/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; or
- 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 taken into account when calculating the distribution percentage applicable to the final distribution. Also, early access payments made to guaranty funds 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 funds

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 unclaimed distributions will escheat 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 Web site. 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.

**XII. EXHIBITS**

*Exhibit 1-1: Model Language for Selected Provisions of Liquidation Orders for Property and Casualty Insurers*

*Exhibit 1-2: Model Language for Selected Provisions of Liquidation Orders for Life and Health Insurers*

*Exhibit 1-3: Insurer Insolvency Questionnaire*

**Exhibit 1-1: Model Language for Selected Provisions of Liquidation Orders for Property and Casualty Insurers**

MODEL LANGUAGE FOR SELECTED PROVISIONS  
OF LIQUIDATION ORDERS  
OF PROPERTY AND CASUALTY INSURERS

1. FINDING OF INSOLVENCY LANGUAGE

[Insolvent Company] is hereby found to be insolvent, within the meaning of [cite provision of liquidation statute stating insolvency as a ground for liquidation].

2. ORDER OF LIQUIDATION LANGUAGE

An Order of Liquidation with a Finding of Insolvency is hereby entered against [the Insolvent Company].

3. LANGUAGE CANCELING THE POLICIES OF THE INSOLVENT COMPANY

All of the contracts, covenants, bonds or policies, evidences, or certificates of coverage or insurance issued by or in the name of [the Insolvent Company], under which any guarantee or insurance is provided, shall be canceled upon the earliest of the following:

- (a) Thirty (30) days after the date the Order of Liquidation is entered, at 12:01 a.m. local time of the insured or policyholder of such direct policy or certificate of insurance; or
- (b) Upon the expiration date of any such direct policy and/or certificate of insurance, if the expiration date is sooner than thirty (30) days after the entry of the Order of Liquidation; or
- (c) Upon the date the insured or policyholder of any such direct policy and/or certificate of insurance replaces the direct policy and/or certificate of insurance, or effects cancellation, if the insured or policyholder does so within thirty (30) days after the entry of the Order of Liquidation; or
- (d) Upon such other date as established by the court.

[Another provision of the Order will deal with cancellation of assumed reinsurance contracts.]; or

4. LAST DATE TO FILE CLAIMS

- A. The Liquidator shall notify all persons who, according to [the Insolvent Company's] books and records, have or may have claims against [the Insolvent Company], its property or assets, to present and file with the Liquidator or a duly authorized Ancillary Receiver of [the Insolvent Company], proper proofs of claim in the form hereafter set forth, on or before 4:30 p.m., [Time Zone] [Date]. Said notice by the Liquidator shall specify [Date] at 4:30 p.m., [Time Zone], to be the last day by which a proof of claim may be received by the Liquidator, or a duly authorized Ancillary Receiver of [the Insolvent Company], for purposes of participating in any distribution of assets that may be made on timely filed claims that are allowed in these proceedings.
- B. The Liquidator shall also provide notice by publication to all persons who have or may have claims against [the Insolvent Company] or against its insureds or policyholders, by causing a notice to be published [at least once a week for three (3) consecutive weeks] in a newspaper of general circulation published in the County of \_\_\_\_\_, State of \_\_\_\_\_,

- and such other newspapers as the Liquidator may deem advisable. The notice shall: (a) advise all such persons of their right to present their claim or claims against [the Insolvent Company], its property or assets, or against an [Insolvent Company] insured or policyholder, to the Liquidator; (b) advise all such persons of the procedure by which they may present their claims to the Liquidator; (c) advise all such persons of the Liquidator's office where they must present their claims; and (d) specify the last day by which proofs of claim may be received by the Liquidator for purposes of participating in any distribution of assets that may be made on timely filed claims allowed in these proceedings.
- C. All persons having or claiming to have any accounts, debts, claims or demands against [the Insolvent Company], its property or assets, or against an [Insolvent Company] insured or policyholder, shall present their claims to the Liquidator at his or her office as designated in the notice, on or before the claim filing deadline set forth above, by way of a properly completed proof of claim. A proof of claim must consist of a statement, under oath, in writing, signed by the claimant, setting forth the following: 1) the specific claim and the consideration therefore; 2) whether any payments have been made on the claim, and, if so, what payments; and 3) that the sum claimed is justly owing from [the Insolvent Company] to the claimant. Whenever a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim and, if such instrument is lost or destroyed, a statement of such fact, and the circumstances of the loss or destruction shall be filed under oath with the claim.

**Exhibit 1-2: Model Language for Selected Provisions of Liquidation Orders for Life and Health Insurers**

MODEL LANGUAGE FOR SELECTED PROVISIONS  
OF LIQUIDATION ORDERS  
OF LIFE AND HEALTH INSURERS

1. FINDING OF INSOLVENCY LANGUAGE

[Insolvent Company] is hereby found to be insolvent, within the meaning of [cite provision of liquidation statute stating insolvency as a ground for liquidation].

2. ORDER OF LIQUIDATION LANGUAGE

An Order of Liquidation with a Finding of Insolvency is hereby entered against [the Insolvent Company].

3. LANGUAGE REGARDING THE POLICIES OF THE INSOLVENT COMPANY

- Upon issuance of this Order, the rights and liabilities of [the Insolvent Company] and of its creditors, policyholders, shareholders, members and all of the persons interested in this estate are affixed as of the date of the filing of Petition for Liquidation except as provided in [statutory reference] and in this Order.
- Entry of this Order of Liquidation shall not constitute an anticipatory breach of any contracts of [the Insolvent Company], and it shall not be grounds for revision, revocation, or cancellation of any contracts of [the Insolvent Company] in force as of the date of liquidation, except as provided in [statutory reference].
- All of the policies of life or health insurance or annuity contracts of [the Insolvent Company] shall continue in force until such time as the guaranty associations and liquidator implement a reinsurance plan or the guaranty associations assume the covered portions of those policies. Moreover, the policies of life or health insurance or annuity contracts or any other type of policies or contracts about which there is an issue of guaranty association coverage shall not terminate until such time as a non-appealable Order has been entered by a court of competent jurisdiction on whether such contract or policy is entitled to guaranty association coverage.

1. LAST DATE TO FILE CLAIMS

- A. The Liquidator shall notify all persons which [the Insolvent Company's] books and records reveal have, or may have, claims against [the Insolvent Company], its property or assets, to present and file with the Liquidator, or a duly authorized Ancillary Receiver of [the Insolvent Company], proper proofs of claim in the form hereafter set forth, on or before 4:30 p.m., [Time Zone] [Date]. [Said notice by the Liquidator shall specify [Date] at 4:30 p.m., [Time Zone], to be the last day by which a proof of claim may be received by the Liquidator, or a duly authorized Ancillary Receiver of [the Insolvent Company], for purposes of participating in any distribution of assets that may be made on timely filed claims which are allowed in these proceedings.]
- B. The Liquidator shall also provide notice by publication to all persons who have, or may have claims against [the Insolvent Company] or against its insureds or policyholders, by causing a notice to be published [at least once a week for three (3) consecutive weeks] in a newspaper of general circulation published in the County of \_\_\_\_\_, State of \_\_\_\_\_



\_\_\_\_\_, and such other newspapers as the Liquidator may deem advisable. The notice shall: [(a) advise all such persons of their right to present their claim or claims against [the Insolvent Company], its property or assets, or against [an Insolvent Company] insured or policyholder, to the Liquidator; (b) advise all such persons of the procedure by which they may present their claims to the Liquidator; (c) advise all such persons of the Liquidator's office where they must present their claims; and (d) specify the last day by which proofs of claim may be received by the Liquidator for purposes of participating in any distribution of assets that may be made on timely filed claims allowed in these proceedings.]

- C. All persons having or claiming to have any accounts, debts, claims or demands against [the Insolvent Company], its property or assets, or against an insured or policyholder, excepting only persons whose claims arise under life insurance policies or annuity contracts, shall present their claims to the Liquidator at his or her office as designated in the notice, on or before the claim filing deadline set forth above, by way of a properly completed proof of claim. A proof of claim must consist [of a statement, under oath, in writing, signed by the claimant, setting forth the following: 1) the specific claim and the consideration therefore; 2) whether any payments have been made on the claim, and, if so, what payments; 3) that the sum claimed is justly owing from [the Insolvent Company] to the claimant.] Whenever a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim and, if such instrument is lost or destroyed, a statement of such fact, and the circumstances of the loss or destruction shall be filed under oath with the claim. Owners of life insurance policies and annuity contracts whose claims arise under such policies or contracts shall not be required to file a proof of claim to the extent such claims are limited to the benefits due under such policies or contracts.

**\*\*NOTE:** This sample retains most of the language from Exhibit 1-1 for Property and Casualty Insurer liquidations, however for Paragraphs 4B and 4C, the language will only apply where the life or annuity company has health policies with potential claims by health policyholders or providers; these provisions will have little value in a life or annuity insolvency where all life and annuity policyholders will have claims (e.g. cash surrender value) regardless of specific policy triggering events.

Exhibit 1-3: Insurer Insolvency Questionnaire

INSURER INSOLVENCY QUESTIONNAIRE

Investigative Checklist

I. Identification

1. Company name: \_\_\_\_\_
Last business address: \_\_\_\_\_

2. Contact person for information regarding this estate:
Name: \_\_\_\_\_
Address: \_\_\_\_\_
Title: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

3. State of domicile: \_\_\_\_\_

4. Corporate structure: Stock [ ] Mutual [ ] Other [ ] \_\_\_\_\_

5. Type of insurer: Life & Health [ ] P&C [ ] HMO [ ] Other [ ] \_\_\_\_\_

6. Estimated amount of insolvency \_\_\_\_\_ Date \_\_\_\_\_

7. If part of a holding company system, attach organizational chart.

8. Grounds for Delinquency proceedings

(Check all that possibly apply.)

- Inadequacy of capital and surplus [ ] Failure to utilize good info or to react to bad information [ ]
Inability to pay debts when due [ ] Pricing [ ]
Reserving [ ] Asset portfolio investments [ ]
Delegation of authority or control [ ] Inadequate control of administrative expenses [ ]
Fraud [ ]
Party-at-interest transactions [ ] Other [ ]
(Example: excessive level of fees paid to affiliates or parent company)

II. Legal Activities

9. Status of company and date of court orders:

	Date	Docket Number	Jurisdiction
Conservation/supervision	_____	_____	_____
Rehabilitation	_____	_____	_____
Liquidation	_____	_____	_____
Other	_____	_____	_____
Closed	_____	_____	_____

10. If this company is a closed or discharged rehabilitation, how was it resolved? (Check all that apply.)

Sold company	<input type="checkbox"/>	Business was run off	<input type="checkbox"/>
Sold subsidiaries	<input type="checkbox"/>	Sold lines of business	<input type="checkbox"/>
Infusion of additional capital	<input type="checkbox"/>	Other (please describe)	<input type="checkbox"/>
		_____	
		_____	
		_____	

11. This receivership is/was:

Agreed	<input type="checkbox"/>	Adversarial	<input type="checkbox"/>
Non-contested default	<input type="checkbox"/>	Other (please describe)	<input type="checkbox"/>
		_____	
		_____	
		_____	

12. Material litigation initiated, pending or completed as of date of report? (Please repeat for each piece of litigation.)

Caption	_____
	_____
	_____
Docket	_____
	_____
	_____
Jurisdiction	_____
Brief description	_____
	_____
	_____

If litigation is completed, what is the result?

Judgment                       Settlement                       Dismissal



E. Location of suspected offenses \_\_\_\_\_

F. Approximate date and dollar amount (prior to any allowance for restitution or recovery) of suspected violation.

Date \_\_\_\_\_ Amount \_\_\_\_\_  
mo./day/yr.

G. Is person still affiliated with the insurance entity?

\_\_\_ yes \_\_\_ no If no, \_\_\_ terminated \_\_\_ resigned

Date \_\_\_\_\_  
mo./day/yr.

H. If person is not affiliated with insurance entity, was person:

_____	Policyholder	_____	Doctor
_____	Lawyer	_____	Other professional
_____	Accountant	_____	Other (specify)
		_____	
		_____	

I. Prior or related criminal referrals? \_\_\_ yes \_\_\_ no  
If yes, please identify.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

J. Is person affiliated with any other insurance entities?

\_\_\_ yes \_\_\_ no

Or business enterprise?

\_\_\_ yes \_\_\_ no

K. Has there been any admission or a confession?

\_\_\_ yes \_\_\_ no

If so, by whom \_\_\_\_\_

To whom was confession made? \_\_\_\_\_

16. Witnesses:

If the information is available, list any witnesses who might have information about the suspected violation and describe their position or employment. Indicate if they have been interviewed. (Use continuation sheet if necessary.)

	<u>Name</u>	<u>Position</u>	<u>Address</u>	<u>Tele.</u>	<u>Interviewed</u>	
					Yes _____	No _____
(1)	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____		
(2)	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____		
(3)	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____		
(4)	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____		

Have you sent this referral to any other state, local or federal agency? If so, please list below:

<u>Agency</u>	<u>City/State</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Questions to be Asked by Investigator**

Explanation/description of suspected violation. (Give a brief summary of the suspected violation, explaining what is unusual or irregular about the transaction.) Details will be required below. The purpose of this paragraph is to provide a summary description of the overall transaction.

Give a chronological and complete account of the suspected violation. (Use continuation sheets, if necessary.)

- Relate key events to documents and attach copies of those documents.
- Explain who benefited, financially or otherwise, from the transaction, how much and how.
- Furnish any explanation of the transaction provided by the suspect and indicate to whom and when it was given.
- Furnish any explanation of the transaction provided by any other person.
- Furnish any evidence of cover-up or evidence of an attempt to deceive state examiners, auditors or others.
- Suggest any further investigation that might assist law enforcement in fully examining the suspected violation.

**THIS SECTION OF THE REFERRAL IS CRITICAL.** It should be as detailed as circumstances permit. The care with which this section is written may make the difference in whether the described conduct and its criminal nature are clearly understood. The discussion points listed in this section are not exhaustive. They should be covered, but to the extent additional explanation would be useful as to any particular item or to the extent an additional category should be addressed, it should be done here. Feel free to use attachments or to continue the description on a separate sheet. Include any suggestions for the interviewing of any witnesses, gathering of any documents, or other suggestions that might prove useful in following up on the referral (e.g., tracing of proceeds).

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*Chapter 1 – Takeover & Administration*

In order to effectively utilize the following pre-receivership procedures, it is recommended to first differentiate between a stand-alone entity and a group. To make the best judgement, evaluate the type of the entity and choose the applicable components of the checklist.

<b>Checklist 1—Pre-Takeover</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<u>INITIAL STEPS</u>				
Assign takeover responsibilities for each of the insurer’s departments/functional areas to an appropriate representative of the Receiver’s team and distribute checklists accordingly.				
Undertake a thorough review of available information pertaining to the insurer, its operations and a description of core lines of business to obtain a detailed understanding of the insurer to assist the receiver in planning an efficient and effective takeover.				
Review commercial publication reports such as A.M. Best, Dunn & Bradstreet, Standard & Poor’s, and Moody’s in order to obtain an overview of the insurer.				
<u>REGULATORS AND SUPERVISORS</u>				
Determine the identities and contact information of all relevant supervisory authorities. (i.e. from most current analysis, examination or supervisory college information)				
Secure contact information for the person(s) at the Department of Insurance responsible for oversight of this company.				
Receiver’s staff should meet with the Department of Insurance to obtain background information and specific issues with the insurer.				
<u>COMPANY INFORMATION &amp; OVERVIEW</u>				
Obtain overview of the insurer’s situation, including type of proceeding and timing of takeover.				

*Receivers Handbook for Insurance Company Insolvencies*

<b>Checklist 1—Pre-Takeover</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Obtain from the Department of Insurance <ul style="list-style-type: none"> <li>• Its most recent examination work papers,</li> <li>• The insurer’s most recent annual and quarterly statements,</li> <li>• Audited financial statements with auditor’s opinion,</li> <li>• Actuarial certifications,</li> <li>• Any SEC filings,</li> <li>• Tax returns and any other financial statements,</li> <li>• Holding Company Analysis,</li> <li>• Most recent Insurer Profile Summary,</li> <li>• Most recent Holding Company Registration Statement and related filing (Form B, Form F, etc.)</li> </ul>				
Obtain copies of any other insurer documents held by the Department such as insurer charter, by-laws, Form A’s and other applications, etc.				
Obtain list of management, including officers and directors, along with biographical affidavits on file with the Department.				

Chapter 1 – Takeover & Administration

Checklist 1—Pre-Takeover	Project Assigned To	Date Completed	Completed By	Notes
<p>Obtain or prepare an organization chart of the insurer and its subsidiaries and affiliates. A description of the company’s organizational structure, including:</p> <ol style="list-style-type: none"> <li>1) A hierarchical list of all material entities within the company’s organization (including legal entities that directly or indirectly hold such material entities) that identifies:               <ol style="list-style-type: none"> <li>a) The holder of each legal entity and foreign office,</li> <li>b) Differentiate between stand-alone and group</li> <li>c) The location, jurisdiction of incorporation, licensing, and key management associated with each material legal entity and foreign office identified.</li> <li>d) Whether the company utilizes any third party vendors (affiliated or unaffiliated )                   <ul style="list-style-type: none"> <li>• Investment manager,</li> <li>• Managing General Agents (MGA), Third Party Administrators (TPA), Individual Practice Associations (IPA)</li> <li>• Reinsurance intermediary</li> </ul> </li> <li>e) Working relationships with                   <ul style="list-style-type: none"> <li>• Professional Employer Organizations (PEO)</li> <li>• Administrative Services Organizations (ASO)</li> </ul> </li> <li>f) Identify if a premium finance company is being utilized for any material contracts, such as the D&amp;O policy.</li> </ol> </li> <li>2) A mapping of the company’s critical operations and core business lines, including material asset holdings and liabilities related to such critical operations and core lines of business, to material entities.</li> </ol>				
<p>Obtain description and review foreign operations.</p>				
<p>Obtain description of the corporate governance structure and processes related to resolution planning.</p>				

*Receivers Handbook for Insurance Company Insolvencies*

<b>Checklist 1—Pre-Takeover</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
If possible, obtain all of the above for any affiliated companies that might be affected by the takeover such as parent, affiliates and/or subsidiaries.				
<ul style="list-style-type: none"> <li>• Obtain a detailed inventory and description of the key management information systems and applications, including those for risk management, policy and claims administration, reinsurance, and financial and regulatory accounting, used by the company and its material entities.</li> <li>• Draft a description of each system or application provided to identify the legal owner or licensor, the use or function of the system or application, service level agreements related thereto, any software and system licenses, and any intellectual property associated therewith.</li> <li>• Obtain detail on the company’s system back-up procedures. Include information on the following:               <ul style="list-style-type: none"> <li>○ Frequency of back-up and software/methods used for backup process.</li> <li>○ Location of any off-site storage and frequency of back-up restored off-site.</li> <li>○ Date of oldest back-up.</li> <li>○ Date of most recent back-up.</li> </ul> </li> </ul>				
Obtain an identification of the scope, content, and frequency of the key internal reports that senior management uses to monitor the financial health, risks, and operations of the company, its material entities, critical operations and core lines of business.				

Chapter 1 – Takeover & Administration

Checklist 1—Pre-Takeover	Project Assigned To	Date Completed	Completed By	Notes
<p>Review the processes the company employs for:</p> <ol style="list-style-type: none"> <li>1) Determining the current market values and marketability of the core lines of business, critical operations, and material asset holdings of the company;</li> <li>2) Assessing the feasibility of the company’s plans for executing any sales, divestitures, restructurings, recapitalizations, or other similar actions; and</li> <li>3) Assessing the impact of any sales, divestitures, restructurings, recapitalizations, or other similar actions on the value, funding, and operations of the company, its material entities, critical operations and core business lines.</li> </ol>				
<p>Obtain a description of the process for the appropriate supervisory or regulatory agencies to access the management information systems and applications.</p>				
<p>Obtain a mapping of the key management information system/application to the material entities, critical operations and core lines of business of the company that use or rely on them.</p>				
<p>Obtain information on remote access to company management information systems (e.g., Who has access? How is remote access implemented and managed?)</p>				
<p>Obtain information regarding location of offices and storage facilities, staffing and how to deal with satellite offices.</p>				
<p>Obtain information on office layouts and security issues.</p>				
<p>Pre-inspect premises if possible.</p>				
<p>Obtain information on related party transactions and agreements, including leases, service agreements, agreements containing collateral calls, and ownership of shared assets, including personnel.</p>				

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<b>Checklist 1—Pre-Takeover</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Obtain information on items that will affect immediate operational needs such as leases (including those on computers), telephones, Web sites, supply vendors and key personnel.				
Obtain information on agents, TPAs, administrators, MGAs, intermediaries and reinsurers, including locations and contacts.				
Obtain information on auditors/accountants and attorneys.				
Request information relating to payroll and employee benefits. Is payroll handled internally or by a payroll provider? How frequently is payroll made? If it is handled by a payroll provider, obtain the name of the provider. What types of benefits does the company provide to its employees (401K, health insurance, etc.)?				
Identify banking relationships and obtain information on bank accounts, financial institutions and securities custodians (including Federal Home Loan Bank agreements, if applicable). This information should include the bank contact's name and title, the branch address, and the contact's information (phone, fax, email address, etc.).				
Obtain information on licenses in other states, statutory deposits, special deposits and communications with other states.				
Determine any possible guaranty/fund association involvement. Contact NCIGF and/or NOLHGA if insurer was licensed in multiple states. If guaranty funds/associations are involved, advanced planning for the transition of claims data and file information is essential. Please see Chapter 6 of the Receivers Handbook for additional information.				
<u>FINANCIAL INFORMATION</u>				
Review and analyze insurer's annual statement balance sheet by line item to obtain as much information as possible about the assets and liabilities, including any subsequent events, potential problems/unusual circumstances and special items in the Examiner's report for each line item.				

Chapter 1 – Takeover & Administration

Checklist 1—Pre-Takeover	Project Assigned To	Date Completed	Completed By	Notes
<p>Obtain or develop an unconsolidated balance sheet for the company and a consolidating schedule for all material entities that are subject to consolidation by the company.</p> <p>Also include request from most recent exam, CPA workpapers or recent analysis.</p>				
<p>Obtain a description of the material components of the liabilities of the company, its material entities, critical operations and core lines of business that separately identifies types and amounts of short-term and long-term liabilities, and secured, unsecured, and subordinated liabilities.</p>				
<p>Request claim information for the company, to include averages of count of claims/year, total amount in claim payments/year, and funding mechanism(s) for claim payments.</p>				
<p>Review financial information regarding the company’s capital position and major sources of capital and funding.</p>				
<p>Review description of funding, liquidity and capital needs of, and resources available to, the company and its material entities, which shall be mapped to its critical operations and core business lines.</p>				
<p>Review any material off-balance sheet exposures (including guarantees and contractual obligations) of the company and its material entities.</p>				
<p>Review notes and interrogatories to financial statements.</p>				
<p><u>DERIVATIVES AND COUNTERPARTY EXPOSURE</u></p>				
<p>Obtain information and describe the practices of the company, its material entities and its core lines of business related to the booking of trading of derivative activities.</p>				
<p>Identify material hedges of the company, its material entities, and its core lines of business related to trading and derivatives activities, including a mapping to legal entity.</p>				

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<b>Checklist 1—Pre-Takeover</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Review the hedging strategies of the company.				
Review the process undertaken by the company to establish exposure limits.				
Identify the major counterparties of the company and describe the interconnections, interdependencies and relationships with such major counterparties.				
Analyze whether the failure of each major counterparty would likely have an adverse impact on or results in the material financial distress or failure of the company.				
Identify each trading, payment, clearing, or settlement system of which the company, directly or indirectly, is a member and on which the company conducts a material number or value amount of trades or transactions. Map membership in each such system to the company's material entities, critical operations and core lines of business.				
Identify the processes used by the company to: <ul style="list-style-type: none"> <li>1) Determine to whom the company has pledged collateral;</li> <li>2) Identify the person or entity that holds such collateral; and</li> <li>3) Identify the jurisdiction in which the collateral is located, and, if different, the jurisdiction in which the security interest in the collateral is enforceable against the company.</li> </ul>				
<u>NEXT STEPS</u>				
Review condition and location of insurer's books and records.				
Coordinate with counsel to assist in preparation of the petition and order and determine parties to be served.				
Determine method(s) of notification of various parties in other locations, e.g., financial institutions, securities custodians, etc.				



Chapter 1 – Takeover & Administration

<b>Checklist 1—Pre-Takeover</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Reconfirm Receivership team assignments, and determine Receivership team needs in other locations and logistics of getting team members to assigned locations.				
If possible arrange for a meeting with management to discuss ramifications and procedures.				
Prepare agenda for meeting with insurer personnel (or memo for distribution to personnel) that discusses ramifications of order and procedures to be implemented.				
Prepare phone scripts for customer service representatives.				
Prepare information to be posted on Web sites.				
Prepare notices for posting on office doors as may be required.				
Determine if security service is required and hire as needed.				
Determine frequency of Receiver team meetings after takeover and method of communicating issues to team/Receiver and the decision-making process.				
Contact applicable guaranty association(s) as early as possible.				

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<b>Checklist 2—Takeover</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<i>Overview</i>				
Meet with management to discuss procedures, unless a meeting was held pre-takeover.				
Meet with insurer personnel (or distribute memo to insurer personnel) that discusses order and procedures to be implemented.				
Meet with the insurer’s CFO/accounting manager (and/or other appropriate personnel) to discuss the insurer’s financial operations in general, managers/supervisors and their responsibilities, staffing, and what will be required from their department’s staff as a result of the order.				
Identify if insurer has internal actuary or if they utilize external actuarial firm. Obtain appropriate information.				
Inform insurer management and personnel that document destruction must immediately cease.				
Post door signs/notices as required to inform visitors of receivership.				
Secure insurer Web site and post information as needed.				
If necessary, determine current status of insurer’s state licenses and requirements to avoid revocation.				

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Checklist 3—Human Resources and Payroll	Project Assigned To	Date Completed	Completed By	Notes
<p>nce on site, meet with the insurer’s personnel manager (and/or appropriate personnel) to discuss:</p> <ul style="list-style-type: none"> <li>▪ Jobs that need to be accomplished (also what resources/personnel you’ll need)</li> <li>▪ What he or she can expect and what is expected from him/her</li> </ul>				
<p>If multiple entities exist, determine the entity that employs personnel and what entity funds payroll.</p>				
<p>Consult human resources counsel and tax advisors to determine any requirements that must be met or what notices should be sent.</p>				
<p>Determine the insurer’s next payroll date and lead time for processing and make arrangements for distribution. Discuss payroll process with the payroll manager and document (flow chart).</p>				
<p>Determine if payroll is processed by a service or in-house.</p> <ul style="list-style-type: none"> <li>▪ Determine who has access to personnel and payroll records.</li> </ul> <p>If by a service:</p> <ul style="list-style-type: none"> <li>▪ Obtain contract</li> <li>▪ Contact service to notify of order</li> <li>▪ Work with service on logistics of issuing checks considering possible new checking account and new authorized signatures</li> <li>▪ Work with accounting on securing facsimile signature of appropriate receiver personnel.</li> </ul>				
<p>Interview human resources manager and staff to obtain:</p> <ul style="list-style-type: none"> <li>▪ Insurer organization chart</li> <li>▪ Organization charts by department, staffing and tasks</li> <li>▪ Specify number of full-time, part-time and temporary employees, including location, department, job, salary, accrued leave time, employment date and review date</li> <li>▪ Telephone directory for each office/branch location</li> <li>▪ Listing of the insurer’s officers and directors</li> </ul>				

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<b>Checklist 3—Human Resources and Payroll</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Identify control of access to insurer’s facilities, review employee access rights and modify as necessary.				
<b><i>Records Security</i></b>				
<p>Secure the following payroll and personnel files after takeover:</p> <ul style="list-style-type: none"> <li>▪ Payroll files and computer runs, including current and historical q-t-d and y-t-d cumulative totals and most recent W-2s and 1099s</li> <li>▪ Payroll tax records, including all deposits</li> <li>▪ Personnel files</li> <li>▪ Computerized personnel data</li> <li>▪ Employment contracts</li> <li>▪ Union contracts</li> <li>▪ Employee claim files, e.g., workers’ compensation claims, unemployment claims, employment discrimination claims, etc.</li> <li>▪ Employee disciplinary files</li> <li>▪ Documentation pertaining to cash advances or short-term loans to officers or employees</li> <li>▪ Personnel rules (e.g., employee handbook, policy and procedures manual, holiday schedule, memos addressing personnel issues, etc.)</li> <li>▪ Material regarding insurer profit sharing, credit unions, thrift, savings, tuition reimbursement programs, 401(k) or pension plans</li> <li>▪ Personnel forms used</li> <li>▪ Employee leave balance reports</li> <li>▪ Documentation pertaining to phone and car allowance for the employees, officers and directors</li> </ul>				

Chapter 1 – Takeover & Administration

Checklist 3—Human Resources and Payroll	Project Assigned To	Date Completed	Completed By	Notes
<i>Payroll</i>				
Obtain and confirm most current pay period data to documentation in the insurer’s personnel files (including all deductions), including: <ul style="list-style-type: none"> <li>▪ Verifying the appropriateness of each check/voucher issued</li> <li>▪ Verifying the payee and check amount</li> <li>▪ Verifying direct deposit authorizations and procedures</li> </ul>				
Review current payroll procedures, including direct deposits and/or voluntary deductions and determine and publish any new procedures, including approval processes for personnel and payroll actions.				
Determine procedures for handling payroll functions at off-site locations.				
Consider procedures for reimbursement of the payroll account when insurer employees work for other entities.				
Upon distribution of first payroll after takeover, consider requiring identification and a signature before distributing paycheck to assist in determining if individuals who are not performing services for the insurer are receiving paychecks.				
Review all employment contracts and determine any actions necessary.				
If the insurer is involved with a union of any kind, obtain a copy of all contracts and related material.				
Determine whether there are any personnel matters in dispute or litigation.				
Identify any potential leave payout liability for the insurer.				
Identify any employees on special leave status, such as FMLA.				

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<b>Checklist 3—Human Resources and Payroll</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
For employees of related entities who are paid through the insurer's payroll, ensure that personnel/payroll records are copied and forwarded to the appropriate entities.				
<b><i>Employee Benefits Packages</i></b>				
Prepare an assessment of the employee benefits package to determine any required changes: <ul style="list-style-type: none"> <li>▪ Determine if any of the programs are self-administered.</li> <li>▪ Determine whether benefits will continue to be offered.</li> </ul>				
Review employee benefits package, particularly insurance coverage and retirement plans. Ensure that the benefits package agrees to the current policies and employee handbook.				
Contact benefits vendor(S) to inform them of the receivership process and any changes that should be implemented.				
For any of the following that exist, review a plan document or detail for each. Determine if any modifications are necessary and, if so, update written materials and communicate with affected parties: <ul style="list-style-type: none"> <li>▪ Group insurance coverage (e.g., life/ad&amp;d, medical, dental, vision, COBRA, STD etc.):               <ul style="list-style-type: none"> <li>○ Review enrollment cards or applications for each type of coverage to determine proper enrollment.</li> <li>○ Review payroll deductions for above and compare to monthly premium billings.</li> <li>○ Locate employee claims. Document claims submission and processing procedures.</li> <li>○ If the benefit package is self-funded or self-administered, review the claims processing procedures to determine if insurer funds are being properly handled.</li> <li>○ Review COBRA processing procedures.</li> </ul> </li> <li>▪ Defined benefit (pension) and/or defined contribution (401(k)) plans:               <ul style="list-style-type: none"> <li>○ Review the plan document, summary plan description, and trust agreement.</li> </ul> </li> </ul>				

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Checklist 3—Human Resources and Payroll	Project Assigned To	Date Completed	Completed By	Notes
<ul style="list-style-type: none"> <li>○ Determine details of plan operation. Ensure timeliness of all reporting to plan participants and federal authorities (DOL, PBGC, IRS).</li> <li>○ Verify that all payments and funding are made timely.                             <ul style="list-style-type: none"> <li>▪ Workers’ compensation</li> <li>▪ Profit sharing or thrift plans</li> <li>▪ Severance plans</li> <li>▪ Stock options</li> <li>▪ Credit union</li> <li>▪ Bonus plan</li> <li>▪ Loans to employees</li> <li>▪ 401(k) and/or other retirement plans</li> </ul> </li> </ul>				
<p>Determine whether there are any pensioners who have health coverage or participate in other benefit programs through the insurer. If so, prepare a schedule of the pensioners listing their benefits.</p>				
<p>Determine if there are key employees to be retained and if a retention/bonus program needs to be implemented for them (or all employees).</p>				
<p>Ensure that copies of the receivership order are sent to third parties who:</p> <ul style="list-style-type: none"> <li>▪ Administer any programs</li> <li>▪ Hold or distribute funds</li> <li>▪ Issue drafts</li> <li>▪ Coordinate data input and report preparation</li> </ul>				
<p>Determine which bank accounts are used for payroll (including payment of taxes—FUTA, FICA, etc.), and whether they are current with respect to:</p> <ul style="list-style-type: none"> <li>▪ Social security and taxes (e.g., federal, state, and city quarterly reports)</li> <li>▪ Insurance premium payments</li> <li>▪ Workers’ compensation assessments</li> <li>▪ Unemployment insurance payments</li> </ul>				

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<b>Checklist 3—Human Resources and Payroll</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<ul style="list-style-type: none"> <li>▪ Other benefit contributions</li> <li>▪ If self-funded, outstanding claim payments to employees</li> <li>▪ Loan payments due the insurer by employees</li> </ul>				
<b><i>Organizational Overview</i></b>				
Review organizational charts of insurer departments to determine staffing needs, terminations, etc.				
Secure or prepare a personnel listing of current and recently terminated employees including name, social security number, job title, current salary, starting date, and termination date.				
Determine if any outstanding personnel audits need to be handled, such as unemployment compensation or time and wage audits.				
In early January following the takeover of the insurer, prepare to distribute W2s. Note that extra W2s or 1099s may need preparation if additional compensation (e.g., benefits, expenses, etc.) was not properly reported. Ensure mailing of these forms no later than the last day of January.				
Send COBRA and/or other required notices to terminated employees. Certain state and federal laws may require the insurer to notify terminated employees of their right to extension of benefits, conversion privileges, or other contractual obligations due them by the insurer.				
Determine whether the insurer must file an EEO-1, Form 5500, census, or other federal, state, or city reports. Assure that all necessary reports are filed in a timely manner or that timely request for extension has been filed.				
<b><i>Employee Termination</i></b>				
As employees separate or are terminated from employment, coordinate with Accounting/Asset Recovery sections to determine if laptops, cell phones or other property in the possession of the employee should be returned to the receiver.				



<b>Checklist 4—Property, Real Estate, Records and Facilities Control</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<i>Investigation / Identification</i>				
Meet with insurer officer and/or personnel in charge of real estate properties and mortgage loans, and discuss: <ul style="list-style-type: none"> <li>▪ Location of all real estate files</li> <li>▪ Location of all mortgage loan files</li> <li>▪ List of property management contracts</li> <li>▪ List of real estate brokerage contracts</li> <li>▪ List of appraisal contracts</li> <li>▪ List of mortgage servicing contracts</li> <li>▪ List of mortgage sales contracts</li> <li>▪ All other associated files</li> </ul>				
Establish a secured space on-site for Receiver’s use and records storage.				
Secure access to property files.				
As appropriate, notify all current property managers and servicing agents of receivership.				
Notify landlord(s) of receivership and landlords’ obligations.				
Notify tenants of receivership and tenants’ obligations.				
Inspect and digitally photograph and/or videotape exterior and interior of all business locations and off-site storage facilities, and digitally photograph and/or videotape property within.				
Obtain plans of interior premises – all locations.				

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<b>Checklist 4—Property, Real Estate, Records and Facilities Control</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<p>Change locks/secure premises:</p> <ul style="list-style-type: none"> <li>▪ Obtain security service to secure premises</li> <li>▪ Notify local law enforcement and provide copy of court order</li> <li>▪ Contact locksmith to meet onsite</li> <li>▪ Re-key exterior locks, as required</li> <li>▪ Re-key/secure interior room(s) for takeover team</li> <li>▪ Change computer area locks</li> <li>▪ Change locks on postal boxes</li> <li>▪ Secure safe and have accounting inventory contents</li> <li>▪ Change alarm codes and contact names</li> <li>▪ Collect exterior door/elevator pass cards and change card codes if applicable</li> <li>▪ As necessary, collect keys to all doors, locked cabinets, etc.</li> <li>▪ Change alarm codes/locks on off-site storage areas</li> <li>▪ Secure shipping and receiving facilities</li> </ul>				
Suspend document destruction. Secure all shredding machines. Possibly secure wastebaskets and recycle bins.				
Determine location of all personal property. Computers, cars, etc., might be in the possession of employees off-site.				
<p>For all assets identified in the books and records, and for all of those physically located:</p> <ul style="list-style-type: none"> <li>▪ Determine ownership</li> <li>▪ Verify that assets were seized and are under the receiver's control</li> </ul>				
Review all affiliate books (if available) to see if any assets recorded on their books are actually the assets of the insurer.				
Identify missing property.				

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Checklist 4—Property, Real Estate, Records and Facilities Control	Project Assigned To	Date Completed	Completed By	Notes
Identify, secure and inventory all records located at off-site storage areas.				
<b><i>Furniture and Fixtures</i></b>				
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.				
<b><i>Equipment</i></b>				
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: <ul style="list-style-type: none"> <li>• Cell phones</li> <li>▪ Pagers</li> <li>▪ PDAs</li> <li>▪ Blackberries</li> <li>▪ Laptops</li> <li>▪ Flash drives</li> <li>▪ Vehicles</li> <li>▪ Security</li> <li>▪ Maintenance agreements</li> <li>▪ Copiers</li> <li>▪ Office equipment</li> </ul>				

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<b>Checklist 4—Property, Real Estate, Records and Facilities Control</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>Vehicles</i></b>				
Locate and inventory all insurer-owned vehicles.				
Identify leased vehicles.				
If appropriate, retrieve keys to vehicles.				
Obtain copies of leases and determine appropriate action.				
List insurer-owned vehicles (assets).				
Locate titles and verify ownership on insurer vehicles.				
Record valuation of assets at receivership date.				
<b><i>Control of Real Estate</i></b>				
Identify leased real property.				
Obtain copies of leases.				
Prepare detailed inventory of real property owned by insurer.				
Locate titles and other evidence of ownership and verify ownership.				
Identify all mortgage loans held. Obtain listings of same and reconcile to the general ledger and Schedule A.				
Review carrying value of all owned real property.				
Obtain property summaries with all pertinent details, including location, encumbrances, value, etc.				

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Checklist 4—Property, Real Estate, Records and Facilities Control	Project Assigned To	Date Completed	Completed By	Notes
Inventory all of the following: <ul style="list-style-type: none"> <li>▪ Title policies</li> <li>▪ Appraisals</li> <li>▪ Mortgage serving contracts</li> <li>▪ Property management reports &amp; operating projections</li> <li>▪ Deeds and notes</li> <li>▪ Escrow funds</li> <li>▪ Loan funding commitments</li> <li>▪ All other pertinent files as necessary</li> </ul>				
Obtain and update rent rolls for each commercial property, including the following: <ul style="list-style-type: none"> <li>▪ Scheduled monthly rent</li> <li>▪ Common area, real estate tax &amp; property insurance charges</li> <li>▪ Prepaid rents</li> <li>▪ Security deposits</li> <li>▪ Delinquent rents</li> <li>▪ Other commercial property accounts receivable</li> </ul>				
If Appropriate, discontinue the following: <ul style="list-style-type: none"> <li>▪ Janitorial services</li> <li>▪ Electric services</li> <li>▪ Gas</li> <li>▪ Building lease(s)</li> <li>▪ Water</li> <li>▪ Pest Control</li> </ul>				
Obtain and update an overall review of all accounts receivable from commercial properties, including a narrative, status of the receivable and spreadsheet.				
Obtain and update an overall review of the disposability of real estate assets and mortgage loans based on the insurer’s needs.				
Contact all property managers & servicing agents and review current marketing and management plans, as required.				

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<b>Checklist 4—Property, Real Estate, Records and Facilities Control</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Change title of insurer assets to that of receivership (if necessary).				
Determine valuation needs.				
Determine which properties should be reappraised: <ul style="list-style-type: none"> <li>▪ Prepare a list of accredited potential appraisers (e.g., MAI or ASA if commercial real estate, or SRA appraisers if residential property). Request at least three (3) quotes.</li> <li>▪ Prepare a list of potential secondary market buyers for mortgage loans. Request at least two (2) bids to establish values on loan portfolios.</li> </ul>				
Prepare a final asset disposal plan for real estate and mortgage loan assets based on objectives.				
Prepare a list of potential listing brokers and property managers for real estate assets.				
Prepare a list of potential purchasers and servicing agents for mortgage loan assets.				
Prepare individual marketing plans for each real estate and mortgage loan asset based on objectives.				
Schedule meetings with the potential property manager, broker, servicing agent or collectors to review and discuss their marketing and/or management plans.				
Finalize selections of appraisers, brokers, property managers, collectors and servicing agents.				
Contact all contracted brokers, property managers and servicing agents, and emphasize marketing and/or management plans for the particular property.				
Arrange for sale or liquidate owned property.				

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Checklist 4—Property, Real Estate, Records and Facilities Control	Project Assigned To	Date Completed	Completed By	Notes
<i>Property Records</i>				
Determine or locate insurer’s inventory of files housed at each branch location, outside facility or other location. Verify accuracy of existing inventory or arrange for an inventory to be taken.				
Determine if insurer uses bar code system for record management and determine ownership of the system.				
Determine if files at branches or outside facilities need to be returned or sent to other locations.				
Complete ID of all property files.				
<i>Insurer Mail</i>				
Establish procedures for all incoming and outgoing mail.				
Direct the mailroom staff (under receivership employee supervision) to open all incoming mail on hand and turn over all checks to Receiver’s accounting staff for deposit.				
Open, time/date stamp, and review for sorting by department.				
Distribute mail appropriately.				
Plan scheduled pick-ups of outgoing mail.				
Serve a copy of the court order to the insurer’s local postmaster, advising of the insurer’s status, and including the names of receiver team members and/or insurer personnel authorized to pick up mail or receive mail.				
Secure lock boxes.				
Determine need for continued use of P.O. Boxes. Cancel if not necessary.				
Secure mailroom, postage machine and all outgoing mail. Pull all checks out of outgoing mail (optional) and provide to receiver’s financial representative.				

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<b>Checklist 4—Property, Real Estate, Records and Facilities Control</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Request information on any other postal accounts held by the insurer.				
Prepare check log.				
Provide mailroom a list of receiver's employees to establish proper distribution of mail.				
<b><i>Records</i></b>				
Determine insurer's record storage media (paper, image, etc.)				
Determine where the insurer has records stored in the home office, branch offices, off-site locations, or safe.				
Serve any facility/lesser with a copy of the court order, advising of the insurer's status; if permissible, arrange for changes in locks and/or security. Specify authorized access to facilities.				
Determine outstanding invoices for storage facilities and make arrangements for prospective storage.				
Serve vendors with court orders at locations where files are housed.				
Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken.				
Determine if there has been unusual activity regarding disposal of records.				
Determine if files at branches or outside facilities need to be returned or sent to other locations.				
Obtain copies of any and all inventories prepared on files/data from the following areas: <ul style="list-style-type: none"> <li>▪ Legal</li> <li>▪ Claims</li> <li>▪ Underwriting</li> <li>▪ Accounting</li> </ul>				



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<b>Checklist 4—Property, Real Estate, Records and Facilities Control</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<ul style="list-style-type: none"> <li>▪ Tax &amp; Compliance</li> <li>▪ Agents’ Balances/Subrogation/Salvage</li> <li>▪ Property</li> <li>▪ Reinsurance</li> <li>▪ Personnel and Payroll</li> <li>▪ Customer Service</li> <li>▪ Information Technology</li> </ul>				
<p>Determine/establish a file charge-out or sign-out procedure for the use of records located on/off-site. If a procedure is already in effect at the insurer, review for adequacy regarding security.</p>				
<p>As requested by receivership team members, assist in sorting and packing records to be transported to any other office locations or off-site warehouse.</p>				
<p><b><i>Facility Closures</i></b></p>				
<p>Adjust night/weekend answering service as needed.</p>				
<p>Adjust voicemail capability as needed.</p>				
<p>Discontinue phone lines as needed.</p>				
<p>Adjust phone system as needed.</p>				
<ul style="list-style-type: none"> <li>▪ Arrange for closing of utility accounts as appropriate.</li> <li>▪ Arrange for moving/storing and/or disposal of furniture and equipment.</li> <li>▪ Arrange for transportation of files to receiver’s office.</li> <li>▪ Arrange for cleaning or maintenance of facility as needed.</li> <li>▪ Determine if deposit was posted for any equipment, utilities and leased premises.</li> <li>▪ Discontinue any additional services, such as cleaning,</li> </ul>				

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<b>Checklist 4—Property, Real Estate, Records and Facilities Control</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
trash removal, lawn care, window washing, etc. ■ Meet with building management, return keys to property and receive letter stating facility was left in appropriate order.				
Complete and deliver mail forwarding card to post office prior to vacating any facility.				

Chapter 1 – Takeover & Administration

Checklist 5—Customer Service	Project Assigned To	Date Completed	Completed By	Notes
<i>Phones</i>				
Meet with insurer’s manager for the customer services section to discuss the insurer’s procedures, staffing and duties required as a result of the order.				
Interview the customer services manager (and/or other personnel as appropriate) to discuss the insurer’s customer services functions and operations to determine how phones, e-mail requests, etc., are handled by the insurer. Document same. Be sure to obtain information regarding the insurer’s night/weekend answering service and automated call distribution system (ACD).				
Meet with the insurer’s customer service representatives to inform them of the receivership processes and take control of the customer service process.				
Secure switchboard.				
Secure account numbers for phone lines.				
Obtain customer service representatives’ passwords for ACD and other systems so as to ensure that the receiver has full access and rights to any ACD system.				
Meet with insurer’s phone programmer—adjust outgoing phone message.				
Distribute prepared phone script, provider refusal forms, accord forms, etc.				
Train customer service reps on phone script, advising that all responses to inquiries are to be consistent with information on script.				
Increase the number of call sender staff to handle incoming calls, if necessary.				

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<b>Checklist 5—Customer Service</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Take advantage of large agent network, if applicable, to provide a mass email and physical mailing of key information to active agents.				
Determine need for bilingual reps.				
Determine need to maintain phone logs to determine types and number of calls, types of questions raised and need for additional types and updated scripted responses so that the information is current and meaningful.				
Obtain Department of Insurance complaint logs.				
Establish and monitor dedicated phone line.				
Review customer service representative's daily/hourly logs.				
Manage customer service representative's phone/time schedules.				
Monitor backlogs, or development thereof, and determine how to minimize/control.				
Modify instructions to night/weekend answering service as needed.				
<b><i>Web site</i></b>				
Provide copy of phone script to Webmaster for inclusion on Web sites.				
Provide Webmaster with other information to be posted on Web sites.				
Develop, post to the website and maintain Frequently Asked Questions (FAQs) for the public.				
Provide information to the possible electronic filing of proof of claim (Claim Net), as appropriate.				
Monitor/distribute for response any consumer inquiries received via Web site.				

Chapter 1 – Takeover & Administration

Checklist 6—Underwriting	Project Assigned To	Date Completed	Completed By	Notes
<i>Overview</i>				
Meet with underwriting manager (and/or other appropriate personnel) to discuss the insurer’s procedures, management/ supervisors and their responsibilities, staffing and duties required as a result of the order.				
Interview the underwriting manager (and/or other personnel as appropriate) to discuss the insurer’s underwriting function and operation to determine the progression of documents through the department. Document same.				
Obtain copies of departmental procedures, underwriting, code and rate manuals.				
Determine whether the insurer used an off-site storage facility and coordinate with other team members to ensure that any off-site records are inventoried and accounted for.				
Determine the underwriting department’s filing system, noting: <ul style="list-style-type: none"> <li>▪ Locations of files and documents</li> <li>▪ Filing method (e.g., alphabetical, numerical, terminal digit, etc.)</li> <li>▪ Possible segregation by line of business</li> <li>▪ Who has access to files and file sign-out procedures – modify as appropriate</li> <li>▪ Whether files are copied to electronic media</li> </ul>				
<i>Insurance</i>				
Locate, obtain copies and review all insurance policies and contracts: <ul style="list-style-type: none"> <li>• General Liability</li> <li>▪ Property</li> <li>▪ Auto</li> <li>▪ Workers’ Compensation</li> <li>▪ Fidelity Bond</li> <li>▪ Directors and Officers</li> <li>▪ Large Deductible Endorsements</li> </ul>				

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<b>Checklist 6—Underwriting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<ul style="list-style-type: none"> <li>▪ Errors and Omissions</li> <li>▪ Professional Liability</li> </ul>				
Determine that insurance coverage is adequate or modify as appropriate for property lines.				
Check on status of pending claims filed against the insurer.				
Obtain payment status on all coverage.				
Renew coverage as necessary.				
<b><i>Gathering Documentation</i></b>				
Determine location of all underwriting records – secure and inventory. This should include: <ul style="list-style-type: none"> <li>▪ Blank policies, binders and/or applications</li> <li>▪ Pending policies, endorsements and applications</li> <li>▪ Underwriting procedure manuals</li> <li>▪ Issued policies and associated underwriting files</li> <li>▪ Specimen copy of each type of insurance contract written by the insurer, including all endorsements, side letter agreements and other forms that may have been used with each policy; document any unique or special forms, exclusions, etc.</li> </ul>				
Determine types and lines of business written by the insurer. Obtain a listing, by state and policy line, detailing the following information: <ul style="list-style-type: none"> <li>▪ Valuation of policies</li> <li>▪ Number of policies in-force</li> <li>▪ Annual premium volume</li> <li>▪ Reserves</li> <li>▪ Unearned premium</li> <li>▪ Audit Premiums</li> </ul>				
As you become aware, document any limited or unusual exposures that do not appear on the insurer's policy registers.				

Checklist 6—Underwriting	Project Assigned To	Date Completed	Completed By	Notes
Obtain a listing of in-force policies, as of date of liquidation, which should include (and be able to sort by): <ul style="list-style-type: none"> <li>▪ Policy or certificate number</li> <li>▪ Insured name</li> <li>▪ Type of coverage</li> <li>▪ Effective and expiration date</li> <li>▪ Cancellation date if applicable</li> <li>▪ In-force and written premium</li> <li>▪ Premium frequency</li> <li>▪ Paid premium</li> <li>▪ Premium paid thru date</li> <li>▪ Unearned premium</li> <li>▪ Resident state</li> <li>▪ Audit premiums</li> <li>▪ Collateral postings</li> <li>▪ Indemnification agreements</li> </ul>				
Obtain group table that lists premium history.				
Obtain expired/cancelled policy listing by policy number.				
Obtain expired/cancelled policy listing by policyholder.				
Review the insurer’s underwriting interface with the insurer’s computer systems: <ul style="list-style-type: none"> <li>▪ Is the rate/quote system separate from the Policy Mgmt system, or combined? (e.g.: Generate and WINS)</li> <li>▪ What are they? How long have they been in place?</li> <li>▪ If separate systems, determine if there is an electronic interface.                             <ul style="list-style-type: none"> <li>○ How often is it run?</li> <li>○ Are they immediate or batch process systems?</li> <li>○ If batch, when is it run and by whom?</li> <li>○ What are the backup strategies?</li> </ul> </li> <li>▪ Are they under maintenance or license agreement contracts currently?</li> </ul>				

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<b>Checklist 6—Underwriting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Compile an all-time policy report which includes limits information.				
Document whether home office copies of declaration pages are maintained by the insurer.				
Determine the existence of surplus lines policies. Determine whether surplus lines are identifiable by: <ul style="list-style-type: none"> <li>▪ Code number</li> <li>▪ State code</li> <li>▪ Policy number</li> <li>▪ Other marking</li> </ul> Request a computerized listing of surplus lines policies if available.				
<b><i>HMO/Health Insurer</i></b>				
Obtain copies of all health plans.				
Obtain databases for each of the following: <ul style="list-style-type: none"> <li>▪ All subscribers, listing name, address, subscriber number, enrollment date, and group name and number</li> <li>▪ Dependents, including their age, enrollment date and subscriber number</li> <li>▪ All COBRA subscribers</li> <li>▪ All conversion subscribers</li> <li>▪ All Medicare/Medicaid subscribers</li> <li>▪ All subscribers of downstream provider groups, if available</li> </ul>				
<b><i>Binding Application and Non-Renewals</i></b>				
Determine and secure insurer's method for binding policies.				
If writing of new business has been prohibited, determine which pending applications are binding. Return all other applications along with an approved form letter.				
Work with Legal to compose a letter to be used in the non-renewal notification process, if renewals have been prohibited.				



Chapter 1 – Takeover & Administration

Checklist 6—Underwriting	Project Assigned To	Date Completed	Completed By	Notes
<b><i>Status of Work</i></b>				
Obtain all pending and/or in-process work from the underwriting department and determine its nature and volume.				
Determine which work may be completed and processed, and establish priorities.				
Utilize the telephone script of responses to common questions regarding the receivership that may be asked by policyholders, producers and claimants.				
<b><i>Producers of the Insurer</i></b>				
Obtain a list of all producers who did business with the insurer. The list should contain names, addresses, phone numbers and insurer identification number. If possible, the list should also identify type of producer (agent, broker, general agent, etc.).				
Obtain copies of all producer, TPA and general agent agreements. Distribute copies to other takeover team members as requested.				
Determine ownership of policy renewals.				
Be sure Accounting has a copy of the producer’s accounts receivable open balances.				
<b><i>Loss Experience</i></b>				
As necessary, coordinate with other departments to obtain and review copies of the following: <ul style="list-style-type: none"> <li>▪ Loss experience reports for the past 3 to 5 years (if premium detail isn’t included on reports, obtain premium reports for corresponding periods)</li> <li>▪ Actuarial reports (including year-end actuarial reports)</li> <li>▪ Underwriting composite experience reports</li> <li>▪ Premium and loss analysis reports</li> </ul>				

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<b>Checklist 6—Underwriting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>Large Deductible Policies</i></b>				
Review underwriting, billing and collateral records to determine which policies have large deductible endorsements and the status of collateral held, billings, and reserve calculations				
Arrange for continued reporting of loss experience to insureds/producers as appropriate.				
<b><i>Premium Finance Companies</i></b>				
Obtain an address listing and database of premium finance companies.				
Determine if premium finance information is available on a policy-level basis electronically or manually.				
Determine whether there is an in-house, affiliate or subsidiary finance company. If so, document all aspects of the finance company.				
<b><i>Policies and Premium</i></b>				
Review policy files to determine whether they appear to be complete. <ul style="list-style-type: none"> <li>▪ Determine if it is the insurer's policy that some documents are retained by producers.</li> <li>▪ Determine if lack of completeness is relevant to the current situation.</li> <li>▪ If missing contents are available, but have not yet been placed in files or are in another department, designate a company employee to coordinate retrieval and drop filing of the documents.</li> </ul>				
Capture all records pertaining to certificate holders, subscribers, etc.				
Verify that all UDS return premium data and optional data can be obtained from the insurer's records.				
Assist in the composition and/or approval of any notices to be sent				

<b>Checklist 6—Underwriting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
to policy and certificate holders regarding the receivership.				
Monitor premium receipts to ensure correct application to producer accounts and policies.				
Coordinate with appropriate guaranty associations to provide copies of policy forms.				
Determine if the department has a work backlog, and if so: <ul style="list-style-type: none"> <li>▪ Determine the extent of the backlog</li> <li>▪ Determine the volume of work involved</li> <li>▪ Determine what work needs to be completed and processed</li> <li>▪ Develop production goals for elimination of the backlog</li> <li>▪ Begin processing work</li> <li>▪ Provide periodic status updates of processing progress</li> </ul>				
<b><i>Premium Auditing and Retrospective Rating</i></b>				
Review billing records to determine which policies require premium audits or are retrospectively rated.				
Determine whether the insurer performs its own premium audits or if an audit service provides this function. Determine the following: <ul style="list-style-type: none"> <li>▪ If audits are handled by mail or electronically</li> <li>▪ If the insureds' records are examined on-site</li> <li>▪ How often policies are audited or retrospectively rated</li> <li>▪ If audit procedures are sufficient and cost effective</li> <li>▪ Whether alternative audit procedures need to be established</li> </ul>				
<b><i>Producer Notifications and Commissions</i></b>				
Create an appropriate form letter notifying producers of the following: <ul style="list-style-type: none"> <li>▪ The insurer's state of receivership</li> <li>▪ Revocation of binding authority</li> <li>▪ Subsequent procedures to be followed, including procedures for remitting premiums</li> </ul>				

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<b>Checklist 6—Underwriting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Prepare a list of commissions due from producers and notify producers accordingly.				
<b><i>Certificate of Authority</i></b>				
Obtain a list of states in which a Certificate of Authority has been approved and verify what lines of business the insurer is authorized to write in each state.				
Determine whether the insurer is complying with other state insurance department's C&Ds, or actions taken by foreign departments.				
Contact DOIs to advise of status of rehabilitation, and request suspension rather than revocation of Certificate of Authority.				
If in liquidation, obtain the original Certificates of Authority, coordinating with Legal as necessary.				
Determine if any business, other than surplus lines, is being written in states where the insurer is not an authorized insurer.				
<b><i>Underwriting Records</i></b>				
Determine if files at branches or outside facilities need to be returned or sent to other locations.				
Complete ID of all underwriting files.				

Chapter 1 – Takeover & Administration

Checklist 7—Information Systems	Project Assigned To	Date Completed	Completed By	Notes
<i>Overview and Assessment</i>				
Meet with the insurer’s IT Manager (and/or other appropriate personnel) to discuss department procedures, managers/supervisors and their responsibilities, staffing, and what will be required from their department’s staff as a result of the order and any dependence on outside third parties/consultants.				
Coordinating with Human Resources, obtain or create an organizational chart of the IT Department and review staffing requirements.				
Obtain operating procedures, IT hours of operation and schedule for various activities, including processing and back-up operations.				
Identify and meet with key IT staff.				
Back up files upon arrival (1 <sup>st</sup> day) and all subsequent key dates: i.e., month-end, quarter-end, year-end, conservation, rehabilitation and liquidation.				
Obtain administrator rights: <ul style="list-style-type: none"> <li>▪ Servers</li> <li>▪ Devices</li> <li>▪ Network</li> <li>▪ Applications</li> </ul>				
Provide receiver on-site access to all applications where possible.				
Obtain passwords and change/modify as appropriate: <ul style="list-style-type: none"> <li>▪ Administration rights</li> <li>▪ User passwords</li> </ul>				
Obtain and secure physical access to the insurer’s computer facilities and change/modify security as appropriate.				
Secure data communications, including Internet.				
Secure e-mail.				
Shut down all remote access to systems (1 <sup>st</sup> day), if appropriate.				

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<b>Checklist 7—Information Systems</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Obtain hardware/software license agreements.				
Identify operating system environments.				
Obtain network/computer diagrams.				
Obtain and/or create a systems flow overview and narrative of the insurer's major systems. (Each line of business may be processed differently. One line of business may be processed on a mainframe and another on a PC. Depending on the line of business, different factions (e.g., agents, brokers) may be responsible for various functions. All processes may not be centralized.				
Review system status, reports, internal audits and steering committee minutes.				
Determine whether the insurer hires an outside service for computer processing, and if so, document the applications.				
<b><i>System Security and Control</i></b>				
Document backup procedures for mainframe, LAN, servers, PCs and laptops. <ul style="list-style-type: none"> <li>▪ Verify or establish routine backup procedures</li> <li>▪ Obtain or create backup schedules to be followed</li> <li>▪ Document the storage location and creation date of the last full backup</li> <li>▪ Request a full backup of the insurer's system and send off-site for holding</li> <li>▪ Establish a backup file rotation</li> </ul>				
Obtain most recent backups and assure completeness: <ul style="list-style-type: none"> <li>▪ Operating systems/utilities</li> <li>▪ Application systems</li> <li>▪ <u>All</u> data</li> <li>▪ E-mail</li> <li>▪ Complete backups (not incremental)</li> </ul>				

Chapter 1 – Takeover & Administration

Checklist 7—Information Systems	Project Assigned To	Date Completed	Completed By	Notes
Establish control of the backup file rotation through the following steps: <ul style="list-style-type: none"> <li>▪ Instruct the insurer’s mainframe, LAN, servers, PC and laptop operators to send the following backups to the designated location:</li> <li>▪ Initial backup (1<sup>st</sup> day)</li> <li>▪ Date of liquidation</li> <li>▪ Last day backup (Final)</li> <li>▪ Conversion tapes</li> </ul>				
Analyze backups and verify for completeness and ability to restore: <ul style="list-style-type: none"> <li>▪ Media</li> <li>▪ Formats</li> <li>▪ Backup program versions</li> </ul> Anticipate restore issues and set plan.				
Obtain information concerning the insurer’s disaster recovery plan. Evaluate and modify as appropriate.				
Determine processing locations: <ul style="list-style-type: none"> <li>▪ On site</li> <li>▪ Off site</li> <li>▪ Affiliates providing servicing</li> <li>▪ Third parties providing servicing</li> </ul>				
Obtain information concerning the insurer's off-site storage of computer backup files, including: <ul style="list-style-type: none"> <li>▪ Vendor name, address and phone number</li> <li>▪ Contact person at the location</li> <li>▪ The quantity and content stored</li> </ul>				
Ensure that the authorization signatures for access at off-site storage facilities are changed.				
Review ISP/Web domain services.				
Coordinating with Webmaster, determine and effectuate any modifications that need to be made to the Web site, including posting of the court order.				

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<b>Checklist 7—Information Systems</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Obtain hardware and software maintenance agreements for computer equipment. Review to determine continuation or modification as appropriate.				
Obtain copies of all outstanding purchase orders for computer hardware, software, supplies and services.				
Inventory equipment, including the insurer's mainframe, LAN, servers, PC and laptop equipment. Ensure that the following information is available: <ul style="list-style-type: none"> <li>▪ Type of equipment</li> <li>▪ Make, model, serial number</li> <li>▪ Person and department assigned</li> <li>▪ Workstation address, controller, jack or port identification number</li> <li>▪ System connected</li> <li>▪ Lease or owned</li> <li>▪ Cost of equipment (if known)</li> <li>▪ Purchase date (if known)</li> </ul>				
Verify and document ownership of computer equipment: <ul style="list-style-type: none"> <li>▪ For equipment owned by the insurer, obtain a copy of the invoice, draft or check purchasing item</li> <li>▪ For leased equipment, obtain a copy of the lease</li> </ul>				
Identify and obtain list of all users (including equipment that may be off-site), including: <ul style="list-style-type: none"> <li>▪ System utilized—mainframe, LAN, servers, PCs, laptops and Blackberries</li> <li>▪ Department name, user name, address and phone number</li> <li>▪ Service provided and reports produced</li> </ul>				
Identify current use of outside computer consultants, vendors, service bureaus and other outside organizations: <ul style="list-style-type: none"> <li>▪ Service provided/expertise</li> <li>▪ Name/address/telephone numbers</li> <li>▪ Contact person</li> <li>▪ Current assignments, status and costs</li> </ul>				



<b>Checklist 7—Information Systems</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<ul style="list-style-type: none"> <li>▪ Determine contractual obligation, if any</li> <li>▪ Rate for services</li> <li>▪ Obtain copies of all outside service contracts and/or agreements</li> <li>▪ Determine unpaid amounts by vendor and dates of service or item delivery</li> <li>▪ Determine vendor items/services to be returned or canceled</li> <li>▪ Identify planned activities with vendor</li> <li>▪ Identify current active projects. Determine status and need for continuation</li> </ul>				
<p>Change vendor/supplier staff contacts as necessary.</p>				
<p>Verify with the insurer’s IT Manager whether invoiced services or items have been received and the necessity of the purchase of services or items to the departments past and continued operation.</p>				
<p>Review all current and ongoing IT expenses; determine any need for modifications and adjust as appropriate.</p>				
<p>Review fire protection equipment and procedure. Evaluate and modify as appropriate.</p>				
<p>Review power protection – UPS (uninterruptible power supply). Evaluate and modify as appropriate.</p>				
<p><b><i>Application/Data Security and Control</i></b></p>				
<p>Secure all original operating/application software. Obtain or create a list of all applications on the insurer’s various computer systems (mainframe, LAN, servers, PCs and laptops). Identify and describe each of the major applications found within each of the systems, noting:</p> <ul style="list-style-type: none"> <li>▪ Purpose of the application</li> <li>▪ Departments using application</li> <li>▪ What other applications it interacts with</li> <li>▪ Type of control it provides</li> </ul>				

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<b>Checklist 7—Information Systems</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<ul style="list-style-type: none"> <li>▪ Last rewrite date of application (noting by whom)</li> <li>▪ Application language</li> </ul>				
<p>Obtain and/or create file layouts for each application. (Tables that define code values may change over time. Find out when the codes were established and became effective, since the database may contain codes from a prior designation.):</p> <ul style="list-style-type: none"> <li>▪ Obtain and/or create definitions for all fields (note that documentation may not accurately reflect the actual use of a field, and the definition should be confirmed with IT personnel)</li> <li>▪ Obtain tables for required fields</li> <li>▪ Develop a list of files related to the application</li> </ul>				
Obtain copies of and secure all operating/application documentation (manuals, input/output forms, data dictionaries, reports, etc.)				
Develop and test data extract routines.				
Review/test systems and data integrity.				
<p>Review all reports and data available and determine those elements required to fulfill receivership requirements. Specifically, review the following:</p> <ul style="list-style-type: none"> <li>▪ Policy/contract information</li> <li>▪ Reinsurance information</li> <li>▪ Financial information</li> <li>▪ Need and ability to convert existing data into another computer system</li> </ul>				
<p>As to the insurer's IT projects, verify and complete information obtained:</p> <ul style="list-style-type: none"> <li>▪ Project title and description</li> <li>▪ Current priority level</li> <li>▪ Reason for project and impact if the project was stopped</li> <li>▪ Current schedule for completion</li> </ul>				

Checklist 7—Information Systems	Project Assigned To	Date Completed	Completed By	Notes
Obtain licensed software inventories: <ul style="list-style-type: none"> <li>▪ Identify and separate by mainframe, LAN, servers, PC and laptop.</li> <li>▪ Name and address of the developer</li> <li>▪ Release number (current)</li> <li>▪ Software ownership</li> <li>▪ Users’ rights and limitations purchase date (obtain copy of purchase order)</li> <li>▪ Lease (obtain copy of lease agreement)</li> <li>▪ Approximate cost</li> <li>▪ Application software is/was used on</li> </ul>				
<b><i>System Control and Processing</i></b>				
Evaluate continued use of in-house systems and evaluate alternatives: <ul style="list-style-type: none"> <li>▪ Servicing by outside sources, which might result in the sale of equipment and facilities</li> <li>▪ Termination of hardware leases</li> <li>▪ Termination of computer support</li> </ul>				
Identify and evaluate IT items to be sold or destroyed.				
Evaluate termination of computer hardware leases and arrange for physical removal of the equipment with vendor representative.				
Evaluate termination of vendor services and arrange with vendor representative for physical removal of any equipment and/or software.				
Determine whether to ship insurer-owned hardware to another location or sell.				
Provide regular processing and periodic reports of data.				
At appropriate time, obtain and pack all data processing records. Coordinate removal to appropriate location(s).				

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<b>Checklist 7—Information Systems</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<p>At appropriate time, arrange for orderly shutdown of the computer system, confirming:</p> <ul style="list-style-type: none"> <li>▪ All records are updated</li> <li>▪ Final reports are run</li> <li>▪ Data processing checklist documentation is complete</li> <li>▪ Full system backup has been performed and all files cleared on the system</li> <li>▪ System is powered down</li> </ul>				
<p>Review and identify files and related data that may be used to identify proofs of claim by block of business, verifying content of information necessary for the block of business.</p>				
<p>Provide the following information and procedures by block of business:</p> <ul style="list-style-type: none"> <li>▪ A listing of outstanding claims</li> <li>▪ A review of any problems that may exist as to reserve amounts</li> <li>▪ A review of how far back information is available on paid claims</li> </ul>				
<p>Provide the following information by block of business:</p> <ul style="list-style-type: none"> <li>▪ A listing of in-force policies by state (totals by state and as a whole) and by line of business</li> <li>▪ A review of how far back information is available on policies</li> <li>▪ A review of any problems that may exist</li> </ul>				

Chapter 1 – Takeover & Administration

<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<i><b>Control of Bank Accounts</b></i>				
Complete a Bank Signature Authorization List in advance of takeover.				
Obtain new authorized signature specimens on an exhibit for distribution to financial institutions, investment custodians, etc.				
Prepare a bank notification letter. Be sure letters include: <ul style="list-style-type: none"> <li>▪ Copy of receivership order</li> <li>▪ Request for a cut-off statement at the effective date of the order</li> <li>▪ Instructions to clear or return outstanding checks/drafts</li> <li>▪ Instructions for wire transfers, authorization procedures and authorized individuals</li> <li>▪ Request to terminate Internet access to accounts until instructed otherwise</li> <li>▪ Notification of authorized persons on the account including signatures of same</li>   <li>▪ Request for a listing of all accounts in the company's name (perhaps affiliates also)</li> <li>▪ Request to identify any liens on accounts</li> <li>▪ Request for a listing of any safe deposit boxes and authorized signers</li> <li>▪ Request that copies of monthly statements be forwarded to designated team member</li> </ul>				
<i><b>Insurance Background Information</b></i>				
Obtain or prepare an organizational chart, job descriptions and employees responsible for various tasks or areas.				
If a procedure manual is available for all accounting functions, obtain, review and discuss any issues with management.				
Document the flow of accounting transactions including decision points, authorizations and controls.				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Utilize above information to evaluate: <ul style="list-style-type: none"> <li>▪ Procedures</li> <li>▪ Controls</li> <li>▪ Staff requirements</li> <li>▪ Current personnel</li> </ul>				
<b><i>Establish Control of Bank Accounts</i></b>				
Compare preliminary list of financial institutions holding the insurer's cash, investments, and other assets obtained during pre-takeover phase to information provided by management and in insurer records. (The insurer's annual statement (Schedule N) will contain a listing of their open deposits.)				
Serve all banks with a certified copy of the receivership order, proof of service, and bank letter.				
Obtain proof of service of court orders on senior bank official(s).				
Remove all insurer officials' names from signatory authority with any financial institution.				
Continue contact and follow-up with all financial institutions and investment custodians regarding new procedures, authorizations and checks outstanding at takeover date.				
<b><i>Operating Bank Accounts</i></b>				
List all bank accounts, including current balances.				
List all funds held, letters of credit (LOC), collateral, and trust and depository accounts with current balances and maturity dates.				
Obtain a listing of funds held by or deposited with ceding companies by insurer. Confirm these amounts and review calculations for amounts. This should include any posted LOCs. Determine and prepare schedule identifying type of LOC and expiration dates.				
Review current bank reconciliation and determine accuracy.				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Obtain cut-off statements for all accounts.				
Reconcile all bank accounts to cut-off statements, noting long outstanding reconciling items and any need for further investigation.				
Determine process for monitoring available cash and overnight investing.				
Obtain a schedule of cash utilization for the past six months.				
Prepare cash requirement projections.				
Determine available cash and liquid assets. Compare to cash requirement projections and determine length of time cash will be available to fund the operations of the insurer, particularly the payment of workers' compensation indemnity, health insurance, disability and long-term care.				
Establish cash monitoring process.				
Consider any need to open new accounts and transfer funds.				
Review all corporate bank resolutions.				
<b><i>General Ledger (G/L) Cut-Off and Accounting Records</i></b>				
Obtain most current trial balance.				
Obtain chart of accounts and descriptions of any accounts that are not self-explanatory.				
Document the insurer's G/L closing procedures and obtain a cut-off G/L as of the takeover date. Identify the last closed accounting period.				
Determine if all G/L accounts have been reconciled to subsidiary ledgers, listings or computer runs for the most current month end.				
List all documents required in the above processes.				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Obtain any other support reports/schedules/trial balances for the cut-off G/L to complete reconciliations.				
<p>Determine location of all accounting records—secure and inventory. This should include:</p> <ul style="list-style-type: none"> <li>▪ General ledgers, trial balances and other month-end reports</li> <li>▪ Financial statement support work papers – for monthly, quarterly and annual financials</li> <li>▪ Bank statements, check registers, reconciliations and cancelled checks</li> <li>▪ Short-term investment/treasury files</li> <li>▪ Investment statements and reconciliations</li> <li>▪ Support for other investments – real estate, mortgages receivable, etc.</li> <li>▪ Support for premium, reinsurance and agents receivables</li> <li>▪ Support for fixed and other assets</li> <li>▪ Accounts payable and vendor files, including service and supply contracts</li> <li>▪ Support files and runs for claim and other liabilities</li> <li>▪ Debt/notes payable files</li> <li>▪ Lease files</li> <li>▪ Insurance files</li> <li>▪ Correspondence with CPA</li> </ul>				
Utilizing cut-off G/L and related trial balance and detailed transaction listing(s), investigate and document insurer assets as indicated in following sections.				
Have staff begin reconciling all accounts to detail and cut-off statements as of the takeover date.				
Monitor and review all work to determine if any additional investigation or action is required as a result of reconciliations.				



Chapter 1 – Takeover & Administration

<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Inventory and secure any original documents found in the above files such as mortgage notes, stock certificates, or notes (payable or receivable).				
If originals of such assets and liabilities are not in above files, locate, inventory and secure.				
Determine location of corporate documents such as corporate seal, minute books, stock registers, stock certificates, articles of incorporation and by-laws. Inventory and secure.				
Determine need to secure or obtain any of the above items and information for any affiliates of the insurer.				
Establish a secure room/space for accounting records.				
<b><i>Petty Cash</i></b>				
Determine if a petty cash fund exists (which may include such items as postage stamps, etc.), who has control of fund and procedures for disbursement, replenishment and reconciliation.				
If petty cash fund exists, secure, count and inventory contents and establish receiver controls and disbursement.				
<b><i>Establish Cash Receipt Procedures</i></b>				
Document receipt procedures from receipts and deposits to the recording of receipts.				
Determine the physical location of cash receipts – any lock boxes, mail room, post office boxes, agents, etc. Secure and change authorizations for access as necessary. Counsel may need to be consulted to secure and change authorization for post office boxes not in the insurer’s name that receive insurer’s cash.				
Determine if any receipts are not to be accepted – e.g., renewal premium, rent receipts, etc.				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Establish any new procedures as appropriate to maintain security, to include that all incoming checks are logged and given to Accounting for recording and deposit.				
Provide notice of the order and appropriate collection procedures to any third party that had been authorized to accept cash on behalf of the insurer.				
Review the flow of all cash receipts and disbursements, and modify as appropriate.				
<b><i>Secure Miscellaneous Items</i></b>				
Determine if there are any corporate credit/phone cards outstanding; collect/cancel/secure as appropriate.				
Determine necessity to secure blank letterhead, blank purchase order stock, blank stock certificates; blank invoice stock, billing forms, etc.				
<b><i>Control Check Stock and Establish Disbursement Procedures</i></b>				
Secure and establish cash disbursement procedures, including: <ul style="list-style-type: none"> <li>▪ Control of check stock</li> <li>▪ Authorization for disbursements</li> <li>▪ Check signing authority</li> </ul>				
Locate, secure and inventory all check and draft stock (including payroll).				
Document current disbursement procedures, including flow of information and physical check movement from origination to mailing.				
Establish a control log for all unused check and draft stock on each bank account. Determine who has access to and is authorized to issue check stock and at what quantities – modify as necessary.				
Ensure segregation of duties with regard to control of check stock and check signing equipment.				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Secure check imprinting machines, signature stamps, plates and signature machines. Disable electronic and digital signatures. (May also be offsite at payroll service, etc.)				
Review and restrict signature authority.				
Make effort to identify and hold any checks in the mailroom on day of takeover.				
Determine disposition of checks issued prior to order date.				
Review wire transfer procedures and modify as appropriate.				
Identify and cancel bank accounts handled by third parties, as appropriate.				
Obtain a schedule of all recurring disbursements including payee, frequency of payment and approximate amounts of payments. This should include items such as daily claim payments, payroll, lease payments (equipment, office, storage, etc.), supply acquisitions, insurance coverage payments, service/maintenance agreement payments, memberships and dues, etc.				
Obtain contracts for vendors on above schedule to determine potential needed actions or modifications/cancellations of any contracts.				
Determine if insurer handles payroll internally.				
If appropriate, switch to payroll service.				
Contact payroll service to set up year-end W-2 procedures.				
If multiple entities exist, determine the entity that employs personnel and what entity will fund payroll.				
Determine whether there are any safes on premises and conduct a physical inspection and inventory of contents. The safe should be re-keyed, if deemed necessary.				

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Checklist 8—Accounting	Project Assigned To	Date Completed	Completed By	Notes
Identify and secure any investments, securities, or cash kept on premises.				
Confiscate keys and change safe deposit box access privileges with the appropriate institutions.				
Identify, analyze and secure control of other liquid assets.				
<b>Securities</b>				
Identify letters of credit, trust agreements and other collateral held to secure obligations of policyholders under large deductible endorsements, and review and/or establish procedures for reviewing the adequacy of such collateral.				
Determine and list investments by type and reconcile to schedule D: <ul style="list-style-type: none"> <li>▪ Bonds               <ul style="list-style-type: none"> <li>○ Municipal</li> <li>○ Corporate</li> </ul> </li> <li>▪ U.S. government obligations</li> <li>▪ T-Bills</li> <li>▪ Strips</li> <li>▪ Notes</li> <li>▪ Agency obligations</li> <li>▪ Stocks               <ul style="list-style-type: none"> <li>○ Common</li> <li>○ Preferred</li> </ul> </li> <li>▪ Repurchase agreements</li> <li>▪ Advance Agreements</li> <li>▪ Funding Agreements</li> <li>▪ Cash balance if not above</li> <li>▪ Partnership agreements</li> <li>▪ Stock options/warrants</li> <li>▪ Collateral loans</li> <li>▪ Other</li> </ul>				
Identify assets that are held as collateral, outstanding advances or otherwise restricted and the circumstances that could initiate calls on such assets.				

Chapter 1 – Takeover & Administration

<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Continue contact and follow up with all custodians (and FHLBank, if applicable) regarding new transaction procedures and authorizations.				
Obtain cut-off statements for all custodial accounts.				
Reconcile all investment accounts to cut-off statements, noting any unusual items for further investigation.				
Obtain current market values for all invested assets.				
Establish procedures for monitoring status of current investments and procedures for investing maturities and new funds that will comply with maturity requirements for cash flow needs.				
Establish a protocol with FHLBank, if insurer is a member, to coordinate all activities relating to applicable Advance or Funding Agreement(s).				
Notify paying agents on registered bonds to forward future checks to receiver.				
Obtain a list of securities held for statutory deposit/state deposits; confirm with applicable states.				
Determine type and amounts of all statutory deposits, special or general.				
<b><i>Review of Insurer's Internal Controls</i></b>				
Obtain and review any internal control reports prepared during the previous year by a public accounting firm.				
Obtain and review any documentation related to the insurer's recent internal audits (e.g., internal audit reports, work papers, etc.).				
Note any reported significant weaknesses in any of the above reports. Determine if corrective procedures were implemented.				
Implement any additional changes in procedures as necessary.				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>Review Of Audit Work papers</i></b>				
Meet with outside auditors to discuss recent audit(s), issues and problems.				
Obtain copies of all work papers, including correspondence, permanent files and memos. Review files for: <ul style="list-style-type: none"> <li>▪ Corporate documents</li> <li>▪ Analyses and memos on significant transactions</li> <li>▪ Agreements</li> <li>▪ Memos to management and internal firm memoranda that might indicate issues</li> <li>▪ Work papers for issues and unresolved items</li> </ul>				
<b><i>Receivables</i></b>				
Review large deductible billing procedures to determine that all amounts are billed timely. Determine that there are no outstanding items for billing and obtain an aging of outstanding receivables.				
Identify, review and evaluate: <ul style="list-style-type: none"> <li>▪ Trade receivables, especially premiums</li> <li>▪ Mortgage loans and other promissory notes               <ul style="list-style-type: none"> <li>○ Identification, location, terms, and amounts</li> <li>○ Notification to appropriate parties</li> </ul> </li> <li>▪ Valuation of asset; escrow funds</li> <li>▪ Interest receivables</li> <li>▪ All MGAs, brokers and agents</li> <li>▪ Letters of credit</li> <li>▪ Notes receivable</li> <li>▪ Lease funds receivable</li> <li>▪ Royalties</li> <li>▪ Reinsurance receivables</li> <li>▪ Receivables from parents, subsidiaries and affiliates</li> <li>▪ Other receivables</li> <li>▪ Dividends</li> <li>▪ Bonds receivable</li> <li>▪ Premiums and agents' balances receivable</li> </ul>				

<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Determine if there are any unsettled balances from affiliates or subsidiaries, how long they have been outstanding, and collectability.				
Determine the transactions that gave rise to the outstanding balances and determine appropriateness of the transactions and amounts.				
Obtain all agreements between insurer and affiliates that give rise to inter-insurer receivables/payables – review and determine appropriateness.				
Review reinsurance recoverables billing procedures to determine that all amounts are billed timely. Determine that there are no outstanding items for billing, and obtain an aging of outstanding receivables.				
If applicable, establish procedures for billing of allowed claims if in liquidation.				
Evaluate premiums and agents' balances receivable: <ul style="list-style-type: none"> <li>▪ Identify all managing general agents, brokers, agents</li> <li>▪ Perform any needed audits</li> <li>▪ Review all fiduciary accounts, deposits with brokers and agents</li> <li>▪ Analyze setoff and net settlements</li> <li>▪ Evaluate return premiums</li> <li>▪ Evaluate assumed reinsurance premium</li> </ul>				
Evaluate reinsurance transactions: <ul style="list-style-type: none"> <li>▪ Treaties and facultative certificates</li> <li>▪ Setoffs improperly taken</li> <li>▪ Ceded reinsurance premium payable</li> </ul>				
<b><i>Other Assets</i></b>				
Identify, review and evaluate the following: <ul style="list-style-type: none"> <li>▪ All funds held by others</li> <li>▪ Deposits</li> </ul>				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<ul style="list-style-type: none"> <li>▪ Prepaid deposits</li> <li>▪ Prepaid taxes</li> <li>▪ IRS taxes</li> <li>▪ State taxes</li> <li>▪ Local taxes</li> <li>▪ Unearned revenue</li> <li>▪ Prepaid insurance premiums</li> <li>▪ Retainers for professional services</li> </ul>				
<p>Obtain listings of all retainers and advance deposits. Notice holders of the funds and recover as appropriate:</p> <ul style="list-style-type: none"> <li>▪ Valuation of assets resident in subsidiaries</li> <li>▪ Overall value of companies</li> <li>▪ Initial capitalization of subsidiaries; return of investment</li> </ul>				



Chapter 1 – Takeover & Administration

Checklist 8—Accounting	Project Assigned To	Date Completed	Completed By	Notes
<i>Liabilities and Other Claims</i>				
Identify, review and evaluate: <ul style="list-style-type: none"> <li>▪ Accounts payable</li> <li>▪ Notes payable</li> <li>▪ Loss and LAE</li> <li>▪ Funds held for others</li> <li>▪ Lease obligations</li> <li>▪ Mortgage obligations</li> <li>▪ Unearned proceeds</li> <li>▪ Inter-company payables</li> <li>▪ Reinsurance not ceded</li> <li>▪ Professional services</li> <li>▪ Audit/pre-receivership billings</li> <li>▪ Federal home Loan Bank Advance or Funding Agreements</li> <li>▪ Other</li> </ul>				
<i>Unclaimed Property Reports</i>				
Consult with insurer personnel to determine if unclaimed property reports have been filed with the respective states and if they are current.				
Secure most recently filed unclaimed property reports.				
Prepare listing of state reports required and due dates.				
Determine whether appropriate support is available to complete future unclaimed property reports. This includes outstanding checklists for all active and closed bank accounts and other information such as check issue date, payee address and type of expense.				
Determine if there are any separate accounts established strictly for unclaimed property purposes that eventually will be turned over to the states.				

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<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>Investigation</i></b>				
Review corporate and committee minutes of the insurer and its subsidiaries and summarize items of significance, noting: <ul style="list-style-type: none"> <li>▪ Financial decisions</li> <li>▪ Approved transactions and agreements</li> <li>▪ Resolutions</li> <li>▪ Related parties</li> </ul>				
Develop a list of the insurer's officers, directors, controlling shareholders and related parties.				
Obtain a listing of insurer employees, noting all family members and their positions within the insurer or its affiliates.				
Obtain an ownership analysis of the insurer from Legal.				
Document background information pertaining to subsidiaries, including: <ul style="list-style-type: none"> <li>▪ Business purpose</li> <li>▪ Relationship to the insurer</li> <li>▪ Directors and officers</li> <li>▪ Current financial status</li> <li>▪ Agreements/service arrangements between the companies</li> <li>▪ Shared offices, equipment, employees, etc.</li> </ul>				
<b><i>Accounting Records</i></b>				
Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken.				
Determine if files at branches or outside facilities need to be returned or sent to other locations.				
Complete ID of all accounting files.				

Chapter 1 – Takeover & Administration

<b>Checklist 8—Accounting</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<p>If required for state reporting or tax purposes, prepare current annual statement and/or quarterly statutory financial statements. Related work papers should be secured and reviewed so sheet items at date of liquidation can be properly updated for subsequent periods.</p>				

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<b>Checklist 9—Tax and Compliance</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>Income Taxes (Federal and State)</i></b>				
File federal, state and municipal returns at appropriate reporting dates (income tax, premium tax, information returns, etc.)				
<p>Meet with company personnel responsible for filing the corporate income tax returns and obtain background information. Determine the following:</p> <ul style="list-style-type: none"> <li>▪ If the returns have been filed on a consolidated basis with affiliated entities.</li> <li>▪ The filing form used (i.e., 1120, 1120L or 1120-PC).</li> <li>▪ If the company is current with its filings and tax payments (including current-year estimated tax payments if applicable).</li> <li>▪ Which state income tax returns were filed.</li> <li>▪ If there are any outstanding tax refunds or unused losses that can be utilized in the current period or carried back. If so, file appropriate return such as an amended return with net operating loss carryback claim.</li> <li>▪ If returns are consolidated, secure a copy of the current tax sharing / tax allocation agreement. Discuss with company personnel. Verify that the companies are adhering to the provisions of the agreement, including the settling of balances due.</li> </ul>				
Complete and mail the Power of Attorney, Form 2848, to the IRS within 15 days of receivership.				
File Form 56 (Notice Concerning Fiduciary Relationship) with the IRS. Enclose a certified Order of Conservation, Rehabilitation or Liquidation. Also, formally request a record of account from the IRS for at least the past three years for income and payroll taxes.				
Obtain and review copies of most recently filed federal and state income tax returns, including any returns necessary to review if net operating losses for those years are still available.				

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<b>Checklist 9—Tax and Compliance</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Determine and schedule the date of when the next returns are to be filed. If the deadline cannot be met, file the appropriate application for extension.				
Secure and review tax return work papers for last year filed. Work papers should include details of adjustments from book income to taxable income. Copy relevant documents as necessary.				
Meet with outside accounting firm and discuss company’s tax situation, if applicable. Request and review tax work papers for most recently filed return.				
Determine what sources are to be used for filing income tax returns.				
Obtain a copy of the following documents for the period up to the date of liquidation and the previous year-end: general ledger (including a listing of all posted entries within each account), trial balance, chart of accounts and financial statements. Review general ledger for unusual items or discrepancies. Obtain backup information and discuss with company personnel as necessary to get a better understanding of financial statement items.				
Obtain a copy of the last published annual statement and any subsequent quarterly financial statements filed.				
Consult with company personnel to determine if any IRS or state assessments have been made, liens filed or bank accounts levied. Assessments include penalties and interest for late filing or non-filing of income tax, payroll, and information returns and/or late payment or nonpayment of the related taxes. Request an abatement of penalties for reasonable cause if not already done so.				
Prepare a listing of government agencies (and their addresses) where income tax returns are filed so proofs of claims can be mailed.				

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Checklist 9—Tax and Compliance	Project Assigned To	Date Completed	Completed By	Notes
<b>Information Returns</b>				
Meet with company personnel to determine which information returns apply. Use the current year IRS packages, Instructions to Filers of Forms 1099/1096, 1098, 5498, W-2G, W-3, 940, and 946 or Instructions for Form 5500 as a guide.				
Prepare a listing of reports to be prepared and filing due dates. File an available application for extension of time to file the return(s), if necessary.				
Monitor preparation and/or file various information returns required by the IRS. Common information returns for insurance companies include Forms 1099-MISC/1096 (Miscellaneous Income), 1099-R/1096 (Distribution from Pensions, Annuities, IRAs, Insurance Contracts, etc.), 5498 (Individual Retirement Information), 1098 (Mortgage Interest Statement), 5500 (Annual Return/Report of Employee Benefit Plan), W-2/W-3, 940 and 941. Coordinate efforts with the payroll department regarding the 5500s.				
Secure copies of information returns and recent Form W-9s (Request for Taxpayer Identification Number and Certification). Review work papers or any related support and consult with company personnel and/or the third-party administrator, if applicable.				
Determine what data sources are needed to file 1099s. If sources are computerized, coordinate with the IT Department to extract these reports. Also work with IT to transmit 1099 information to IRS electronically or via magnetic media (required if 250 or more forms.)				
Determine whether all information needed to file returns is available. Obtain a list of names, addresses and phone numbers of vendors. If taxpayer identification numbers are not on hand, request such via mailing of Form W-9 to the appropriate parties (or obtain via phone, fax or e-mail). Use company personnel if available.				

<b>Checklist 9—Tax and Compliance</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>State Premium, State Franchise and Municipal Taxes</i></b>				
Determine if the company is current with its state and local premium tax return filings, including those required for interim periods and state franchise returns. Secure documents noting any estimated tax payments made during current tax year or prior year.				
Determine whether there were any premium tax overpayments that have not yet been received. Also, determine if there are any unused credits available for the current period.				
Extract statistical reports to be used for filing state premium and municipal taxes before closing down on-site operations.				
Prepare and file premium or municipal tax returns as required. Use company personnel if available. <ul style="list-style-type: none"> <li>▪ Advise entities that returns are final, if appropriate</li> <li>▪ Enclose a copy of the liquidation, rehabilitation or conservation order</li> <li>▪ For companies in liquidation, where taxes are due, obtain a Proof of Claim form and enclose with return</li> </ul>				
<b><i>Companies in Conservation or Rehabilitation</i></b>				
In cases when receiver is unable to file certain reports or it is deemed too costly to prepare, advise state of such. Request a waiver of filing requirement and/or any related penalties for non-compliance.				
<b><i>Tax and Compliance Records</i></b>				
Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken.				
Determine if files at branches or outside facilities need to be returned or sent to other locations.				
Complete ID of all tax and compliance files.				

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<b>Checklist 10—Claims</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>Overview</i></b>				
Inform insurer personnel of new procedures for handling claims: if claims continue to be paid, if a moratorium was issued regarding the payment of claims (if claims will continue to be paid, note specific dollar limits), or if the insurer is in liquidation and claims need to be coordinated with guaranty associations.				
Meet with claims manager (or appropriate personnel) to discuss the insurer's policies and procedures, managers/supervisors and their responsibilities, staffing and duties required as result of order. Document same.				
Conduct interviews of claims department personnel to determine policies and claims processing procedures and to evaluate staff. Document same.				
Determine whether any special technical knowledge is required for claims arising from the insurer's line of business.				
Document the claim department's check/draft signature procedures. Coordinating with accounting, determine if new check/draft request procedures need to be established. Assist in the implementation of controls as necessary.				
Coordinating with Accounting, secure any non-negotiated check/draft stock located in the insurer's claims department.				
Coordinating with Accounting, obtain a listing of outstanding checks/drafts. If the check/draft will not be honored, the claim file listing must be updated to reflect the open status.				
Obtain management reports, analyses, or other supporting memos regarding claims/underwriting matters.				
<b><i>Claims Records</i></b>				
Determine location of all claims records.				
Secure all claim manuals.				



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Checklist 10—Claims	Project Assigned To	Date Completed	Completed By	Notes
Obtain claim register.				
Obtain list of current litigation related to claims, including: <ul style="list-style-type: none"> <li>▪ Bad-faith actions</li> <li>▪ Excess exposures of the insurer</li> <li>▪ Errors and omission claims against insurer personnel</li> </ul>				
Obtain list of: <ul style="list-style-type: none"> <li>▪ Defense counsel name and address</li> <li>▪ All subrogation attorneys used by insurer</li> <li>▪ Outside adjusters used by insurer</li> <li>▪ Any independent appraisal firms used by insurer</li> </ul>				
Obtain list of: <ul style="list-style-type: none"> <li>▪ Claims handled by outside adjusters</li> <li>▪ Open claims reserve report by claim number</li> <li>▪ Open claims reserve report by insured</li> <li>▪ Open claims report by residential state of the insured, so that information can be made available to appropriate guaranty associations. Update on daily basis to reflect new loss reports</li> </ul>				
Obtain an address listing and database of all premium finance companies, licensed agents, brokers and reinsurance intermediaries and copies of servicing agreements with agents/brokers.				
Obtain copies of all active indemnity agreements.				
Document the layout of claim files, noting the following: <ul style="list-style-type: none"> <li>▪ Claim numbering sequences/series</li> <li>▪ Filing procedures</li> <li>▪ Forms and form letters used by the insurer’s claims department</li> <li>▪ Other related reference material</li> </ul>				
Document claims department filing procedures.				

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<b>Checklist 10—Claims</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Identify, review and sort claim files into categories: <ul style="list-style-type: none"> <li>▪ OK for payment but the check/draft has not been issued</li> <li>▪ Open</li> <li>▪ Hardship</li> <li>▪ Lawsuit</li> <li>▪ Arbitration</li> <li>▪ Subrogation</li> <li>▪ Salvage</li> <li>▪ Closed</li> </ul>				
Obtain copies of all forms used by the claims department.				
Note any surety bonds and claims that arise from surety bonds.				
Determine claims backlogs and establish priorities, including: <ul style="list-style-type: none"> <li>▪ The set-up of new loss reports</li> <li>▪ Note the adjustor's average file counts on pending claims</li> <li>▪ Monthly opening and closing file counts</li> <li>▪ Review the adequacy of mail pulls, check/draft procedures, diary pulls, etc.</li> </ul>				
Monitor the setup of new claims.				
Designate team member(s) to review mail received to determine quantity of correspondence, attempt to spot problems, note patterns on established procedures, etc.				
Oversee filing of communications in claims files.				
Consult with the Department of Insurance regarding complaints filed with the Department.				
Obtain subrogation and salvage logs and/or diaries.				
Salvage & subrogation – determine whether a review of closed files is required to identify maximum recoveries.				
Initiate new procedures as to the receipt of a lawsuit, either: <ul style="list-style-type: none"> <li>▪ Arising from the policy defense of an insured, or</li> <li>▪ Direct actions against the insurer</li> </ul>				

Chapter 1 – Takeover & Administration

Checklist 10—Claims	Project Assigned To	Date Completed	Completed By	Notes
<b><i>Branches and Outside Facilities</i></b>				
Identify all branch offices and outside facilities at which claim files are housed.				
Determine approximate number of files housed at each facility and arrange for inventory to be taken.				
Determine if files need to be returned or sent to other locations.				
<b><i>HMO/Health Insurers</i></b>				
Obtain original or copies of all provider contracts.				
Obtain a listing and database of all medical providers that lists tax ID numbers and contract rates.				
Obtain a listing of disputed claims.				
Obtain a certificate of coverage table.				
Obtain a pay history table by subscriber/patient.				
<b><i>Proof of Claim</i></b>				
<p>Determine what parties are to receive Proof of Claim forms and obtain listings of last known address, including:</p> <ul style="list-style-type: none"> <li>▪ Guaranty associations</li> <li>▪ Ancillaries</li> <li>▪ Policyholders</li> <li>▪ Loss claimants</li> <li>▪ TPAs, MGAs, MGUs, Premium Finance Companies</li> <li>▪ Brokers/Agents</li> <li>▪ Intermediaries</li> <li>▪ General creditors</li> <li>▪ Employees</li> <li>▪ Vendors</li> <li>▪ Government entities</li> <li>▪ Shareholders</li> </ul>				

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<b>Checklist 10—Claims</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<i>Coordinate with P&amp;C Guaranty Associations</i>				
Prepare UDS worksheet or submission on all open and recently opened claims.				
Coordinate with NCIGF to transmit UDS information to guaranty associations.				
Inventory and forward loss files to the appropriate guaranty associations.				

<b>Checklist 11—Large Deductible Policies</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<p><i>Overview</i></p> <ul style="list-style-type: none"> <li>• Meet with Manager of Large Deductible Collections (and/or other appropriate personnel) to discuss large deductible Collection procedures, personnel and responsibilities, staffing and what will be required from staff as a result of the order</li> <li>• Conduct interviews of appropriate large deductible collection department personnel to determine policies and procedures. Document same.</li> <li>• Establish a large deductible recoverable balance as of the receivership date</li> </ul>				
<p><i>Gathering Documentation</i></p> <ul style="list-style-type: none"> <li>• Determine location of large deductible records – secure and inventory. This should include:</li> </ul>				

<ul style="list-style-type: none"> <li>• All policies containing large deductible endorsements</li> <li>• Claims files arising under such policies</li> <li>• Correspondence files</li> <li>• Billing records             <ul style="list-style-type: none"> <li>○ Letters of credit, trust agreements, deductible reimbursement policies or other collateral</li> </ul> </li> <li>• For all LOCs, trust accounts, funds withheld:             <ul style="list-style-type: none"> <li>○ Secure all originals</li> <li>○ Notify all banks and trustees of the order</li> </ul> </li> </ul>				
<p><b><i>Documenting Large Deductible Collection Procedures</i></b></p> <ul style="list-style-type: none"> <li>• Review recent billings for all large deductible policies</li> <li>• Obtain a list of large deductible payment history and determine whether insured payments have been ongoing or if payment from collateral has been required.</li> <li>• Obtain a list of paid and unpaid bills updated after liquidation</li> <li>• Obtain claim documentation for claims arising under large deductible policies             <ul style="list-style-type: none"> <li>○ By paid loss and loss reserves and ALAE paid and reserves</li> <li>○ List of claims in litigation/arbitration</li> </ul> </li> <li>• Review large deductible billing system; determine that all paid losses arising under large deductible policies have</li> </ul>				

<p>been billed.</p> <ul style="list-style-type: none"> <li>• Determine whether large deductible endorsements provide that losses within the deductible are limited in the aggregate</li> <li>• Evaluate recovery processes and determine if new procedures are appropriate</li> <li>• Determine whether collateral is held by affiliated/unaffiliated third party via large deductible reimbursement policy, trust agreement or other vehicle, and evaluate whether collateral can be transferred to the receivership</li> <li>• Document insured collection disputes</li> <li>• Determine which functional group handles disputes</li> <li>• Interview members of each group responsible for coordinating, monitoring and controlling large deductible collection disputes</li> <li>• Audit large deductible collection-specific systems. Track data from source to final product to verify billings are correct and inclusive and internal controls are adequate</li> </ul>				
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Chapter 1 – Takeover & Administration

Checklist 12—Reinsurance	Project Assigned To	Date Completed	Completed By	Notes
<b>Overview</b>				
Meet with the insurer’s reinsurance manager (and/or other appropriate personnel) to discuss the reinsurance procedures, managers/supervisors and their responsibilities, staffing and what will be required from their department’s staff as a result of the order.				
Conduct interviews of appropriate insurer reinsurance department personnel to determine policies and procedures. Document same.				
Create a chart of reinsurance coverage based on interviews with reinsurance personnel, schedule F (P&C) or schedule S (L&H), and documents obtained below. See Chapter 7 – Exhibits 1 & 2.				
Send copies of liquidation orders certified/registered mail to intermediaries (or reinsurers, if no intermediaries).				
Establish reinsurance recoverable balance as of receivership date.				
<b>Gathering Documentation</b>				
<p>Determine location of all reinsurance records – secure and inventory. This should include:</p> <ul style="list-style-type: none"> <li>▪ Reinsurance treaties, including all endorsements or amendments</li> <li>▪ Facultative certificates (may be in policy or claim files)</li> <li>▪ Placement slips</li> <li>▪ Correspondence files</li> <li>▪ Claim files (coordinate with claims)</li> <li>▪ Broker of record letters</li> <li>▪ Intermediary agreements and correspondence</li> <li>▪ Reinsurance accounting records, including computer runs and bordereaux (coordinate with Accounting)</li> <li>▪ Letters of credit or other collateral</li> <li>▪ Trust agreements</li> <li>▪ Commutation agreements</li> </ul>				

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Checklist 12—Reinsurance	Project Assigned To	Date Completed	Completed By	Notes
For all LOCs, trust accounts, funds withheld: <ul style="list-style-type: none"> <li>▪ Secure all originals</li> <li>▪ Notify all banks and trustees of the order</li> </ul>				
For all treaties and facultative contracts: <ul style="list-style-type: none"> <li>▪ Obtain/develop schematic (ceded, assumed, retroceded)</li> <li>▪ Determine and document the methodology of applying losses to treaties</li> <li>▪ Obtain security policy register for facultative policies assumed</li> <li>▪ Obtain samples of all pertinent documentation relative to reinsurance and underwriting operations, including, but not limited to, policy wording and endorsements.</li> </ul>				
Obtain inventory and backup of all reinsurance PC workstations and mainframe, including file descriptions (reinsurance information is often kept on stand-alone PCs within the department).				
Obtain copies of all system codes, lists, tables, etc., applicable to each system.				
<b><i>Documenting Reinsurance Procedures</i></b>				
Review the recent reinsurance billings for ceded and assumed reinsurance programs.				
Obtain a list of reinsurance claims and payment history.				
Obtain a list of paid and unpaid claims updated after liquidation.				
Obtain claim documentation: <ul style="list-style-type: none"> <li>▪ Bordereaux of paid and unpaid losses and LAE figures, reserves and premiums</li> <li>▪ List of claims in litigation/arbitration</li> <li>▪ Facultative registers</li> <li>▪ Claims handling procedures</li> </ul>				
Determine that all paid losses covered by reinsurance have been billed.				



<b>Checklist 12—Reinsurance</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Evaluate recovery processes and determine if new procedures are appropriate.				
Evaluate procedures for notifying reinsurers of claims liabilities and determine any need for new procedures.				
Determine appropriate action for continued relationships with TPAs, MGAs and intermediaries, including funds and/or LOCs held by any of these entities and records retained by them off-site.				
Document insurer reinsurance party disputes: <ul style="list-style-type: none"> <li>▪ Interview all department heads and determine which functional areas are responsible for litigation, arbitration, etc.</li> <li>▪ Interview members of each functional area responsible for coordinating, monitoring and controlling reinsurance disputes.</li> </ul>				
Determine if any reinsurance audits are ongoing, have been performed, or are currently scheduled, and obtain copies of reports and work papers.				
Evaluate reinsurance-related data currently produced and that data to be stored for future use.				
Audit reinsurance-specific systems. Track data from source to final product to verify billings are correct and inclusive.				
<b><i>Third-Party Dispute</i></b>				
Segregate third-party disputes into the following classifications: <ul style="list-style-type: none"> <li>▪ Reinsurance-specific issues</li> <li>▪ Declaratory judgment actions affecting reinsurance</li> </ul>				
Determine if there are any appeal bonds pending the appeal of a judgment for or against the insurer in connection with any issue that might impact reinsurance.				
Ensure that reinsurers are kept apprised of any developments.				

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<b>Checklist 12—Reinsurance</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
<b><i>Intercompany Reinsurance Transactions</i></b>				
Obtain source documentation for intercompany relationships.				
Analyze and document mechanics of intercompany agreement(s) including premium and loss payments, commissions, advancements, etc.				
Compare results of agreement analysis to ensure that the accounting methodology utilized is in compliance with the contract. Document findings.				
Determine if intercompany relationships have any bearing on other reinsurance facilities.				
<b><i>Reinsurance Records</i></b>				
Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken.				
Determine if files at branches or outside facilities need to be returned or sent to other locations.				
Complete ID of all reinsurance files.				

Chapter 1 – Takeover & Administration

Checklist 13—Legal	Project Assigned To	Date Completed	Completed By	Notes
Coordinate preparation and filing of Petition and Order of Receivership with various responsible parties (e.g., Department of Insurance, attorney general and/or outside counsel).				
If proceedings are agreed to by insurer: <ul style="list-style-type: none"> <li>▪ Obtain Corporate Resolution by insurer’s board of directors or shareholder(s)</li> <li>▪ Include Consent to Order of C-R-L</li> <li>▪ Include Waiver of Service of Process</li> <li>▪ Include Waiver of Right to Appear-Answer-Appeal</li> </ul>				
Prepare Petition/Order setting bar dates and claim filing procedures, if applicable.				
Identify affiliates.				
Distribute copies of the order to receiver’s staff.				
Serve certified copy of the order on: <ul style="list-style-type: none"> <li>▪ Insurer officers and directors</li> <li>▪ Insurer affiliates</li> <li>▪ Insurer attorneys</li> <li>▪ Plaintiff attorneys</li> <li>▪ Guaranty associations</li> <li>▪ Other key people</li> </ul>				
Coordinate with Accounting to prepare letters for financial institutions for service of order.				
Prepare any publication notice that might be required.				
Secure corporate administrative records.				
Secure corporate/minute books and corporate seal(s).				
Obtain or create list of all directors, executive officers and stockholders of insurer, all subsidiaries, and, if possible, affiliates.				
Secure contracts and agreements.				
Secure legal records.				

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<b>Checklist 13—Legal</b>	<b>Project Assigned To</b>	<b>Date Completed</b>	<b>Completed By</b>	<b>Notes</b>
Identify all pending litigation involving the insurer and determine appropriate actions.				
Obtain list of lawyers representing/pursuing the insurer: <ul style="list-style-type: none"> <li>▪ Contact and notify of new procedures as appropriate</li> <li>▪ Establish new reporting lines and oversight procedures</li> </ul>				
Review insurer's insurance policies and determine applicable contractual limitations period for filing a notice of claim. (change in control)				
File notice of claim as appropriate.				
Deliver notice of the receivership order's stay provision and/or other injunctive relief to litigation parties.				
Begin preparing plan for rehabilitation/liquidation.				
Draft Petition/Order Approving Plan of Rehabilitation/Liquidation.				
Draft Plan for Early Access Distribution of Assets to Guaranty Associations, if appropriate.				
Draft Petition/Order for Approval of Early Access Distribution, if appropriate.				
File order with Recorder of Deeds as may be appropriate.				
File lis pendens with county where real property is located.				
<b>Legal Records</b>				
Determine the approximate number of files housed at each branch, outside facility or other location and arrange for an inventory to be taken.				

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## 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 utilize 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 & Health, 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.

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 requirements and issues may be anticipated during the receivership process. Insurers will vary in size and the degree of system sophistication. Each insurer will present varied problems and issues dependent on their situation. The guidelines, considerations and checklists provided herein are very broad in nature. Management judgment will best determine the appropriate degree of applicability or whether alternate processes are required.

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 Chapter 1 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 non-existent. 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. 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.

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 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;
- 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 non-technical 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; and
- Backup procedures.

## **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.

In conducting a security review, the receiver is cautioned that relevant and important data records may reside on mainframe computers, servers, PCs, 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 Web site (see section G—Internet/Intranet/Web site), which should also be included in the security review.

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 Chapter 1—Takeover 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 Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, among others. Additional requirements may be found in state statutes, data security breach laws and in state insurance regulations, including those based upon the NAIC Privacy of Financial Information Regulation 2000. 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.

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, should address potential security threats in three areas: administrative, technical and physical.

See [http://www.naic.org/committees\\_e\\_receivership.htm](http://www.naic.org/committees_e_receivership.htm) for this document and other helpful receivership tools, such as the NAIC receivership Data Privacy and Security Procedures policy. Since 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 which could be edited for purposes of individual receiverships.

#### 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.
- 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 viruses, worms, Trojan horses or e-mail bombs.
- Check references prior to retaining new staff.
- Periodically test and monitor the effectiveness of the security procedures.
- Evaluate and adjust the security procedures in light of 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.

#### Technical Safeguards

- Use password-activated screensavers.
- Use strong passwords.
- Change passwords periodically.
- Prohibit posting of passwords near employee's work station or computer.
- Encrypt sensitive information when it is transmitted electronically over networks or stored online.
- 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.

#### Physical Safeguards

- Lock rooms and cabinets where sensitive data or data storage equipment is kept.
- 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 or other storage media containing sensitive information.
- Ensure that storage areas are protected against physical hazards such as fire, flood or physical intrusion.
- Maintain a current inventory of all computer equipment.
- Collect keys, computer equipment and other storage devices from employees prior to termination.

### **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 non-renewal 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 (UDS);
- Salvage and subrogation accounting and collections;
- Inventory and liquidation of physical assets; and
- Transmission of policyholder records and data to assuming insurer for life and health insurer receiverships.

### **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 personnel with incentives to continue their employment as the receiver requires.

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, other insurers and agencies. All equipment should be inventoried, including all types of portable computers 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:

- CPUs (central processing units);
- Data storage devices;
- Printer(s);
- Tape drives;
- Terminals;
- Data communications equipment; and
- 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;
- 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, wireless e-mail devices (e.g., Blackberries), etc.; and
- UPS (Uninterruptible Power Sources) 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 will be 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.

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.

It will be necessary for the receiver to identify the applications that address the following functional requirements:

- Marketing and sales management;
- 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;
- Word processing and publishing;
- Company Web site; and
- External interfaces and data sources.

#### **G. Internet/Intranet/Web site**

Increasingly, insurers are utilizing 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 should be documented and service contracts obtained and reviewed. The receiver should assume the role of Web-master or make arrangements with a third-party vendor. This may require that external Internet service providers 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.

#### **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 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.

### **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.

## **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, or may be in the form of files/databases that reside on non-removable disks and are created by one application system, then later input or electronically transmitted to another application system. 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 occurs.

The receiver should verify that these 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. More frequently, the end user or owner identifies the availability of, and acquires, updates. The receiver should determine 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 impact business decisions regarding continued utilization of the existing system.

## **D. Networks**

Network systems in which a file server or central processing unit 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 determined. Networks may include not only the insurer, but other affiliates of the insurance company; thus, the ability to separate the network into independent components may be problematic.

## **E. System Location**

The physical location 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 out-sourced operations.

### **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. 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 under the control of the receiver. The receiver may wish to retain an independent consultant to assist with the migration. 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.

## **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.

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 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 PCs.

## **G. Conversion**

It may be desirable to relocate the insurer's systems operations to a new facility; therefore, the ability to relocate the existing systems should be ascertained. If the systems cannot be relocated, it may be possible to create a clone. The receiver should determine the cost of and ability to create a clone prior to implementing a plan to relocate an office. Alternatively, the receiver may elect to convert the data for use in another system. Sufficient planning and testing by the receiver should be undertaken prior to any decision to 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.

### **1. 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, and claims and reinsurance 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.

### **2. 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 Uniform Data Standard (UDS) transmissions to guaranty associations.

### **3. 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 extremely 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.

### **4. 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.

## 5. 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 and the account current systems.

## 6. Investments

Information regarding the insurers' investments most likely will be found on a PC 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.

## 7. 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.

## 8. 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,

9. 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.

## 10. Other

There may be other information systems, including PC-based calendar and tickler systems, time tracking and personnel systems, and litigation support systems on either PCs or larger computers. Further, through Web sites and online services, computers now serve as important common communication devices. The company's Web site 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 or impossible to use. In the event of liquidation, the receiver may be compelled to export these electronic documents to the receiver's systems, as they serve as the only official company records.

#### **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 provided by existing systems. If this level of functionality is deemed to be unacceptable, the receiver will need to modify the existing systems or replace them to provide the required information processing.

This section provides a checklist of the functions associated with insurance, reinsurance and receivership that should be considered when evaluating systems requirements, including software and hardware considerations. Software considerations will include data capture, processing and reporting capabilities. Hardware requirements will consider system sizing for central processing units (CPUs) and data storage devices, such as DASD and tape drives, as well as peripheral equipment and related items.

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); and
- Geographic distribution:
  - by state, whether one or many;
  - territory, county or zip code breakdowns within a state;
  - by guaranty fund; and
  - 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. This analysis will provide a general idea of systems sizing and related requirements and 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 included large-deductible or loss-sensitive features such as retrospectively rated premiums, there will be additional system demands. This also will impact the amount of historical information that must be maintained in the systems.
- Insurance/reinsurance/both – If the insurer wrote only direct or primary insurance, the ability to process assumed reinsurance may not be of 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.

### **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 information systems needs.

### **E. Sources of Production**

The manner in which a company acquired its business (e.g., was it a direct writer, did it use 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;
- TPAs;
- Agent/MGA; and
- Other subsidiaries, related operations.

### **G. Affiliated Companies**

Different companies with a common parent often use a single, centralized system, which can result in data security problems. As a consequence, the receiver may be required to separate the data of the company in receivership from the affiliates' data.

### **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 manual processing. If it is the latter, the receiver should then determine whether the level of supplemental manual 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 which 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; and
- 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

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. Hardware 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 downsizing.

1. Data Storage Requirements and Sizing

The technical staff needs to consider the volume of historical, current and anticipated future records that will need to be stored on the computer system.

2. Printer Requirements and Sizing

Many factors will impact how the receiver assesses the number and type of printers required to efficiently disseminate critical information. These include type of system (batch systems are more report-dependent than online systems), office layout (are there multiple floors or locations) and anticipated volume of report production.

## **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.

### **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 Uninterruptible Power Source (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.

### **1. Guaranty Association Information**

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. For property and casualty 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.

## 2. Compliance with UDS

The UDS is a precisely defined series of data file formats and codes used by receivers and property/casualty 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 January 1, 2005.

The National Conference of Insurance Guaranty Funds (NCIGF) developed a secure process for transferring UDS data from the property and casualty insurance guaranty associations to insurance receivers. The concept proposed by the California Liquidation Office in 2005 and the process advanced by the NCIGF in 2007 is known as SUDS (Secure Uniform Data Standards System) utilizes 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. SUDS is available at no charge to insurance receivers or the guaranty associations.

For further details about the implementation of UDS, please refer to the UDS Operations Manual. Both the NAIC and the National Conference of Insurance Guaranty Funds (NCIGF) maintain updated copies of the complete UDS Manual. The Financial Information formats are contained in a complete and separate manual. The NCIGF maintains both manuals, in electronic form, on their Web site, [www.ncigf.org](http://www.ncigf.org), under the Uniform Data Standards tab. Information is also included relative to individuals that may be contacted for further information or with questions about UDS.

## 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: 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.

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. 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 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, 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. A review should also be 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 back up 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.

**B. Enhancement**

If 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 may require restructuring of the operating system or supplementation of available software. In like manner, available staff may be inadequate for the anticipated needs.

1. Determine Availability of Enhancements

Once the required enhancements are identified, availability should also be ascertained. If additional hardware is required, it should be determined at what cost and how quickly it can be acquired. The same is true of additional software. Where restructuring or reconfiguration of the existing system is necessary, the availability of qualified personnel should be similarly confirmed.

## 2. Plan and Schedule Implementation

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. Throughout the implementation of the enhancements, the plan should ensure that receivership functions can continue without interruption. This may require the operation of shadow systems on a parallel track with the implementation of the enhancements. The plan should confirm that the enhanced system will meet all of the receiver's needs.

## 3. Devise Enhancement Testing Methodology

Testing methodology should be implemented to confirm that the enhancements were successful and sufficient. After reviewing the documentation and testing the integrity of the enhancements, the system should be reviewed to determine whether additional enhancements are needed. This can be done by assessing the results of the review done in the Information System Deliverables section of this chapter, and coordinating with the appropriate personnel from the receiver's office as to their information needs.

### 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. Comparison of available equipment and software should result in identifying the replacement system that can best meet the receiver's needs at the lowest cost and at the earliest opportunity. Once the replacement system has been identified, the receiver should follow the appropriate purchasing process. A target production date to complete the installation and activation of the replacement system should be set. A plan for migration from the existing system to the replacement system should be implemented, bearing in mind the following factors:

- Preparing migration schedule;
- Staffing;
- Hardware;
- Software;
- Data Conversion;
- Implementation;
- Testing; and
- Legal considerations and/or court approval.

A schedule should be set for implementation of the migration plan with the following stages clearly identified and scheduled in a manner that is consistent with other needs of the receivership:

- Installation of new system;
- Backup and conversion of data;
- Testing of new system;

- Parallel testing of operations;
- Erasure of all old system data;
- Shut down of old system; and
- Disposal of old system.

#### **D. Third-party Vendors**

The receiver may decide to dispense with an in-house system and rely principally on a third-party vendor-hosted system.

##### 1. Prepare Detailed Needs List

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.

##### 2. Identify Possible Vendors

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:

- Short-term and long-term availability;
- Expertise and demonstrated ability;
- Price and method of charging;
- 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; and
- Familiarity with the type of business involved.

##### 3. 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.

#### 4. Operating Protocols

Once an agreement in principle has been reached with the vendor, protocols should be established for the operational relationship. These should include, but not be limited to, reporting procedures, billing procedures, confidentiality, consumer privacy, and comprehensiveness and timeliness of reports. Once operating protocols have been agreed upon, they should be implemented, monitored and observed.

#### 5. Assessing Operational Results

A plan should be devised for assessing whether a third-party vendor satisfies the requirements of the contract.

#### 6. 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. It is suggested that the system run in parallel with the third-party vendor's system for a period of time before it is shut down. If parallel testing reveals that the selected third-party vendor cannot meet all anticipated needs, a new third-party vendor should be selected.

#### 7. 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. This means that components will have to be appropriately packed, safely stored, and documentation prepared and maintained through which the receiver's staff can determine the system's historical performance and capabilities. 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. Appraisals should be obtained and court approval may be required. Hardware should be sold at auction or through private sale at the best available price. Proprietary software developed solely by the insurer may also be marketable. Software bought on the open market is unlikely to be marketable, and licensing agreements may require its destruction or return to the vendor.

### **E. 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. If the information is migrated to the receiver's in-house computer system, then it is simply a matter of reviewing the data that will be needed and the method of transferring the information from one system to another. In either case, 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.

### **F. 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 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 immediately upon entry of a liquidation order. 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. 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. The sooner the guaranty associations are included in the analysis of the data, the more complete the UDS data will be. Additionally, the transition of claims to the guaranty associations needs to occur as soon as possible after entry of the order of liquidation to ensure continuation of critical claims such as workers' compensation indemnity payments, annuity payments, etc.

It is likely that the initial UDS plan will be modified as the receiver completes its review of the company's systems.

### **G. Information Systems Report**

A detailed analysis of the inadequacies of the insurer's information system should be undertaken, including a review of past Information Systems Questionnaire responses and information systems audits. A report of this analysis should be provided to the regulatory agency to help improve future insurer audits. This report should also be included as a part of a larger review and report of the circumstances that led to the insolvency of the insurer.

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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—Takeover & Administration. 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.

In particular, 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 control of the impaired or insolvent company’s bank accounts and invested 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 CPA firms to do 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. Health maintenance organizations (HMOs) often have excess of loss or stop-loss reinsurance where recoveries of amounts due the HMO should be investigated.
- The need to prepare financial statements and related information in a format (examples attached as Exhibits 3-1, 3-2 and 3-3) 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 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 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 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 objective is 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 to 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), 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 Securities and Exchange Commission (SEC), or consolidated tax returns for the IRS. However, it is generally not the

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 that 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 of responsibilities that the receiver has to 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 HMO) and reinsurers.
- Shareholders.
- Federal, state and local taxing authorities.
- State guaranty funds, The National Organization of Life and Health Guaranty Associations (NOLHGA) or 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 HMO).

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 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, 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.

### III CASH AND LIQUID INVESTMENTS

#### A. Cash

The receiver must determine the existence, location and amount of all cash and short-term investments through direct confirmation with financial institutions, investment managers and other third parties thought to be holding cash 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. 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 e-mailed 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 his designated representatives having signatory authority to disburse funds. The receiver of a workers' compensation carrier 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 cover letter should be sent, giving 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 or other restricted cash.

## **B. 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 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.

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.

Sometimes it is easier for the receiver to transfer securities to a financial institution with which he is 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 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.

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:

- 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 Centers for Medicare and Medicaid Services (CMS) for all approved plans.
- Review recent claims and loss adjustment expense 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.

## V. INVENTORY AND DESCRIPTION OF ACCOUNTING RECORDS

### 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 and documents that are necessary to maintain and review the accounting functions of the insurer. Familiarity with the pre-existing 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 pre-existing 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.

This section summarizes and describes the pre-existing accounting records that are typically maintained at various locations of the insurer and/or at affiliated and non-affiliated entities. This chapter should be read in conjunction with Chapter 1—Takeover and Administration, 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.

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 that the company records may also be located at third-party administrator, managing general agent 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, Flow Chart 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 flow chart of the accounting process might describe what action is taken for the significant functions or accounting processes. The flow chart may summarize the route of the original accounting documentation from when it is received in the mailroom to when it is recorded and filed into folders. Most importantly, the flow chart 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 flow chart may also identify the responsibilities of each significant function in the accounting department. If a flow chart 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. 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 may be unintentionally misleading as to the actual processes currently in place. A walk-through of key systems and/or inquiry of the insurer's personnel will help to confirm the accuracy of such documentation.

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

## 2. General Ledgers, Subledgers, Accounting Registers and Journals, Cash Receipts and Disbursements Books

The receiver should find a complete set of records at the home office. The general ledger is the book of control and 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 and by identification number. The period entered and the identification number may allow the receiver to locate the "support" or underlying documentation for the entry. This information will be valuable in the audit procedures; and
- A journal entry listing that specifies, by period and by identification number, 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 subledgers will provide details of balances that are summarized and posted in the general ledger. Subledgers may be in place for various accounts of the general ledger, typically those that include large quantities of homogeneous transactions. Some of the subledgers 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

The subledgers may be in various forms (i.e., either manual or in computer printout).

Accounting registers and journals detail the daily accounting activity of the company. Registers typically are organized in file-sequence order (i.e., policy number, producer number, claim number, etc.), while journals usually are organized in chronological order. At a minimum, registers and/or journals are generally maintained for premiums written and claims paid. Registers and/or journals may also be maintained for investment purchases and sales. The registers and journals may be in computer printout form.

Cash receipts and disbursements books are maintained for the daily cash activity of the insurer. An individual cash receipts and disbursement book may be kept for each office or location for each checking account(s). On a regular basis, usually daily or weekly, the total amount of checks deposited and the total amount of checks issued are entered in the books. The amounts deposited are supported by the deposit slips, remittance advices and check copies. The amounts disbursed are supported by disbursement vouchers or a list of checks issued.

### 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) and are all important. The more crucial files are:

- Certificate of deposit files and investment accounting files
- Cash accounting files
- Agents' and producers' accounting files
- Contingent commission files

- Claim files (if maintained in the accounting department)
- Reinsurance accounting files
- Federal, state and local tax files
- All related correspondence files

The insurer may have several years of accounting files on the premises and keep the older accounting files 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 files should support the investment transactions of the insurer. Included in the files should be broker slips, bank advices and custodian statements. Monthly reconciliations of the custodian statements to the related general ledger account balances may also be found here. For more information on investment files, see section on Investments (Section IX) in this chapter.

Cash accounting files contain cash receipt and disbursement vouchers that support the cash entries made on a daily basis. Deposit slips, copies of checks, bank memos and records of disbursements may also be found in these files. In addition, banking records, such as authorized signatory lists and agreements with banks regarding custodial and other matters may also be found here.

Agents' and producers' files should contain copies 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 files should contain the computations for any contingent commission or profit-sharing commission paid to agents and producers. Included may be copies of any agreements to support the calculations.

The accounting department or home office claims department may retain skeleton files of claims that are adjusted at other locations, such as branch offices or service companies. These files may include copies of proof of coverage, proof of claim, accident reports, and explanation of benefits and vouchers for payment.

The accounting files for reinsurance ceded by the insolvent insurer prior to receivership should contain the details for any of the insurer's reinsurance transactions. Depending on the insurer, the files may be filed by reinsurer or intermediary, or numerically by reinsurance treaty. In each case, the file should contain summaries of reinsurance premiums and loss calculations for each treaty or reinsurer. The files should also contain copies of the account statements sent to each reinsurer. Each file may also include a copy of 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.

Nonetheless, the receiver may want to determine that the documentary information maintained by the ceding company or intermediary supports the bordereau.

Tax files (federal, state, local and payroll) should contain copies of the tax returns that have been filed with each jurisdiction. The files may include copies of disbursement vouchers and may detail how and from which original source the information was compiled. The Tax Issues section of this chapter (Section VIII) 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.

Written communications, if not maintained in the related accounting folders, may be maintained in separate correspondence files. These files may be organized in the same order as the related accounting files, either by name, by producer number, or in bulk by accounting function (e.g., correspondence with banks).

#### 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, 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 letter of credit agreements. For health maintenance organizations, 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—Takeover and Administration has more information on contracts, and Chapter 7—Reinsurance has more information on reinsurance treaties and letters of credit.

#### 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 chief accounting officer. Otherwise, the receiver should discuss what reports and filings are produced and available with the chief financial officer.

The financial reports that the insurer should have readily available include: 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 files with related workpapers that support the reports, identify sources of data and reconcile the reports to books of control.

Other external financial reports that may be found in the accounting department include: insurance department examination reports, actuarial reports and opinions, and certified public accountants’ 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 exchange, the insurer is required to file an annual report and various interim documents with the Securities and Exchange Commission (SEC). 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.

Many computer tabulations may be required and maintained by the accounting department. An inventory of tabulations and their purpose, description and retention may be available. Tabulations that should be on hand include: written, in-force and unearned premiums; accounts receivable; claims paid; and outstanding reserves. Tabulations should be periodically produced or updated and balanced to a control amount. Old tabulations may be stored or discarded. Many insurers have procedures to microfiche or image old records before their destruction. The receiver should secure all available electronic records, whether or not they are also available in hard copies.

Another useful record, which may be in the possession of the accounting department, is the premium dailies. These are copies of declaration pages from policies that have been issued. Agents and producers submit the dailies along with premium statements. The dailies may be filed by policy number, producer number or date of issue.

## **C. Accounting Records at Other Locations**

### **1. Branch Offices**

Branch offices of an insurer may operate independently of the home or main administrative office. In this case, the branch may have its own complete set, or subset, of accounting records, including general ledger, subledgers, journals, registers and cash receipt and disbursement books. (This may include checks for payroll and a petty cash fund that is periodically replenished.) The branch may also keep a related set of accounting files. The receiver should be aware that the branch is required to report to the home office on a periodic basis. 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. Computer tabulations may be available for large volumes of activity, such as premiums written.

### **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. 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 duplicate computer disks and tapes 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 chief accounting officer.

#### **D. Records at Offices of Other Parties**

##### **1. Managing General Agent (MGA)**

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, all related accounting records, as previously described, may be at the office of the MGA. If the MGA has limited authority, then only records that pertain to the specific function will be in the office of the MGA. 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.

##### **2. Third-Party Administrators (TPA)**

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 letters of credit, 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 examination reports, the following documents may be on file with the insurance department: contracts (reinsurance, agents, management, investments, etc.), dividends payment 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, flow-charts, 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 (CPA) 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. 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.

#### 7. Banks

Banks may be able to furnish copies or 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 (IRS)

The IRS may be a source for the insurer's income tax returns and filed payroll tax forms.

#### 9. Securities and Exchange Commission (SEC)

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.

### **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.

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 Sarbanes-Oxley-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.<sup>1</sup>

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 will be useful in identifying controls that should be 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.

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<sup>1</sup> The 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.



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.

**Routine Data Processes:** Accounting applications that process routine financial data (the detailed information about transactions) recorded in the books and records (e.g., the processing of receipts and disbursement transactions, other transaction processing and payroll).

**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).

In evaluating controls over an application, 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 controls 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 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 tapes and disks (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 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 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 and short-term investments should be verified through direct confirmation with financial institutions, investment managers and other third 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, letters of credit or other restricted cash. The initial procedures established with the financial institutions regarding wire transfers, and 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 (bonds, stocks, mortgage loans, etc.) should be confirmed directly with financial institutions, investment 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. 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 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.

The various types of investments that may be recorded on the insurer's books are:

- Stock
- Bonds
- Mortgage or asset-backed securities
- 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 affiliates
- Real estate

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.

### **C. Real Estate**

Determine the existence, location, and the amount of related mortgage/debt and/or income from properties. 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.

### **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.

A receiver should, as part of his 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 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 letters of credit 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.

#### **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, vacation and personal time. 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 and casualty 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 IBNR 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 a third-party administrator 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 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 arms-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. 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 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. Often, related-party transactions are not appropriately reflected on the insurer's books, and 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 very 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 may not be subject to the jurisdiction of the commissioner. To preserve the assets of the insolvent insurer, the receiver must identify all related-party transactions and appropriately account for such transactions on the insurer's books.

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, board minutes or SEC filings. 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 brokers, reinsurers, MGAs, TPAs, premium finance companies, 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 he or she 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 arms-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 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 non-affiliated providers.

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 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).

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.

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 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.

#### **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 which categorizes disbursements by type and which 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.

## **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 non-regulated 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 which 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 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 forward 20 years by property and casualty insurers. Prior to 2018, life insurers were allowed to carry back ordinary losses for 3 years and carry forward

losses for 15 years. No carryback is allowed for operating losses of insurers other than property and casualty insurers for taxable years after December 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 3 years and forward up to 5 years to offset capital gains and 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. An insurer may also 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 Internal Revenue Code, 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 December 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 which 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 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 he is 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 property and casualty 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 15<sup>th</sup> 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 15<sup>th</sup> day of the third month (generally March 15) of the year following the year end of the company.] A six-month extension to October 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’s 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:

<b>Type of Insurer (Based on Business Written)</b>	<b>Federal Income Tax Form</b>
Property/Casualty	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	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 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 percent 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's a change in qualification as a life insurance company as defined in Internal Revenue Code ("IRC") Section 816(a).

For taxable years ending before January 1, 2018, life insurers with less than \$500 million in assets are entitled to a small life insurer deduction of 60 percent 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 December 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 which 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 utilizing 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 January 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. Since most companies in liquidation have virtually zero premium income after the first couple of years of the liquidation, and since 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 January 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.

#### 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 I.R.C. §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 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 (Internal Revenue Code 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 (Internal Revenue Code Section 172(b)(1)(A)). Operational losses of life insurers arising in 2017 and earlier are carried back three years and forward fifteen years. A non-life insurance company can use the full amount of its net operating losses to offset taxable income (Internal Revenue Code Section 172(f)). A life insurance company is limited to an 80% net operating loss deduction against taxable income (Internal Revenue Code 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 December 31, 2017. The net operating loss deduction is limited to 80 percent of taxable income (without regard to the deduction) for losses arising in taxable years beginning after December 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.

### 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 W-2s, as well as Forms 940 and 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 periodically assess insurers to cover their administrative and claim costs. If the insurer is operating under supervision or rehabilitation, it may still be liable for guaranty fund assessments. If the insurer is in liquidation, the funds will typically waive payment of the assessment upon notice of the insolvency.

##### **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.

##### **4. Commissions and Other Payments**

At year-end, insurers are required to file Forms W-2 and/or 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 Forms 1099 and send the forms 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; "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 Property Casualty Insurers Association of America (PCI), the American Insurance Association (AIA) 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 and acceptance of reasonable risk may no longer be appropriate. Concerns of safety and liquidity may be foremost.

#### **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 his 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 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 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—Mortgages; Schedule BA—Other Long-Term Assets; Schedule C—Collateral Loans; Schedule D—Long-term Bonds and Securities; Schedule DA—Short-term Investments; Schedule DB—Financial Options and Futures; and Schedule E—Cash. Also, the General and Special Deposit Schedules found in the annual statement will identify investments on deposit with various regulatory jurisdictions.

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 of the NAIC documentation to support the market value of the securities. The Securities Valuation Office 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. Very often, derivative instruments are used by insurers 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* 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 *Accounting Practices and Procedures Manual* provides additional examples, for both life and property/casualty companies, of complex investment arrangements entered into by insurers.

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 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, 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 should have adequate documentation to support the investment. The documentation should include 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.

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 the Investigation and Asset Recovery Chapter of 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. 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.

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 in many newspapers. The receiver should consider the published market value rather than the NAIC value in the evaluation of the quality of assets because the NAIC value presumes that investments will be held to maturity and redeemed at face value. Often, a receiver is compelled to sell investments prior to maturity to generate cash flow. The NAIC value 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. 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, and 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, 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 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. Since foreign countries may have currency restrictions for repatriation of assets, the receiver should consult with legal counsel.

Special deposits and general deposits with insurance regulators in other jurisdictions in the United States and outside the United States may also present problems to the receiver. Many United States 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 he can divest himself 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 Ruling 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 differs, depending upon the insurer (e.g., direct billing of policyholders vs. billing of agents) and type of insurance (e.g., primary vs. 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 utilize 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 and 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, focusing the review on policies with premiums that are substantial to the overall population.



b. Life and Accident & Health Premiums

Unlike property and liability insurance policies, life and accident and health insurance policies can be guaranteed renewable contracts and are generally accounted for as long-term contracts. Premium payment plans for life, annuities, and accident and health insurance vary. Some policies may be payable monthly, as is frequently the case with group insurance. Others may be payable quarterly, semi-annually and/or annually. Some may be fully paid up when issued.

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, since 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; or
- 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.

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 SSAP 6.) 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; or
- 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 non-payment 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 Only)**

#### 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 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 NAIC *Accounting Practices and Procedures 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- Large Deductible Recoveries - Only)

### a. Large 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 certain losses and LAE incurred. While these policies share some characteristics with retrospectively rated policies, the accounting treatment of recoveries under the two types of policies is different.

### b. Accounting Practices

Under statutory accounting practices, recoveries under large deductible policies are not treated as premium. Unpaid losses are booked net of the deductible, except where the deductible is deemed not to be collectible, in which case the losses are booked on a gross basis. Because losses within the large deductible limit are not booked, 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. Because these recoverables do not appear on the balance sheet unless uncollectible, but may be a significant recoverable amount, the receiver should examine the scope of the large deductible business written, and the collection and collateral procedures employed by the company. The High Deductible Disclosures, Note 31 in the Annual Statement Disclosure should aid the regulator in this review.

## **E. Reinsurance**

For additional information on reinsurance, see Chapter 7—Reinsurance.

### **1. Reinsurance Recoverables**

For property/casualty insurers, reinsurance recoverables on unpaid losses are not reported in the cedent's financial statement as receivables, but are accounted for as a reduction of its gross liabilities for unpaid losses and loss adjustment expenses. Reinsurance recoverables on loss payments and loss adjustment expenses 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 property/casualty 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.

## **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 that have been generated by the company. The results of the procedures described in the preceding sections of this chapter should of course 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) 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**

IRMA requires that within 180 days after the entry of an order of receivership by the receivership court, and at least quarterly thereafter, the receiver shall comply with all requirements for receivership financial reporting as specified by the NAIC. 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 IRMA 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.

Under IRMA, within 180 days after the entry of an order of liquidation by the receivership court, and at least quarterly thereafter—or at such other intervals as may be agreed to between the liquidator and the guaranty associations, but in no event less than annually—each affected guaranty association shall file reports with the liquidator in the case of liquidation. The reports shall be in a format compatible to that specified by the NAIC. These reports shall be incorporated into financial statements reports filed with the receivership court.

For good cause shown, the receivership court may grant relief for an extension or modification of time to file the 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.

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 very 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.

### **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 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 property/casualty insolvencies only, loss and loss adjustment expense 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 utilized 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. 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 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.

## **XII. EXHIBITS**

*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*

*Exhibit 3-1: Example of Financial Reporting Format*

**STATEMENT  
OF  
NET ASSETS**

**COMPANY NAME  
BALANCE SHEET  
DATE**

Date of Receivership:

**Unrestricted Invested Assets:**

Cash .....

Short-Term Investments.....

Bonds .....

Stocks.....  
    Preferred.....  
    Common.....

Investments in Subsidiaries.....  
    Controlled.....  
    Affiliated Entities .....

Mortgage Loans .....

Real Estate .....

Policy Loans.....

Other Invested Assets  
.....  
.....

    Total Unrestricted Invested Assets.....\$ \_\_\_\_\_

**Restricted Investment Assets:**

Statutory Deposits in This or Other States.....

Funds Held by or Deposited with Reinsured Companies .....

Separate Accounts and Protected Cell Accounts .....

Restricted Other .....

    Total Restricted Invested Assets.....\$ \_\_\_\_\_

**Other Unrestricted Assets:**

Recoverable from Reinsurers on Paid Losses and LAE .....

STATEMENT  
OF  
NET ASSETS

COMPANY NAME  
BALANCE SHEET  
DATE

Less: Allowance for Uncollectible Reinsurance Recoverables on Paid Losses and Loss Adjustment Expenses (LAE) .....	
Reinsurance Recoverables on Unpaid Losses and Unpaid Loss Adjustment Expenses (LAE) .....	
Less: Allowance for Uncollectible Reinsurance Recoverables on Unpaid Losses and Loss Adjustment Expenses (LAE) .....	
Reinsurance Recoverables on Unearned Premiums and Contingent Commissions .....	
Salvage and Subrogation Recoverables .....	
Premiums Due and Accrued for Agents and Policyholders .....	
Receivable from Parents, Subsidiaries and Affiliates .....	
Accrued Investment Income .....	
Receivable from Guaranty Associations – Early Access Payments .....	
Furniture, Fixtures and Equipment .....	
Prepaid Expenses .....	
Other Assets .....	
Total Other Unrestricted Assets .....	\$ _____
<b>Total Assets</b>	<b>\$ _____</b>

**NOTE:** The information contained in this report is prepared by the receiver from information available to or known by the receiver as of the date of the report. The receiver makes no warranty as to the accuracy of the information or of the opinions or evaluations contained in this report and expressly disclaims any liability arising from the statements of fact, evaluation or opinion contained in the report.



**STATEMENT  
OF  
NET LIABILITIES**

**COMPANY NAME  
BALANCE SHEET  
DATE**

Date of Receivership:

**Liabilities**

Secured Claims.....	\$
Special Deposit Claims .....	\$
Administrative Claims	
State/Receiver.....	\$
Guaranty Associations.....	\$
Loss Claims – Guaranty Associations .....	\$
Loss Claims – Other .....	\$
Loss Adjustment Expenses – Guaranty Assns. ....	\$
Loss Adjustment Expenses – Other.....	\$
Unearned and Advance Premium Claims (Non-Assessable Policies) Guaranty Associations.....	\$
Unearned and Advance Premium Claims (Non-Assessable Policies) Other .....	\$
Federal Govt. Claims.....	\$
Employee Claims.....	\$
General Unsecured Creditor Claims (Other than Reinsurance Related) .....	\$
Ceded Reinsurance Related Unsecured Claims.....	\$
Assumed Reinsurance Related Unsecured Claims .....	\$
State and Local Government Claims .....	\$
Late Filed Claims .....	\$
Surplus Notes .....	\$
Unearned Premium Claims (Assessable Policies) – Guaranty Associations .....	\$
Unearned Premium Claims (Assessable Policies) – Other.....	\$

**STATEMENT  
OF  
NET LIABILITIES**

**COMPANY NAME**  
**BALANCE SHEET**  
**DATE**

Shareholder Claims .....	\$
Other Liabilities.....	\$
.....	\$
.....	\$
<b>Total Liabilities</b>	_____
<b>Excess (Deficiency) of Assets Over Liabilities</b>	_____
<b>Total</b>	<u>\$ _____</u>

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**NOTE:** This may not directly tie to the "Class" section prioritizing claimants in accordance with any one state's receivership statute.

**STATEMENT  
OF  
CASH RECEIPTS AND DISBURSEMENTS**

	<u>Current Period to Date</u>	<u>Since Date of Rehabilitation/ Liquidation</u>
<b>Cash Receipts from Operations</b>		
Premium Receipts	\$ _____	\$ _____
Settlements	\$ _____	\$ _____
Policy Loan Receipts, Cash Collected from Policy Loans	\$ _____	\$ _____
Proceeds from Sales of Real Estate and/or Personal Property	\$ _____	\$ _____
Reinsurance Recoveries	\$ _____	\$ _____
Salvage and Subrogation Recoveries	\$ _____	\$ _____
Agents Balances Received	\$ _____	\$ _____
Collection of Affiliate Receivables	\$ _____	\$ _____
Recovery of Taxes Previously Paid	\$ _____	\$ _____
Other Receipts	\$ _____	\$ _____
<b>Total Operational Receipts</b>	\$ _____	\$ _____
Interest and Dividends Receipts	\$ _____	\$ _____
<b>Total Cash Receipts</b>	<u>\$ _____</u>	<u>\$ _____</u>

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**STATEMENT  
OF  
CASH RECEIPTS AND DISBURSEMENTS**

	<b>Current Period to Date</b>	<b>Since Date of Rehabilitation/ Liquidation</b>
<b>Operational Disbursements &amp; Distributions</b>	\$	\$
Deputy Receiver and Consulting Fees and Expenses		
Employee Salaries, Payroll Taxes, and Employee Benefits		
Rent, Office and Other Facility Expenses		
Legal Fees and Expenses		
Accounting and Auditing Fees and Expenses		
SGA – Administration Expenses other than LAE		
Ancillary Administration Expenses		
Other Disbursements		
<b>Total Operational Disbursements</b>	_____	_____
Losses/Benefit Payments – SGA		
Losses/Benefit Payments – Non-SGA		
Losses/Benefit and LAE Payments – Special Deposits		
LAE Payments – SGA		
LAE Payments – Non-SGA		
Early Access Payments		
Reinsurance Payments		
<b>Total Cash Distributions</b>	_____	_____
Investment Expenses		
Purchases of Invested Assets		
Total Disbursements for Investment Activities	_____	_____
<b>Total Cash Disbursements &amp; Distributions</b>	_____	_____
<b>Net Increase (Decrease) in Cash</b>	_____	_____
<b>Cash at Beginning of Period</b>	\$ _____	\$ _____
<b>Cash at End of Period</b>	\$ _____	\$ _____

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**STATEMENT  
OF  
CHANGES IN NET ASSETS**

**COMPANY NAME**  
**BALANCE SHEET**  
**DATE**

Date of Receivership:

**Increase  
(Decrease)**

**Unrestricted Assets:**

Cash Unrestricted.....

Short-Term Investments.....

Bonds .....

Stocks.....

Preferred.....

Common.....

Investments in Subsidiaries.....

Controlled.....

Affiliated Entities .....

Mortgage Loans .....

Real Estate .....

Policy Loans.....

Other Invested Assets .....

Reinsurance Recoverables on Paid Losses and Paid Loss Adjustment  
Expenses (LAE).....

Less: Allowance for Uncollectible Reinsurance Recoverables on Paid Losses  
and Loss Adjustment Expenses (LAE) .....

Reinsurance Recoverables on Unpaid Losses and Unpaid Loss Adjustment  
Expenses (LAE).....

Less: Allowance for Uncollectible Reinsurance Recoverables on Unpaid  
Losses and Loss Adjustment Expenses (LAE) .....

Reinsurance Recoverables on Unearned Premiums and Contingent  
Commissions.....

STATEMENT OF CHANGES IN NET ASSETS

COMPANY NAME
BALANCE SHEET
DATE

Salvage and Subrogation Recoverables .....
Premiums Due and Accrued from Agents and Policyholders.....
Receivable from Parents, Subsidiaries and Affiliates.....
Accrued Investment Income .....
Receivable from Guaranty Associations – Early Access Payments .....
Furniture, Fixtures and Equipment .....
Prepaid Expenses .....
Other Assets.....

Total Unrestricted Assets.....\$

Restricted Assets:

Statutory Deposits in This or Other States.....
Funds Held by or Deposited with Reinsured Companies .....
Separate Accounts and Protected Cell Accounts .....
Restricted Other .....

Total Restricted Assets.....\$

Total Assets

\$

NOTE: The information contained in this report is prepared by the receiver from information available to or known by the receiver as of the date of the report. The receiver makes no warranty as to the accuracy of the information or of the opinions or evaluations contained in this report and expressly disclaims any liability arising from the statements of fact, evaluation or opinion contained in the report.

**STATEMENT  
OF  
CHANGES IN NET LIABILITIES**

**COMPANY NAME**  
**BALANCE SHEET**  
**DATE**

Date of Receivership:

	<b><u>Increase (Decrease)</u></b>
<b><u>Liabilities</u></b>	
Secured Claims.....	\$
Special Deposit Claims .....	\$
Administrative Claims	
State/Receiver .....	\$
Guaranty Associations .....	\$
Loss Claims – Guaranty Associations.....	\$
Loss Claims – Other .....	\$
Loss Adjustment Expenses – Guaranty Assns. ....	\$
Loss Adjustment Expenses – Other.....	\$
Unearned and Advance Premium Claims (Non-Assessable Policies) Guaranty Associations.....	\$
Unearned and Advance Premium Claims (Non-Assessable Policies) Other .....	\$
Federal Govt. Claims.....	\$
Employee Claims.....	\$
General Unsecured Creditor Claims (Other than Reinsurance Related) .....	\$
Ceded Reinsurance Related Unsecured Claims.....	\$
Assumed Reinsurance Related Unsecured Claims .....	\$
State and Local Government Claims .....	\$
Late Filed Claims .....	\$
Surplus Notes .....	\$
Unearned Premium Claims (Assessable Policies) – Guaranty Associations .....	\$
Unearned Premium Claims (Assessable Policies) – Other.....	\$

**STATEMENT  
OF  
CHANGES IN NET LIABILITIES**

**COMPANY NAME**  
**BALANCE SHEET**  
**DATE**

Shareholder Claims .....	\$	
Other Liabilities.....	\$	
.....	\$	
.....	\$	
<b>Total Liabilities</b>		_____
<b>Excess (Deficiency) of Assets Over Liabilities</b>		_____
<b>Total</b>	\$	<u>_____</u>

**NOTE:** The information contained in this report is prepared by the receiver from information available to or known by the receiver as of the date of the report. The receiver makes no warranty as to the accuracy of the information or of the opinions or evaluations contained in this report and expressly disclaims any liability arising from the statements of fact, evaluation or opinion contained in the report.

**NOTE:** This may not directly tie to the "Class" section prioritizing claimants in accordance with state regulatory requirements.



**Exhibit 3-2: Example of Daily Cash Flow**

Cash Activity  
For the Four Week Period Ending \_\_\_\_\_

				Four Week Total

Beginning Cash

- Cash Receipts:
- Investment Income
  - Premium Deposits
  - Investment Sales
  - Transfers In
  - Short-Term Interest
  - Reinsurance Receipts
  - Other Income

Total Cash Receipts

- Cash Disbursements:
- Accounts Payable
  - Policyholder Payments
  - Hardship Surrenders
  - Payroll
  - Transfers Out
  - Tax Payments
  - Reinsurance Payments
  - Returned Checks/  
Other Disb

Ending Cash

**Exhibit 3-3: Example of Budget-Projected Liquidation Expenses**

**PROJECTED LIQUIDATION EXPENSES**

	-----Projected-----					
Since Actual Date of Rehabilitation Liquidation	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date	
<b>Receipts</b>						
Interest Income	\$	\$	\$	\$	\$	\$
Mortgages Interest						
Reinsurance Recoveries						
Rental Income						
Premium Income						
Return Commission						
Collection of Affiliate Receivables						
Principal Collections on Mortgages						
Proceeds from Sale of Real Estate & PP&E						
Escrow - Mortgages						
Recovery of Assets						
Guaranty Fund						
Assessment Refund						
<b>Total Receipts</b>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>
<b>Disbursements</b>	\$	\$	\$	\$	\$	\$
Legal, Audit & Consulting Fees						
Payroll, Other Taxes & Employee Benefits						
Rent and Related Expenses						
Equipment & Office Expense						
Investment Expenses						
Reinsurance Premium Ceded						
Early Access Distribution						
Liquidation/Rehabilitation Expenses						
Establishment of Escrow						
Other Distributions						
<b>Total Disbursements</b>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>
<b>Net Increase (Decrease) in Cash</b>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>
<b>Cash at beginning of period</b>						
<b>Cash at end of period</b>	<u>\$          </u>	<u>\$          </u>	<u>\$          </u>	<u>\$          </u>	<u>\$          </u>	<u>\$          </u>

**Exhibit 3-4: Example of Restructuring Transaction**

**Example: Restructuring Transaction**

When placed into liquidation, Reliance was part of a three-tiered holding company structure, whereby 100% of the stock of Reliance was owned by Reliance Financial Services Corp (“RFS”). RFS, in turn, was wholly-owned by Reliance Group Holdings, Inc. (“RGH”).<sup>[1]</sup> In 2003, a settlement agreement was entered into between Reliance, RFS, and RGH whereby, among other things, the parties created a new consolidated tax group for federal income tax purposes with RFS as the common parent and with Reliance as a member.

In 2015, after collection of certain assets, RFS desired to terminate its existence and dissolve. Because Reliance is part of the consolidated tax group, the dissolution of RFS could have led to a change in ownership of Reliance which, under §382 of the Internal Revenue Code of 1986, as amended (“Code”), could have adversely affected the significant net operating loss carryovers (“NOLs”)<sup>[2]</sup> held by Reliance which may be used to offset future net income, thereby reducing tax liabilities. Therefore, Reliance and its advisors developed a restructuring plan and a transaction which was approved by this Court and executed as of December 31, 2016.

The transaction resulted in an ownership change of Reliance which qualified for the bankruptcy exception under §382(1)(5) of the Code. Pursuant to the plan, all of the issued Reliance common shares are now owned by 4 GAs (“Participating GAs”) who paid Reliance policyholder claims and who received Reliance stock in exchange for the partial cancellation of such indebtedness. Each Participating GA has entered into a shareholder’s agreement which restricts the sale, transfer, pledge or assignment of the shares, and each shareholder executed a revocable proxy granting the right to vote all the shares to the Pennsylvania Insurance Commissioner as Liquidator. The Participating GAs will receive no preference as to their claims against Reliance due to their new ownership status. Furthermore, the Reliance stock issued to the Participating GAs provides them with no additional viable claim against Reliance as assets will be insufficient for distributions to class (i) creditors (shareholders).

The transaction received a favorable private letter ruling on August 24, 2016 from the Internal Revenue Service holding that the Participating GAs would be treated as receiving the Reliance stock in their capacity as creditors of Reliance for purposes of the Code. The plan preserved the substantial NOLs for the benefit of the Reliance estate and allows Reliance to control its own future regarding tax positions and negotiations with the Internal Revenue Service. As a result of the restructuring, Reliance will become its own tax filer and will no longer be part of a consolidated tax group.<sup>[3]</sup>

---

<sup>[1]</sup> RGH and RFS jointly filed for bankruptcy in 2001 and the RGH and RFS reorganization plan was approved in 2005 with RGH converting into a liquidating trust and RFS converting into Reorganized RFS Corporation.

<sup>[2]</sup> As a result of the large losses suffered by Reliance during the final years of its independent operations and during its liquidation, in excess of \$4 billion of NOLs were accumulated through 2014. Approximately \$1.5 billion of that \$4 billion was utilized in the 2015 consolidated tax return.

<sup>[3]</sup> For additional details, see the Liquidator’s Application for Approval of Restructuring Proposal filed with the Court on October 7, 2016, which is document # 3745 on the [www.reliancedocuments](http://www.reliancedocuments) website.

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**CHAPTER 4 – INVESTIGATION AND ASSET RECOVERY**

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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 vs. 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. Further, IRMA allows states the option of granting title to conservators and rehabilitators; a liquidator is always given title. (See IRMA Sections 301A, 401A and 501A.)

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. Oftentimes, receivers can take advantage of the fact that a distribution likely will not occur for months or possibly years by negotiating a larger sale price to be paid over a period of time, as opposed to receiving a smaller lump sum amount at the closing.

An important safeguard for the receiver who agrees to a series of installment payments is to secure the buyer's obligations. In an asset sale, depositing all or a portion of the assets to be sold into an escrow account until all payments have been made is effective. Other forms of security include creation of liens or other security interests, requiring the posting of letters of credit, or obtaining corporate or personal

guarantees, although the protection afforded by guarantees is only as good as the guarantor's ability to pay.

Receivers also may wish to consider negotiating with a buyer to pay the receiver's administrative and legal fees and expenses incurred in connection with the transaction, thereby limiting the risk of the estate having to pay unforeseen costs.

### **C. Tax Consequences of a Disposition**

Regardless of whether a transaction involves a sale of stock or real or personal property, capital gains tax consequences of the disposition warrant consideration before the deal terms are finalized. Upon disposal of an asset, the estate will recognize a capital gain or loss based on the difference between its tax basis in the asset and the consideration received. Oftentimes, because a receiver will have only limited information on prior dealings of the insolvent insurer, it may not be possible to determine the insurer's tax basis in the asset to be sold. Appropriate professional advice should be sought before negotiating and documenting any such transaction.

### **D. Other Terms**

Like most commercial agreements, the form of the sale and purchase agreement may contain boilerplate provisions, including representations, warranties and covenants of the buyer and seller, conditions that must be satisfied before the buyer and seller are obligated to close, indemnification covenants, and releases. Representations and warranties can be problematic for a receiver because they expose the receiver to liability for matters of which the receiver has limited knowledge. In the absence of the knowledge and familiarity with the insurer's business and affairs that would be possessed by managers actively involved in the operation of a solvent insurer, the receiver may wish to sell only on a *caveat emptor* (i.e., let the buyer beware) basis. If the buyer is unwilling to 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.

Subject to applicable law, the receiver may also restrict the receiver's exposure by limiting the period of time within which the buyer may assert a claim against the receiver. Liability also may be limited by restricting the buyer's recourse to a maximum dollar amount not to exceed all or a specified percentage of the profit (net of all costs and expenses) of the receiver arising out of the sale. In return, and subject to applicable law, the receiver may be willing to agree with the buyer that payment of a valid indemnification claim will be deemed an administrative expense of the estate and, therefore, will be entitled to priority of payment in any distribution of the estate's assets.

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. For this reason, reinsurance commutation agreements often include confidentiality provisions and are presented *in camera* to the receivership court when seeking its approval.

Other provisions of contracts should identify the law governing the construction of the agreement and confer exclusive venue and jurisdiction over all disputes arising out of the agreement to the court exercising jurisdiction over the receivership proceedings. 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**

As noted above, subject to the requirements of applicable law, prior approval of the court supervising the receivership proceedings may be required (and desirable) before a receiver enters into an agreement.



Court approval serves two important purposes: First, it protects the receiver against personal liability, and second, it provides assurance to the purchaser that their ownership will be recognized. The petition for approval should summarize the material terms of the transaction and disclose all facts that the court or any interested party may view as material to the receiver's decision. A copy of the agreement should be made available to the court well in advance of the hearing and, subject to the requirements of applicable law, notice of the hearing, by mail and publication, should be provided to all persons entitled to notice.

In liquidation, this issue is covered by IRMA Section 504D. Subsection D(1) sets a threshold for transactions requiring court approval. If the value of the transaction is less than the lower of \$1 million or 10% of the assets of the estate, approval is not required. If the value is greater than the threshold, court approval is required. The liquidator is given the option of petitioning the court for a higher threshold amount. If the value cannot be determined with certainty or if the liquidator feels the court's sanction is necessary or desirable, the liquidator can petition for approval of any transaction.

For conservators and rehabilitators, IRMA contains the general provision that the receiver shall take possession of the assets of the insurer and administer them under the general supervision of the court (IRMA Sections 301A and 401A).

#### **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:

- Assignment of responsibility.
- Location and current status/value of the deposit.
- Methodology for tracking all deposits.
- Cost/benefit analysis for the collection of the asset.
- Process for collections to be coordinated with the estate accountants.
- Procedures for uncollectible deposits.

#### **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 the inference of a conflict of interest.

The receiver should have written policies and procedures that:

- Assign responsibility for the sale and disposal of all real and personal estate property.
- Adopt method(s) to establish value of the asset.

- Adopt method(s) to select outside vendors to assist with sales.
  - Create a sales plan that identifies all approved methods for disposal to include public auctions, consignments, newspaper advertisements, or any reasonable method approved by the receiver that promotes competition and the realization of maximum sales value. The plan should also provide a method of disposal for all property with a de minimus market value.
- Establish a process for evaluating offers.
- Establish conditions of sale to include “sale as is,” method of payment and documentation of the sales transaction.
- Provide for court approval for sales as may be applicable under the receivership order and/or state statutes.

### **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.

The receiver may retain the services of forensic 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 forensic 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. (See Chapter 9—Legal Considerations). (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.

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, 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.

#### 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 particular 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"; and
- 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 IRMA. 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 IRMA is two years. Not all preferences can be avoided by the receiver. Subsection 604B 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; or
- 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; or
  - An affiliate.

Subsection 604C states which preferences may not be avoided even if they would otherwise be avoidable under Subsection 604B. 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: a specific state statute; the Uniform Fraudulent Conveyance Act to the extent adopted in the particular state; and/or the common law of fraud. Fraudulent transfers are covered by Section 605 of IRMA. 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. The receiver should consult 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 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 property and casualty 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 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.

### 1. 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.

The receiver's recovery of reinsurance is also dependent on the claims handling and reporting of both claims covered and those not covered by guaranty funds. There may be as much or more work involved in documenting post-insolvency accruing reinsurance balances resulting from claims covered by guaranty funds and the adjudication of other non-fund covered claims as there is in reconstructing the pre-insolvency balances resulting from pre-insolvency claims activity. See Chapter 2—Information Systems (especially the UDS section), Chapter 5—Claims and Chapter 6—Guaranty Funds for more on the relationship between post-insolvency accruing liability and reinsurance recoverable balances.

### 2. Secured Reinsurance Balances

Reinsurance balances frequently will be secured to ensure collectibility 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 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 letters of credit 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.

### 3. Commutations

Generally, commutations are negotiated terminations of the rights and liabilities between insurers and reinsurers, including premiums due, paid losses, outstanding losses and incurred but not reported (IBNR) losses, loss adjustment expenses (LAE) where applicable, and present or projected profit. A commutation is a settlement of all obligations, both current and future, between the parties for a lump sum payment.

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 abuses. 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, 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 loss adjustment expenses 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; however, the long-term economics of the transaction 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.

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.

### 4. 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.

Stop-loss treaties are also subject to abuse and, consequently, should be carefully evaluated. The amount of loss protected against may be unreasonably high 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.

#### 5. 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 letters of credit. 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 nonadmitted reinsurers may indicate an improper motive for obtaining such reinsurance.

#### 6. 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. Since certain bulk transfers require insurance regulatory approval, it should be determined if there was compliance with applicable requirements.

#### 7. 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, 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.

## 8. 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.)

## **B. Large Deductible Policies**

Large deductible recoveries can represent a significant source of recoveries for insolvent companies, especially those property and casualty companies that wrote workers' compensation insurance. Because these recoverables do not appear on the balance sheet unless uncollectible, but may be a significant recoverable amount, 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. But adequate collateral must be established prior to liquidation as it is unlikely to be collected after liquidation.
  - 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.
  - 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 associations, guaranty association and insured). It must be quickly established with insured as to 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 SUDS server hosted by NCIGF is a useful tool for communication between receivers and guaranty associations. guaranty funds may opt for telephonic communication with insureds. The collection process should proceed with minimal delay as the passage of time will impact 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 ALAE and deductible aggregates where available.
- c. Copies of deductible policies should be made available if required.
- d. Guaranty Association's will provide, through the establishment of UDS data feed, all financial information regarding deductible claims that they are handling.
- e. Receiver will collate data from guaranty associations and review historical billing information to invoice the insureds on a monthly or quarterly basis.
- f. 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 their deductible.
- g. To assist in the collection process receiver and 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 ("PEOs")

- a. Policies issued to 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 PEO may not have received notice of cancelation, leading to coverage disputes. If collateral is inadequate and the PEO does not have assets to pay the deductible 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 commutations of large deductibles. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between insurer and insured, and provide some protection or limitation of exposure from the insolvency of the insured. Commutations 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 three 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; or 3) the investments did not meet the insurer's need for liquidity.

While some states' insurance codes prohibit the acquisition of certain assets, many view such acquisitions as merely nonadmitted 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. 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 (although generally admissible, such assets usually are 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) and common stock, as well as the relative percentages of certain investments. Other 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.

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 those 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
- Schedule D – Bonds and Stocks
- Schedule DA – Short-Term Investments
- Schedule DB – Derivatives
- Schedule E – Cash, Cash Equivalents and Special Deposits

Other sources include internal and external audits, 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, 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 managing general agents (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 retain 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**

Insurer Receivership Model Act (#555, commonly known as IRMA) Section 711 – Qualified Financial Contracts (or Similar Provision) addresses stays termination or transfers of netting agreements or qualified financial contracts (QFCs).

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 qualified financial contracts (QFC) and netting agreements in the event of the insolvency of state regulated insurers.

#### **A. Definition of Qualified Financial Contract**

IRMA 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, 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 qualified financial contract because an insurance contract includes the indemnification against loss. Therefore, reinsurance agreements would not be considered a swap agreement.

### **B. Insolvency Treatment of QFCs under the IRMA Section 711 Provision<sup>1</sup>**

IRMA 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 Federal Deposit Insurance Act (FDIA), as well as laws of other foreign jurisdictions. These safe harbor provisions for QFCs were

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<sup>1</sup> <sup>1</sup> 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 twenty-four-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 Dodd-Frank 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 (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the 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 Dodd Frank, the FDIA, as well as comparable foreign resolution regimes. Notwithstanding 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 QFCs. Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, FDIC and 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>; *Mandatory Contractual Stay Requirements for Qualified Financial Contracts*, 82 FR 56630 (29 November 2017), available at <https://www.federalregister.gov/d/2017-25529>.

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 or 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 IRMA. 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 QFCs held by an Insurer Receivership:**

- Although the Investments of Insurers Model Act (either Defined Limits or Defined Standards) (#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.
- 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 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 central clearinghouses (CCH) 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 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 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 <sup>2</sup>).
- 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 Dodd-Frank 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 collateral and counterparties to the contract. See 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 *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts* [#1556] and accompanying drafting note in the preceding footnote in this Chapter<sup>3</sup>).
- 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.

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<sup>2</sup> See footnote 1 of this Chapter.

<sup>3</sup> See footnote 1 of this Chapter.

- 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 2020)**

The subsequent information provides a general description of how and where qualified financial contracts (QFCs) are reported within the *Accounting Practices and Procedures Manual* and the statutory financial statements.

### Derivative Instruments—AP&P 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 C – Replication (Synthetic Asset) Transactions
  - Section 1 contains the underlying detail of replicated assets open at the end of the year. Section 2 is reconciliation between years of replicated assets.
- 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*
- Notes to Financial Statement – *Investments*
- Notes to Financial Statement – *Derivative Instruments*
- Notes to Financial Statement – *Debt (FHLB Funding Agreements)*
- Notes to Financial Statement – *Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk*
- Notes to Financial Statement – *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, replications are reported in Schedule DB – Part C – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D.

### 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 provides 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, whether acting solo or in concert. This section and the next identify by category the acts and omissions of such persons, the causes of action that may be brought against such persons, and the foundation that the receiver must establish to prevail in such causes of action.

A few caveats should be stated here. Not all of the actions listed here may have been involved directly in the insurer’s problems. In addition, 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.

### 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;
- Deducting excess commissions and/or fees;
- Taking improper set-offs; or
- Improperly using funds to make loss payments.

The investigative examination of the insurer, undertaken at the time the receivership began, may have indicated the presence of these problems. It may be necessary 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; or
- Inordinate delays in collecting reinsurance balances receivable;

#### **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, hopefully, binds the agent or intermediary to adhere to the insurer's articulated underwriting guidelines and limitations. To the extent that any agent exceeded these limits, and caused the insurer to suffer financially, the receiver may be entitled to appropriate remedies.

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; or
- 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;
- Variances from sales plans and volume projections;
- Schedule F or S problems; and

- Reinsurers' resistance to 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 loss-adjustment expenses;
- Unexpectedly high losses;
- Late development of reported losses;
- Policyholder complaints;
- Low salvage recoveries and/or high ratio of salvage costs to amount recovered;
- Low subrogation recoveries and/or high ratio of subrogation cost to recovered amount; and
- Negative market conduct examination report comments.

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, and 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.

## **E. Professional Malpractice**

Insurers frequently retain outside professionals, including attorneys, auditors, 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; and
- 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.

It is particularly important for the receiver to review whether certain professionals that 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, other professionals could 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, 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 took root in bankruptcy cases but has been applied to the insurance insolvency settings. It should be noted that this theory is not universally accepted. Some courts have even found "deepening of the insolvency" to be a separate cause of action, though it would still primarily be based upon some kind of professional negligence action. 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 mispending 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. Net Operating Loss Carrybacks**

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.

As part of the receiver’s investigation, it should be ascertained whether the company has entered into a tax-sharing agreement. If a tax-sharing agreement does not exist, then the Internal Revenue Code (IRC) provides for the allocation of tax among members of a consolidated group. The receiver should determine that 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.

#### **G. Significant Developments in the Insurer Receivership Model Act (#555, known as IRMA)**

In addition to the changes in the rules regarding voidable preferences discussed above, IRMA has several other sections of interest to a receiver in attempting to recover assets for the benefit of the estate.

Section 601 imposes an obligation on third parties holding assets that the receiver reasonably believes are assets of the estate to either deliver them to the receiver or to justify to the receivership court why they are not assets of the estate.

Section 602 authorizes the receiver to recover transfers to affiliates of the insolvent insurer made within five years prior to the petition for receivership, unless the affiliate can prove that at the time the transfer was made the insurer was solvent, the transfer was legal, and neither the insurer nor the affiliate knew or should have known that the transfer would place the insurer in hazardous financial condition.

Sections 603 through 608 substantially conform insurance receivership practice in this area to the current practice in federal bankruptcy actions.

### **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 directors and officers 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 next should focus on what the directors and officers did or did not do. Accordingly, the receiver should begin the investigation by identifying the directors and officers 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 sometimes are defined by statute or contained in the company's bylaws. The receiver should ascertain that the minimum requirements were met. The statutory remedy for failing to meet qualifications is removal from office. However, willful failure to enforce timely action may be actionable if it is shown to have contributed to the insurer's insolvency.

The receiver should pay particular 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 directors and officers 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 directors and officers.

The receiver should review all minutes of the board, and 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, and 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 (RICO)

The availability of the federal Racketeer Influenced Corrupt Organizations (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

Fraud actions may be similar to RICO in that some of the same elements are present. However, the alleged fraudulent activity may involve only one or two persons, and it is not necessary to prove a pattern of activity. A litigation victory on a fraud claim may be a Pyrrhic victory. Collecting on the judgment may not be as easy as winning the case, and fraud is often used as a defense by reinsurers seeking to avoid their obligations. In addition, directors' and officers' (D&O) and errors and omissions (E&O) liability insurers may use assertions of fraudulent conduct as a basis to deny coverage.

#### 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.

#### 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 look for and sources of information 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 officers and directors 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 and consultants.

##### 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, etc. Special facilities, such as leased or company-owned luxury cars, boats or residences maintained for executives may also be suspect.

As seen in the thrift institution scandals, artworks, antiques and oriental rugs may be purchased with company funds for the primary benefit of its officers.

##### c. Investment Transactions

Real estate owned by an officer or director 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 (letters of credit or 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.

Some of these may be attributable to poor judgment or carelessness, intentional breaches of agreements, or dishonesty. In any case, the officer in charge is by definition accountable for the results. 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?
- Did the officer obtain adequate information before making a judgment?

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.

#### 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 loss adjustment expenses 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?
- 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 property and casualty 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 give careful scrutiny to insider stock trading, employment contracts, "golden parachutes," "poison pills," bylaws, etc., to verify that key personnel did not breach this duty.

6. D&O 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. E&O and D&O 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 particular 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.

**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 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 Insurer Receivership Model Act (#555, known as IRMA)**

In litigation between the receiver and affiliates of the insolvent insurer, Section 113 of IRMA 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.

**X. EXHIBIT**

*Exhibit 4-1: Potential Recovery from Unrelated Third Parties Matrix of Relationships*

**Exhibit 4-1: Potential Recovery from Unrelated Third Parties Matrix of Relationships**

Potential Recovery from Third Parties

<u>Causes for Action</u>	<u>Offending Parties</u>	<u>Information Source</u>
1 Breach of Fiduciary Duty		
A) Failure to Maintain Premium Trust Account	A) Managing General Agents	A) Takeover Audit
B) Skimming Premiums	B) Third-Party Administrators	B) Financial Records
C) Withholding Funds Without Authority	C) Other Agents/Brokers	C) Policy File Documentation
D) Failure to Collect and Remit Funds When Due	D) Reinsurance Intermediaries	D) Contract/Treaty File
E) Excessive Commissions and Fees		E) Audits of MGA, etc.
F) Improper Set-offs		F) Insurance Department Files
G) Broker Funding		
H) Improper Co-Mingling of Funds		
2 Abuses Related to Risk Selection		
A) Writing Excluded Classes of Business	A) Managing General Agents	A) Takeover Audit
B) Violating Territorial Limits	B) Third-Party Administrators	B) Financial Records
C) Exceeding Premium and/or Product Mix Limit	C) Attorneys	C) Policyholder File Documentation
D) Improper Use of Binders	D) Other Agents/Brokers	D) Contract/Treaty Files
E) Overlining	E) Reinsurance Intermediaries	E) Audits of MGA, etc.
F) Misrepresenting Risks	F) Policyholders	F) Insurance Department Files
G) Placing Reinsurance with Unacceptable Reinsurers	G) Cedents	G) Premium Audits
H) Failing to Obtain Adequate Security for Ceded Reinsurance		H) Insurer Rating Services
3 Abuses Relating to Loss Settlements		
A) Exceeding Settlement Authority	A) Managing General Agents	A) Takeover
B) Inadequate Claims Investigation	B) Third-Party Administrators	B) Financial Records
C) Failure to Pursue Subrogation and/or Salvage	C) Other Agents/Brokers	C) Policyholder File Documentation
D) Presenting False Claims	D) Reinsurance Intermediaries	D) Contract/Treaty Files
E) Failing to Control Allocated Loss Expenses	E) Policyholders	E) Audits of MGA, etc.
F) Late Reporting of Losses	F) Cedents	F) Insurance Department Files
G) Third-Party Claimants	G) Direct Confirmations	
4 Abuses Related to Premium Computations		
A) Understating Premium Base	A) Managing General Agents	A) Takeover Audit
B) Neglecting to Obtain Premium Audits	B) Third-Party Administrators	B) Financial Records
C) Failure to Report and Remit Premium Adjustments	C) Other Agents/Brokers	C) Policyholder File Documentation
D) Late Reporting of Loss Experience	D) Reinsurance Intermediaries	D) Contract/Treaty Files
	E) Policyholders	E) Audits of MGA, etc.
	F) Cedents	F) Direct Confirmations
5 Professional Malpractice		
A) Incomplete Work Product	A) Certified Public Accountants	A) Takeover Audit
B) Insufficient Analyses	B) Consulting Actuaries	B) Financial Records
C) Failure to Honor Warranty	C) Loss Reserving Specialists	C) Engagement Letters
D) Failure to Meet Minimum Standards	D) Management Consultants	D) Contract Files
E) Unprofessional Conduct	E) Independent Claims Adjusters	E) Service Agreements
	F) Data Processing Consultants	
	G) Other Service Vendors	
6 Fraud – not really a separate category. Any or all of the preceding categories could contain elements of fraud.		
7 Collusion with Management – not really a separate category. If the apparent damage to the insurer extends over a large number of transactions or an extended period of time, collusion may have occurred.		

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**CHAPTER 5 – CLAIMS**

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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 (property and casualty); fidelity/surety; a health maintenance or preferred provider organization; 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; and
- Whether the insolvency crosses state or international borders.

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. The receivership court adjudicates 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. Exhibit 5-1 is a linear summary of claims administration. This chapter addresses each step in the process. Of course, if there are no assets in the estate, no guaranty associations to cover claims and no potential for reinsurance recoveries and the supervising court agrees, the receiver may not need to establish a claims procedure.

## II. ESTABLISHING A CLAIMS PROCEDURE

This section addresses the timetable for the filing of claims, the different types of creditors and their claims, and provision of notice to claimants. Early on in the proceeding, the receiver should petition the court to establish the procedures for adjusting and adjudicating claims. The petition, and especially the order, should describe the proof of claim process, define the required notice to potential creditors and establish 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 the NAIC *Insurer Receivership Model Act* (#555), also known as IRMA, Section 501 B.) 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.

Receivership statutes usually distinguish claims by their relative stage of development on the fixing date. In insurance practice, losses are distinguished as paid, outstanding and incurred but not reported (IBNR). (See generally, IRMA Section 703 A, *et seq.*) These terms correspond to the three general stages of loss development. Losses develop over time and are distinguished on the basis of liability/contingency, value/liquidation and time/maturity. The most common legal distinction 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. Liquidation and maturity of the claim measure the development of non-contingent claims. An unliquidated claim is uncertain as to amount, while a liquidated claim may be expressed in dollars. An immature claim is a liquidated claim that is not yet owing, while a mature claim is ready to be paid. Whether an outstanding or IBNR loss would be deemed a contingent, unliquidated or immature claim depends on its relative stage of development in terms of liability, value and time (date when due). Consulting the statute and regulations in their jurisdiction should enable receivers to determine the applicable use of the terms contingent, unliquidated and immature as applied to claims filed in the estate.

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. (Although the claim is very certain to policyholder B, the insurer nonetheless regards it as contingent until liability is established.) If B sues A and A fails to appear in court to answer the claim, B may be awarded a default judgment against A. B now has a non-contingent claim against A; however, it remains unliquidated until B proves its value, and it is immature until the court enters a judgment on the amount. In short, a claim remains contingent until liability is certain, unliquidated until it is assigned a value and immature until it is due.

Identification of the fixing date may be subject to statutes applicable to both life/health and property and casualty 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. Bar Dates**

### **1. What is a Bar Date?**

A bar date (in some states called a claim filing date) is the deadline for filing proofs of claim against the estate. (See IRMA Section 701 A.) The purpose of the bar date 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 bar date may be excluded, at least initially. In some states, the bar date is absolute, and a proof of claim filed after that date will be disallowed. In most states, claims may be amended or supplemented, subject to certain limitations. In other states, a late-filed claim will be accepted but will 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. IRMA proposes that late-filed claims be assigned to Class 9, provided that the claim was late due to certain specified criteria (IRMA Sections 701 and 801(I)). In some circumstances, claimants need not file a claim to preserve their rights—e.g., policyholders of a life insurance company. 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 bar date. Unearned premium claims may be treated similarly in property/casualty liquidations. The receiver will want to determine whether the insurer underwrote any guaranteed renewable, noncancellable business. If so, claimants may contend that the bar date has

no effect on claims arising under such policies, as may be the case with surety bonds. As always, it is imperative to check local statutes for the appropriate procedure and rule of law.

a. Effectiveness as Against Federal Claims

Whether bar dates cut off untimely claims of the federal government pursuant to federal super priority statute 31 U.S.C.A. § 3713 remains an open question. For a more extensive discussion of this and other claims issues, see Chapter 9—Legal Considerations.

b. Applicability in Rehabilitations

Whether a bar date will be established in a rehabilitation proceeding depends upon the specific circumstances and applicable law. In rehabilitations of a limited or set duration, bar dates enable the rehabilitator to ascertain the amount of outstanding claims and implement a plan to return the insurer to solvency. In other rehabilitation cases, it may be appropriate to use a series of bar dates or a bar date keyed to the occurrence of a particular event.

2. How is a Bar Date Established?

A statute or court order sets the bar dates in a receivership. (See IRMA Section 701, also Chapter 6—Guaranty Associations for bar dates applicable to guaranty associations or ancillary receiverships.) A receivership bar date will also apply to the claims of guaranty associations. There may be more than one bar date for an insurance company receivership, as will be explained further below. Some state statutes specify the length of the period of time for the filing of claims before the 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 types of business written. The receiver may establish a short period if, for example, the receivership is small, the policyholders and creditors are limited in number, the insurer underwrote limited lines of business, or the insurer’s books and records are sufficiently well-organized to allow timely notice to all policyholders and creditors. A longer period may be necessary if the company’s books and records are in disarray, there are a large number of policyholders and creditors, the insurer wrote several different types of business—including noncancellable business, or the receiver wants to keep the policies of insurance (e.g., life insurance) in force during a run-off period. A longer period may also be necessary to facilitate the sale of blocks of business to a solvent insurer. The assumption of blocks of business by a solvent insurer may eliminate the need for many claims to be filed at all. However, the process of concluding an assumption reinsurance agreement can be complicated, requiring flexibility in setting bar dates as the receiver develops and implements an assumption reinsurance arrangement.

3. Coordination of Deadlines

Receivers must be aware that the court-determined bar date may not be the only date set for the filing of claims. It is imperative that the receiver determine whether other persons<sup>1</sup> have set any conflicting deadlines, such as guaranty associations or ancillary receivers who themselves may be subject to court-determined or statutory deadlines. The coordination of deadlines is discussed further below.

a. Guaranty Associations

Guaranty association bar dates should coincide with those set by the receivership court if possible. However, state statute may require a guaranty association to establish a different bar date. To the extent possible, coordination with each state guaranty association involved is essential to ensure that the receiver’s deadlines do not unnecessarily exclude the claims of guaranty associations or claims not fully covered by the associations (i.e., “residual” claims).

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<sup>1</sup> As used herein, “person” means individual, aggregation of individuals, partnership, corporation or other entity (Model #555 Section 104 T).

b. Ancillary Receivers

Deadlines set in a domiciliary proceeding should be followed in ancillary proceedings to promote efficiency of estate administration. Thus, it is important that domiciliary and ancillary receivers coordinate their respective claims procedures. The domiciliary receiver should attempt to obtain and review the proposed petition and order from the ancillary jurisdiction to ensure coordination of bar dates. Ancillary and domiciliary receivers may wish to enter into agreements that ensure that the bar dates set in the ancillary jurisdiction coincide with those in the domiciliary receivership. (They also may resolve issues of reimbursement of expense, disposition of assets located in the ancillary state and, if necessary, indemnification of the ancillary receiver.) Such coordination may depend upon whether the domiciliary and ancillary states are “reciprocal” states. Reciprocal states are those that have adopted the Uniform Insurers Liquidation Act (UILA) or the provisions of the NAIC *Insurers Rehabilitation and Liquidation Model Act* (Model Act) regarding interstate relations. All states adopting IRMA or significant parts thereof are deemed “reciprocal” through the use of “full faith and credit” language, rather than using the word “reciprocal.” If two states have not adopted reciprocal provisions, they may be regarded as non-reciprocal, and bar date conflicts may result. Review of the applicable statutes and relevant case law is essential.

4. Staggered Dates

Although staggered bar dates are not employed frequently, some receivers use them for different types of incurred claims. For example, staggered bar dates might be appropriate if it appears from a review of the insurer’s line of business that some claims simply cannot be submitted during a normal claims filing period. Staggered bar dates might be appropriate if it is likely that the total of direct policyholder claims will outstrip the insurer’s assets. In such a case there may be no need for lower priority creditors to file claims unless payment is likely or some other purpose would be served—e.g., establishing damages for an action against the insurer’s directors and officers. Similarly, a rolling bar date or a series of bar dates could be useful in a rehabilitation proceeding, such as where reinsureds must file claims within a specified period after they pay their own insureds. The receiver needs to be aware of fairness issues if different bar dates are used for the same classes of claims.

5. Extended Deadlines

In some instances, a statute or court order may extend a bar date. For example, if the state receivership statutes allow contingent claims, the receiver may find it useful to petition the court for a second, extended deadline so that evidence may be submitted in support of contingent claims. The extended deadline enables the claimant to accumulate and submit, at a later time, the evidence required to liquidate the contingent claim. Depending on state law, this second date for contingent claims may be extended several times, provided the extension does not interfere with timely closure of the estate. In some states, no extension is necessary because persons who have filed contingent claims are automatically allowed to file supporting documentation at a later date.

It is best to address contingent claims issues from the outset. The receiver will want to determine whether the purposes of the receivership are served by a longer claim filing period to allow contingent claims to develop. It is important to note that a claim may have been incurred during the policy period, but did not become mature or liquidated prior to the bar date. As a practical matter, certain obligations will mature after the bar date. For example, latent environmental or product liability losses, as well as reinsurance obligations assumed, often mature long after the expiration, cancellation or termination of the insurer’s direct policies. Such assumed reinsurance claims might be barred if the claims did not mature prior to the bar date (even though the insurer’s claims against its own reinsurers would not be barred). The receiver also must decide whether allowing such development will facilitate evaluation of the insurer’s outstanding liabilities and its potential rehabilitation or prompt liquidation.

Thus, contingent claims involve potentially conflicting goals. In fairness to creditors, equity attempts to recognize all valid claims against the insolvent insurer's estate. However, to await the outcome of every contingent claim could require keeping the estate open much longer, thereby undercutting the important policy goal of a speedy resolution of the receivership proceeding.

There is legal precedent for the holding that a 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 the Matter of the Liquidation of American Mutual Liability Insurance Company, 802 N.E.2d 555 (Mass. 2004). The American Mutual case holds that the primary purpose of notice of a receiver's appointment is for insured parties to obtain alternative insurance and is unrelated to claims filing.

#### 6. 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 up 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.

### C. Claims Liquidation Date Under Insurer Receivership Model Act (#555, Known as IRMA)

IRMA allows the liquidator to petition the receivership court to set a date prior to which all claims that remain contingent or unliquidated shall be finalized (IRMA Section 705(F)). This section also provides that the liquidator shall give notice of the filing of the petition to all claimants with contingent or unliquidated claims.

### D. Developing the List of Creditors

Once the fixing date has been established and the bar date has been set, potential creditors of the estate can be identified. The first step in this process is to develop a master mailing list of creditors from the insurer's books and records. Legal precedent holds that if claimants can be identified from the books and records of the insolvent insurer, the receiver should send written notice of the claims bar date to known claimants, rather than provide notice only by publication.<sup>2</sup> 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 task of developing a creditor list may present a formidable challenge, but information technology can help. (See Chapter 1—Takeover & Administration).

The priority of distribution is determined by statute (see also IRMA Section 801). The following persons usually will be included in the insurer's mailing list:

#### 1. Guaranty Associations

Guaranty associations triggered by a receivership order are often the estate's largest creditors. The guaranty associations will seek reimbursement from the receiver for paid covered claims and allocated loss adjustment expenses, and the receiver will review and determine whether such claims and expenses are covered under the insolvent insurer's policy terms and within the applicable policy

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<sup>2</sup> 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.

limits. The receiver will also adjudicate the administrative expense claims of the guaranty associations, and establish procedures for the review of supporting documentation.

## 2. Policyholders

Policyholders most often represent the largest group of claimants. Most insurers have an electronic file that includes the names and last known addresses of policyholders, organized chronologically by policy year. The same information is contained in policy and claims files. The receiver typically begins with the list of in-force business. Then the receiver will decide whether any inactive policyholders should be notified, depending on the insurer's lines of business. For example, the receiver may decide to include those policyholders whose policies were cancelled, as well as those inactive policyholders who were covered under occurrence liability policies against long tail risks, such as medical malpractice or products liability. Claims frequently arise out of occurrence policies that were terminated or cancelled prior to receivership. In some instances, the receiver may decide that claims closed by the insurer need to be reopened. There may be situations for which "incident reports" were submitted by insureds to the insurer (now in liquidation) on a confidential basis. The incident reports are confidential and provide notice of potential claims that may be asserted (but have not been asserted) by third-party claimants against insureds. These insureds should be included in the list of creditors who are to receive proofs of claim from the insolvent insurer. In a health maintenance organization receivership, service providers also may be included in the policyholder class. Distinctions may exist between those providers who contractually agreed to hold enrollees harmless and those who did not so agree (e.g., in Illinois). For a full discussion of HMO insolvency, see Chapter 8—Special Receiverships. Finally, in surety receiverships, the receiver may need to search whatever records are available from the obligees under specific bonds, including closed construction bond files where there may have been an extended maintenance period.

## 3. Third-Party Claimants

The next largest group of creditors to be notified consists of claimants who are entitled to file claims against policyholders under the insurer's policies or against the insurer. Review of the insurer's records can yield the name and address of many of these claimants (as well as the numbers assigned to claims they filed pre-receivership). In some situations, the names and addresses of persons having related claims (e.g., if there are multiple plaintiffs, cross- or third-party claimants, or obligees under surety bonds, including third-party payout claimants) may be located only by reviewing each open claim file. Reviewing unprocessed claims also may help identify other third-party claimants.

## 4. Secured Creditors

The receiver needs to identify the members of this group of claimants because the statutes of most states allow secured creditors to apply collateral in satisfaction of their claims without going through the formal claims procedures. Examples include mortgage holders, taxing authorities with perfected liens, etc. Identifying this class of creditors enables the receiver to determine quickly the nature and extent of their security interests, as well as assets available for general distribution, since security provided to a creditor may not be considered a general asset of the estate.

## 5. Government Agencies

All federal, state and local government agencies with whom the insurer dealt, including each state insurance department and taxing and licensing authorities, are potential claimants and should be included in the master list of creditors. Federal and state statutes concerning government agencies (e.g., IRS, Interstate Commerce Commission, public utility commissions, Pension Benefit Guaranty Corporation, departments of motor vehicles) may require notice of policy or bond cancellation. It is common for the receiver to seek a release of liability from the United States Department of Justice (Civil Division in Washington, D.C.) following the liquidation of all receivership claims. The typical release provided by the United States is not for claims of the federal government, but rather, it is a release and discharge of the receiver from any liability under 31 U.S.C. § 3713(b), commonly known as the federal priority statute. Under 31 U.S.C. § 3713(b), the representative of the estate, i.e., the receiver, is made personally liable for payments from estate assets that are distributed prior to satisfying the federal government's claims. Although the United States Supreme Court in *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 508-09, 124 L. Ed. 2d 449, 113 S. Ct. 2202 (1993), concluded that that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, *et seq.* (1945), prevented the federal priority statute from superseding the state priority distribution scheme with respect to policyholders, it did not negate federal statutory priority in all circumstances. By entering into the release, the U.S. effectively subjects itself to the consequences of the claims process and gives up its right to any additional remedy against the receiver personally.

## 6. Wage Claimants

The statutes of most states provide for the payment of certain wage claims that are limited as to time and amount. The identities of such claimants should be readily ascertainable from the insurer's books and records.

## 7. General Creditors

### a. Reinsurers and Reinsureds

If the insurer assumed or ceded reinsurance obligations, the insurer's cedents and its reinsurers, retrocessionnaires, pool participants and those covered by common account (see Chapter 7—Reinsurance) will be included in the list of creditors. All treaties, facultative certificates, pool agreements and common account records should be reviewed to ensure that all insolvency clauses or other obligations are satisfied, especially as to timing and notice. Since reinsurance often is placed through intermediaries (agents, brokers or producers), the intermediary's own records may help the receiver develop this part of the creditor list.

Where another company has "fronted" for an insolvent insurer, claims on policies and bonds written on the fronting company's behalf may be forwarded to the fronting company for adjustment and payment, in appropriate circumstances. Under most statutes, the fronting company then becomes a general creditor of the insolvent company and must file a proof of claim to secure its status in the proceeding.

### b. Intermediaries

Agents, brokers and other producers also may be creditors of the insurer. The receiver should review the terms of any agreement the insurer had with the intermediary to ascertain whether the receiver has any right of access to the intermediary's records. If the agreement includes no such right, the receiver may want to provide for it in the receivership order.

### c. Managing General Agents and Third-Party Administrators

Many of the largest insurer insolvencies have resulted (at least in part) from the fact that the insurer relinquished responsibility for the underwriting and reserving functions to third parties such as managing general agents and third-party administrators. These entities may also make up a portion of the general creditor class of claimants and are an essential source of policyholder and claim information. The receiver may determine the identity of these persons by reviewing the insurer's records.

d. Claims Adjusters

Insurers frequently employ the services of third parties to adjust claims. The receiver thus may identify additional claimants by reviewing the insurer's claims department records for a list of all approved claims adjusters and the lines of business or specific claims they were handling. If this information is not found in a central source, the receiver may need to review each claim file.

e. Defense Attorneys

Attorneys who were representing the insurer or its insureds in litigation or claims handling also should be identified and notified of any stay against the filing or pursuit of actions against the insurer, its assets or its insureds. In many instances, they too are potential creditors of the estate. If not separately listed elsewhere (e.g., in the company's litigation log or the company's 1099 files), a review of each claim file may help to identify the attorney creditors. Some guaranty associations exclude or limit the claims of insureds of a certain net worth. Insureds that are excluded or limited may employ defense counsel to represent their interests in ongoing litigation, since the receiver does not typically provide a defense for claims filed against the insureds after the receivership date. For insureds that hire their own defense counsel, the insured will need to keep the receiver informed of the status of litigation. Insureds will frequently submit their defense cost claims to the receiver. These claims should be processed and, if approved, paid as policy benefit claims at the percentage then approved for policyholder claims. f. Trade Creditors

Open accounts payable listings and unpaid invoice files often will provide the names of most other general creditors, such as consultants, vendors, property managers, utilities and landlords. If the identities of such persons cannot be ascertained, general creditors likely will identify themselves as they seek payment on their outstanding receivables.

8. Equity (Stock or Share) Holders

The identities of these claimants may be ascertained by reviewing the insurer's corporate books and records or annual statements. If the insurer was publicly held, the identities of shareholders may be obtained from the company's stock register or through brokers and regulating government agencies. Subordinated or surplus note holders, members of mutual insurers and convertible debt holders are included in this group. The identification and stake of equity holders may be difficult to determine in the case of mutual or member companies in which each member has a capital account interest in the equity of the insurer, particularly in the case of members where capital account interests are calculated on the basis of historical profits. The process of calculating the prior profitability or losses of the insolvent insurer to determine the stake of certain equity holders is not useful when the insolvent insurer does not have assets available to satisfy equity claims. Nonetheless, equity holders are entitled to notice of receivership developments, so it is better to err on the side of caution all potential equity holders should receive notices from the receivership.

**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.

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 many settings, filing with a guaranty association may constitute filing with the receiver for purposes of satisfying a bar date, but the receiver may need additional information from the claimant that the guaranty association did not elicit. Guaranty associations and receivers should coordinate the claims filing process. With receivership court approval, receivers may deem open claims, as reflected on the books and records of the insolvent insurer, to be timely filed claims. In such circumstances, proofs of claim need not be filed by insureds or third-party claimants for these open claims.

Before any form is created, the receiver will want 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 major type of claimant. Some receivers use only one claim form, but use control numbers (such as an alpha-numeric system) to designate the type of claim presented in the form. This saves the cost of developing separate forms. On the other hand, in surety receiverships, the receiver may wish to use a separate proof of claim form for each type of bond. Either way, the objective is to minimize the amount of exchange required 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 which 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 (IRMA Section 702 C). The receiver may send prompt determinations regarding the class of creditor, if any, that applies for each proof of claim, leaving the determination of an approved amount open for a later date. 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, and also 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.

Most statutes require claimants to provide certain basic information. (See IRMA Section 702.) 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 which 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 (IRMA Section 702 A); and,
- 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 (IRMA Section 702 A).

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 IRMA Section 702 C.) 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 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 utilize the guidance provided in sub-section F. Coordination and Communication with Reinsurers.

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, managing general agents 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 by-laws. 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.

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. IRMA Section 702 D allows a single omnibus claim to be filed by guaranty associations, which may be periodically updated without regard to the bar date, 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 which 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. For example, some states do not require that the federal government submit its claims on proof of claim forms. Similarly, some states allow reinsurers the option to file contingent and undetermined claims where the value of the claim is unknown at the time it is submitted to initially indicate a contingent claim value of \$1.00 when filing their claim and submit supplemental information at some future designated date. This allows the reinsurer to update their claims until a final bar date has been set near an estates closure date. In some states, both reinsurers and guaranty associations have utilized this practice to the benefit of all parties involved.

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.

#### **F. Coordination and Communication with Reinsurers**

Coordination and communication between receivers, reinsurers and other interested parties can be challenging. This can be influenced by what language is in a state's receivership laws and whether they are based upon provisions of the NAIC's *Insurers Rehabilitation and Liquidation Model Act* Section 40 or the current *Insurer Receivership Model Act* (555) Sections 701 (Filing of Claims) and 702 (Proof of Claim) or otherwise known as IRMA.

Coordination and communication involves gaining an understanding of the reinsurance programs and establishing communication protocols. This can be accomplished by compiling records and retaining knowledge of the individual institutions and considering the following:

- Identify all current and prior intermediary and reinsurer relationships, and locate: agreements with reinsurers and intermediaries, cut-through endorsements, letters of credit, and placement files.
- Document company staff's knowledge of reinsurance operations, and obtain contact information for reinsurers and intermediaries.
- Review the reporting and accounting requirements for reinsurance contracts. Determine the company's procedures for tracking and reporting balances on assumed or ceded reinsurance.
- Review and reinsurance placed with affiliated parties to determine if appropriate reporting and risk transfer has taken place.
- Identify any ongoing disputes between the company and reinsurers, and obtain all communication related to disputes.

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 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.

Where staffing, resources and availability permits, reinsurance specialists on staff can serve as the primary liaison with a reinsurer or intermediary for most matters relating to reinsurance during the life of the receivership. Establish contact personnel, and institute a communication process to provide notice of claims and claims status on a regular basis.

The receiver or state liquidation office should compile a list of all reinsurance participants to include all assumed, ceded, and retrocessional participants so they are apprised of all matters arising in the receivership. The list would be compiled from information contained within current year and prior two years' company annual statement information.

Once a company is placed into receivership, written notification of the receivership should be sent to the company's reinsurers/intermediaries. The reinsurance specialist will generally function as the primary receivership contact for the reinsurers/intermediaries and serves to coordinate all issues relating to reinsurance, including claims and collection activities, throughout the life of the receivership. In working with the reinsurers/intermediaries, the reinsurance specialist would be able to identify and correct any practices that are determined to be inadequate. The reinsurance specialist will analyze and evaluate the company's reinsurance program and applicable provisions in the reinsurance contracts with assistance from the receiver's legal team as needed. The reinsurance specialist will provide the claims section with a list of reinsurers/intermediaries to issue proof of claim forms, assist in the evaluation of any reinsurance related claims, and coordinate and communicate all matters with the claims and legal units as necessary. The reinsurance specialist may also assist in resolving reinsurance-related claims prior to filing the claims recommendations with the court. The reinsurance specialist should also coordinate with any receivers of related proceedings as quickly as possible to determine common areas of concern or potential conflict.

In the reinsurance specialist's coordination and communication with the estate's reinsurers, they should ascertain the reinsurer's net position as soon as the winding down of the estate permits. Where applicable, the receiver should be encouraged to opt for the fewest number of requirements possible based on that

state’s receivership laws in order to facilitate communication with reinsurers and to hasten the process of reconciling claims. The reinsurance specialist should request open balance reports from the reinsurer and intermediaries; in order to conduct reconciliation and determine if any differences exist.

Only to the extent that there are any differences or disputed data information, the reinsurance specialist would require the reinsurer to substantiate its position by submitting supplemental information. This may occur at any point of time in the receivership, and the receiver should be encouraged to reconcile any discrepancies as soon as they are identified. The reconciliation should be a process conducted immediately following the development and agreement of the insureds’ claims culminating in a net figure due to or from each reinsurer of the estate. It is important to monitor the reinsurers’ financial status on a periodic basis and perform accounting reconciliations with the intermediaries to ascertain that information has been correctly and timely reported to the reinsurers.

In this regard, it is crucial to keep reinsurers updated of the development of the insureds’ claims as is required by the respective reinsurance contracts. This development will determine whether a reinsurer is a net debtor, i.e. an asset, of the estate or a net creditor who shares in dividends in its class of creditors.

This development would most likely occur after deadlines for filing claims have passed. In this case, if applicable under a state’s receivership laws, receivers should petition the court to allow reinsurers to not initially formally file a claim but rather deem the claims filed but only in the case where reinsurer is considered an asset of the estate based on the financial records of the company in receivership. If inapplicable and the state’s receivership laws prohibit deemed filings, reinsurers should be allowed to file contingent claims (for example, “placeholder claims” at a nominal value of USD 1.00 only) that are amended and proven when the development of the receivership so permits. For further discussion on the assets of the estate, refer to Chapter 1 – Takeover & Administration, Section E. Assets, Sub-section Reinsurance of the *Receiver’s Handbook for Insurance Company Insolvencies*.

It is important to note that the development of the insureds’ claims may not only result in claims against the estates’ reinsurers. Whenever an insured’s claim is allowed at a smaller amount than has already been paid, this will result in refunds that have to be credited to the respective reinsurers. Additionally, there might be reinstatement premiums due to reinsurers, if an insured’s claim is allowed.

Consequently, in many cases, the claims of reinsurers are dependent on the development of the insureds’ claims. Thus, receivers should be encouraged to treat claims of reinsurers as one factor amongst others adding to the net amount of the asset such reinsurers represent. In some cases, however, the overall result will be a net claim against the estate, but at the point of time such claim is certain, it may be allowed and will share in the distributions declared for the respective class of creditors.

If any issues or difficulties are encountered regarding the Proof of Claim form, it is suggested that the reinsurer contact the Receiver’s office directly with any concerns, describe the issue in reasonable detail and in writing, and provide as much information in the response with as many items on the Proof of Claim form as possible. If the Receiver is made aware of an issue or problem in a timely manner, this may enhance the likelihood of a resolution that agrees with the supervising court.

### III. NOTICE

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. If the receiver chooses to use ClaimNet or an alternative Internet-based claims system, notice could be sent to claimants via postcards. (See Exhibit 5-2.) Regardless, the notice should identify the fixing and bar dates and stress the significance of complying with bar date requirements. Highlighting the penalty for failing to file by the bar date will help to avoid problems later. Increasingly, estates use the Internet to post notices, proof of claim forms, and other important information.

In multistate receiverships, all notices to life insurance policyholders and annuity or investment contract holders should be coordinated with affected guaranty associations through the National Organization of Life & Health Insurance Guaranty Associations (NOLHGA). The receiver also may consider coordinating with the National Conference of Insurance Guaranty Funds (NCIGF) in multistate receiverships for issuance of notices sent to property/casualty policyholders. The guaranty associations often will want the receiver to include any appropriate guaranty association notice with 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 bar dates will require immediate public notice of the receivership. Refer to applicable statutes or the court order to determine how frequently notice must be published and through which media forums. Receivers may wish to publish notice via the Internet. For publication notices, the receiver should require a publisher affidavit, to be executed by the newspaper that published the notice, providing a copy of the form of notice and verifying the dates of the published notice. The publisher's affidavit may later be used in court to prove that published notice occurred as required by the receivership court.

The proofs of claim themselves usually are sent by mail, but now may be obtained via the Internet. A copy of the entire mailing list should be maintained, supported by verifications and sworn to by the individual(s) handling the mailing as to the date, content of the mailing and its conformance to the mailing list. Some receivers use a certificate of mailing or a post office mailing book, both of which cost less than certified mail and evidence delivery. If certified mail is required, a post office form mailing book will evidence receipt of certified letters in the addressee's post office. If electronic mail is utilized, appropriate procedures should be developed (particularly to protect information that the insureds provide in completed proof forms). This may be a particular concern for a receiver considering utilizing the Internet.

## IV. CLAIMS PROCESSING

The receiver should make several decisions at the beginning of the liquidation about the proof of claim filing and evaluation process. It is best to make these decisions up front so that claimants can be notified prior to the bar date and the receiver can develop forms and procedures consistent with those decisions. There are two areas that almost all receivers need to address: claims filing and review. Each of these is discussed below:

### A. Filing Methods

Statutes and court orders frequently allow various methods of claims submission, including U.S. mail, personal delivery or private delivery service. The receiver may allow claimants to submit their claims by facsimile or electronic (i.e., computer) transmission. The receiver should determine in advance whether there is a need for the original signed proof of claim, what constitutes acceptable supporting documentation and whether claims need to be submitted during normal business hours.

The statutory and regulatory framework within which the receiver operates allows discretion to adopt claims filing procedures that are “user friendly.” The receiver should encourage everyone involved in the process to provide clear and prompt answers to all questions concerning claims filing. The receiver should consider establishing a toll-free telephone number or Web site to provide answers to the many questions concerning claims filing that arise during the receivership.

When making these decisions, the receiver also should keep in mind other parties that will need the submitted information. For example, do other state departments of insurance or guaranty associations need the information? When should claims be submitted to the guaranty associations? At what point should the reinsurers be notified of such information, etc.?

#### 1. Receipt

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 impact whether certain claims were timely submitted. Consulting the statutory framework or relevant court order will help to resolve these issues.

Documenting receipt of claims is essential. For example, claims may be stamped with the date received and then recorded in the receiver’s (electronic) books and records. (It is best to use a stamp that will not create problems for the receiver at a later date. In one estate, a receiver stamped all incoming claims “ACCEPTED.” When a dispute arose over whether the receiver thereby had approved the claim for payment, the supervising court determined that it had.) It may be prudent for the receiver to retain the envelope with the proof, especially if the claim is considered late-filed. The receiver also may keep detailed mail logs reflecting when proofs of claim were mailed and the date the claims were received. Upon receipt of a completed proof, appropriate verification and recording of the date of filing can be made and subsequently communicated to interested parties such as guaranty associations, so that the status of the claim in the receivership proceeding may be determined.

Some receivers notify creditors of their receipt of claims. If a large number of claims have been submitted, it may not be cost-feasible to acknowledge each claim or piece of correspondence. If acknowledgment of receipt is desired or required, the receiver should establish the timing and form of such acknowledgment. Occasionally, claimants may ask for status reports on their claims. Some receivers provide claimants with periodic reports advising them of the status of their claims; others provide general status reports of the receivership through toll-free numbers or the Internet.

This process may be streamlined by utilizing ClaimNet, which provides documentation of the time and date the proof of claim was received and the ability to provide electronic mail notification to

claimants of receipt of the proof of claim. ClaimNet also allows claimants to check the status of their claim electronically.

## 2. Guaranty Association Claims

The receiver should establish effective communication with the affected guaranty associations at the earliest possible date in the insolvency. (See IRMA Sections 303 and 405.) This is the essential first step to efficient referral of claims to the appropriate associations. After claims have been referred to the guaranty associations, questions about these claims can be directed to the appropriate individuals responsible for handling the claims at the guaranty associations. The receiver also may need to monitor situations 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 transition payments. These payments should be treated as early access or subject to reimbursement by the guaranty associations. The transition payments may be particularly helpful to some claimants, such as workers' compensation claimants. IRMA Section 802 D specifically provides for transition payments to workers' compensation claimants.

Referral of claims to guaranty associations does not end a receiver's involvement with either the guaranty associations or the referred claims. Based upon the projected availability of assets, the receiver has the responsibility to identify claims that guaranty associations may pay in full or in part, either because part of the claim is excluded from guaranty association coverage or exceeds the applicable cap. A "team" or "joint" approach to resolve these types of claims should be considered. Where guaranty associations handle day-to-day claim processing, it is important that the associations keep the receiver advised of developments so that the receiver can comply with reinsurance notice requirements. Such communication facilitates orderly administration and collection of receivables from reinsurers.

Under IRMA, guaranty associations are allowed to file a single omnibus proof of claim for all claims of the association (IRMA Section 702 D). The omnibus proof of claim of the guaranty association may be updated periodically without regard to the claims deadline.

### **B. Review of Claims**

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 (IRMA Section 707 A).

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, *except* 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 (IRMA Section 703 A). However, if there are insufficient assets to justify processing all claims for any class, the liquidator shall report the facts to the receivership court and make appropriate recommendations for handling the remainder of the claims (IRMA Section 703 K). 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 (IRMA Section 703 A).

The receiver should manage the claim staff to achieve these goals. To the extent that claims review and resolution is dependent upon guaranty associations handling the claims, the receiver should consider every opportunity to assist the guaranty associations in resolving claims promptly so the receivership may be closed.



The claims review process assists the receiver in verifying the extent of the insurer’s insolvency, the insurer’s entitlement to reinsurance recoverables, and whether any obligations are owed to the insurer, such as salvage and subrogation recoveries. The receiver in a property and casualty insolvency should evaluate whether the insurer’s salvage and subrogation claim operation is adequate. 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. A carefully crafted proof of claim form, properly completed by a claimant, often reveals such information.

Disputes may arise between receivers and guaranty associations about which party is authorized to collect and retain salvage and subrogation recoveries, including which party will pursue post-receivership subrogation recoveries. In *Cal. Ins. Guarantee Ass’n v. Superior Court*, 64 Cal. App. 4th 219, 220-21 (Ct. App. 1998), the dispute concerned 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 with its own assets, such as proceeds from premiums it charges its members, it is 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 many instances, before the guaranty association assumes responsibility for the handling of a claim, sums have already been paid for indemnity or defense costs toward the payment of a claim, so the pre-receivership payments of the insolvent insurer are part of the subrogation claim. Receivers should review applicable state law on this issue.

In the case of non-contract surety claims, the receiver needs to review the bond file to determine if it is cost-effective for the estate to pursue salvage or subrogation.

In the case of contract surety claims, the receiver will need to review the underwriting file of the contractor (principal). This file may be called something other than the “underwriting file,” such as the “financial file,” “special file” or the like. The receiver should review these files 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 for Timeliness

Timely filing of a proof of claim may determine whether a claim receives any payment and, if so, at what level of priority. It is the receiver’s job to determine whether each claim is timely filed.

Timeliness determinations may be made with reference to the bar date and with regard for the receiver’s policy and/or court orders for determining when a claim is deemed received. If, for example, the receiver concludes that a claim is deemed received when mailed, a proof of claim postmarked by the bar date would proceed to the next level of review. If not, then the claim would be categorized preliminarily as “late-filed,” and perhaps relegated to a lower classification or even disallowed.

##### a. Late-Filed Claims

If a claim is filed late and it is unlikely there will be assets available for distribution to late-filed claimants, then the receiver should notify the late-filing claimant. If the claimant believes there is an excuse for the late filing, the claimant likely will object. Remember, however, that even late-filed claims may generate reinsurance recoveries.

There are a number of situations in which late-filed claims may be treated as timely filed for the purpose of evaluation and distribution of assets. The receiver first should review the receivership statutes for provisions regarding the treatment of late-filed claims. If the statutes are silent, the

receiver may want to provide for their treatment in the liquidation order or some other court-approved declaration of claims handling procedures. The usual statutory threshold criterion is that allowance of the claim must not prejudice the orderly administration of the receivership. Courts have liberally construed such provisions, allowing late-filed claims. IRMA's priority scheme provides that late-filed claims that meet certain specified criteria should be classified in Class 10 (IRMA Section 801).

Failure to give notice may affect the treatment of a late claim. For example, in some states, a late-filed claim may be allowed as a timely filed claim if the claimant can show that he/she was entitled to receive actual notice of the receivership and claim filing procedures but was not sent such notice. In another 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 tends to be fact-intensive, a receiver will probably not be able to rely on published notice if the claimant's name and address are contained in the insurer's records or are otherwise readily available. (See *Elmco Properties* cited above.)

Under many statutes, late-filed claims also may be treated as timely filed if the claim's existence was not known to the claimant at the bar date, but the claimant filed the claim as soon as reasonably possible after learning of the claim's existence. Other late-filed claims that may be allowed include those of creditors who received transfers that were voided or who surrendered the asset transferred to them, and those of secured creditors whose security was valued below the amount of their claims (IRMA Section 701 B). IRMA also provides that a claim filed by a reinsurer whose reinsurance contract is terminated, in which the claim arises from the termination, shall not be deemed late if filed within ninety (90) days of the termination and shall receive a ratable share of distributions, whether past or future, as if the claims were not late (IRMA Section 701 C).

#### b. Post-Bar Date Maturity of Timely Filed Claims

Some claims filed by the bar date may not be absolute for a variety of reasons. The receiver may request the court to set an absolute (or final) bar date, by which timely filed claims must be made absolute. Thus, any claim that is not proven to be absolute, liquidated and mature by that date would be denied.

- Policyholder Protection Claims

Claims that are timely filed, but not yet due (because they are contingent, unliquidated or immature) 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, or hold until a later date, a claim marked "unstated in amount" or "contingent," or that purports to set forth immature claims. Some states permit policyholders to file proofs for claims that they fear or have reason to believe may be brought against them but have not been made as of the bar date. Such "claims" may be referred to as "omnibus" proofs, "policyholder protection" claims and the like. (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 bar date passes. Other receivers allow proof of claim amendments of all types until assets are distributed. Receivers should consult their local statutes and applicable court decisions on this issue.

- Third-Party Contingent Claims

In some states, the claim of a third party (i.e., not a policyholder) that is contingent on prior entry of a judgment establishing liability (i.e., situations in which liability is uncertain but the event that is the subject of the litigation or claim occurred prior to the fixing date) must be considered and reviewed as if there were no contingency. In such states, non-contingent claims—those for which liability is certain but the amount of loss is uncertain (i.e., unliquidated claims) or claims that are due except for the passage of time (i.e., immature claims)—will be handled along with other absolute claims. In some instances, however, immature claims may be discounted to their present value as of the fixing date, at the legal rate of interest. IRMA provides that the third-party claimant may also file claims with the liquidator before expiration of the claims deadline (IRMA Section 706). In such instances, the insured may also file a claim for the third-party claim. IRMA Section 706 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. IRMA Section 706 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.

IRMA Section 706 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.

- Amendment and Supplementation of Claims

Amendments often assist the receiver in the disposition of claims that were timely filed but were contingent, unliquidated or immature at the time of filing. Consistent with statutory authority, the receiver decides what types of amendments, if any, will be allowed. Amendments may include, but are not limited to, correcting or updating the amount, correcting technical defects, and providing sufficient documentation. In some states, insureds may 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 before assets are distributed.

- Assumed Reinsurance Claims

As for the policies of a property and casualty insurer, the liability for claims that a property and casualty 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 claims 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.)

- Claims under Occurrence Policies, etc., under IRMA

Generally, under IRMA, any insured shall have 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 (IRMA Section 704).

- Contingent/Unliquidated Claims under IRMA

Under IRMA, a claim is contingent if the accident, casualty, disaster, loss, event or occurrence that is insured, reinsured or bonded against occurred on or before the date of the liquidation order, but the act or event triggering the company's obligation to pay has not occurred as of that date. A claim is unliquidated if the insurer's obligation to pay has been established, but the amount of the claim has not been determined (IRMA Section 705 A). Under IRMA, a contingent claim may be allowed if the claimant has presented reasonable proof of the insurer's obligation to pay, or the claim was based on a cause of action against an insured and certain other conditions are met (IRMA Section 705 B).

IRMA provides that an unliquidated claim may be allowed if its amount has been determined, or, if the amount remains undetermined, the valuation of the unliquidated claim may be made by estimate (IRMA Section 705 C).

## 2. Review as to Form

Having concluded that a proof of claim was timely filed (or properly amended), the receiver next reviews the form to determine whether all of the required information has been provided and 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) (IRMA Section 703 I).

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

The starting point in the review of any policy claim filed against an insurer is the policy or surety bond. 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 (IRMA Section 703 A).

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 (IRMA Section 706 D). 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 accident and health claims, the receiver should be alert to pre-existing 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 default or by collusion need not be considered as evidence of liability of the amount of damages (IRMA Section 703 E).

b. Assumed Reinsurance Claims

Most states accord cedents' claims the same priority as claims of general creditors (Chapter 9—Legal Considerations). Because there usually are insufficient assets to satisfy all policyholders' claims, the receiver should determine whether there are likely to be sufficient assets to pay any portion of general creditor claims before investing time in reviewing them. If it appears that the insurer's assets will cover only a portion of the policyholder claims, there may be no need to evaluate any general creditor claims, including those of cedents, unless the insolvent company was a reinsurer or if the insurer has retroceded all or a portion of its reinsurance business. In the latter 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. Of course, if the insurer only assumed reinsurance obligations, the cedents will make up the largest class of creditors.

Assuming there are reinsurance recoverables available or that there will be assets to distribute to general creditor claimants, 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, it then is the receiver's job to determine if reinsurance claims are covered. For example, the receiver should determine whether proper notice of the claim was given and whether all premiums and other amounts due the insurer under the reinsurance contract have been paid. The receiver also should pursue any claims the insurer may have against the cedent (e.g., for unpaid premium, salvage, etc.).

c. Certain Other Types of Contracts

The receiver should carefully review the terms of the employment contracts with directors, officers or other individuals performing similar functions or having similar powers. 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 (IRMA Section 703 F). 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 (IRMA Section 703 L).

The receiver also should carefully review the terms of all netting agreements or qualified financial contracts. IRMA provides suggestions for the receiver as to how to deal with these types of contracts. (See IRMA Section 711.)

#### 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). Certain claims may be approved by both entities, but other claims may be approved by one and not the other. 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.

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, 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 property/casualty guaranty associations. Property and casualty guaranty association claims are typically related to terminated policies whereas, life/health guaranty associations obligations are related to the continuation of certain benefits under the insolvent insurer's contracts.

Life/health guaranty associations frequently satisfy coverage obligations by transferring those obligations to a different insurer through an assumption reinsurance agreement negotiated by the NOLHGA. Consequently, the nature of the claims and expenses related life/health guaranty associations obligation is considerably different than the claims and expenses of property and casualty 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. However, some state statutes provide that only the receiver determines whether a claim: 1) is covered by the insolvent insurer's policies; and 2) is within the applicable limits of insurance policy coverage. Although IRMA Section 703 A 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, co-payments, 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 the guaranty associations is essential.

Frequently claims covered by guaranty associations are reinsured. It is important for the guaranty associations to apprise the receiver of developments on these claims so that reinsurance notice requirements may be met. More importantly, a breakdown in communication concerning these claims may hinder the collection of receivables from reinsurers. Because the guaranty associations benefit substantially from reinsurance collections, the receiver and the guaranty associations have a common interest that should encourage cooperation from the receivership's inception.

#### 5. Review as to 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 (IRMA Section 709).

### **C. Quantification/Valuation of Claims**

All claims must be assigned a value before allowance or payment. 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 (IRMA Section 703 H).

#### 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 (IRMA Section 710 A). 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 (IRMA Section 710 C, D).

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. Estimation

##### a. Claims in a Property/Casualty Insolvency

The long-tail nature of some claims in a property/casualty receivership presents special problems 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 normal claims issues of coverage, liability and damages, the receiver should have a plan to deal with long-tail claims. In particular, for purposes of interim dividend distributions, some receivers



use a combination of internal claim estimates and independent actuarial estimates of the total known and future claims, to determine a distribution rate for all non-contingent and liquidated claims. Typically, the distribution rate is conservative so that if claim estimates are incorrect, there will still be sufficient assets available to pay future claims at the same distribution rate as existing claims. Further, there may be disputes about the appropriate priority of certain claims. In such instances, until the priority issue can be resolved by the receivership court, receivers may determine and pay claims at a payout rate based on the assumption that disputed priority claims are ultimately paid at the priority asserted by the claimants. Thereafter, when the disputed priority issues are resolved, the payout rate may be adjusted by the receiver. Assumed payout rates can be used to establish discount rates for present valuation of the total incurred claims for purposes of negotiating commutations with reinsurers.

Before a claim may be allowed, the receiver needs timely and accurate evidence:

- 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.
- 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.

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.

- 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, the governing statutory and case law, the character of the claims and the records available. A number of alternative approaches are available to the receiver:
  - 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 defeats policyholders' reasonable expectations of recovery and may limit the receiver's right to collect from reinsurers.
  - Extensions of claims bar dates may ameliorate, but not eliminate, the risk that a policyholder with a legitimate claim will be left without a real remedy. It sometimes helps to establish a second bar date, just prior to final distribution, in order to allow late-filed claims an opportunity for recovery. This extended cut-off approach does not facilitate early distribution of assets or early closure of the estate.

- Some receivers have obtained approval for plans under which claims bar dates are removed or extended and policyholder claims are allowed for distribution as they mature. This “run-off” approach does not facilitate early distribution of assets or early closure of the estate.
- 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 (IRMA Section 703 D).
- 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) permit the estimation of policyholder claims, statutory authority may not be necessary. However, the receiver should seek receivership court approval for such a plan with proper notice to all interested parties. There is case law that allows for claims estimation when a state statute permits estimation for the payment of claims or recovery of reinsurance proceeds. (See *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.”) *Id.* at \*217-18. At some point after the normal claims bar date, the receivership court may direct the receiver to estimate the ultimate claims of policyholders exposed to late developing losses, and may allow each such policyholder a claim in the amount of the estimate, reduced to present value. Depending on the state law’s provision for late claims, the estimated claims may be allowed at lower priority levels (e.g., Illinois). There is also case law providing 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.) In *Integrity*, the court rejected the holding in the *Holland-America Insurance Company* case that permitted claims estimation for receivership distributions, maintaining that the Missouri court allowed an estimation scheme because it was specifically allowed by statute. *Id.* at \*5. The *Integrity* court decision itself is based on a state statute which provides that no contingent claim shall share in a distribution of the assets of an insolvent insurer, except that such claims will be allowed to share in the assets of the insurer if they become absolute and non-contingent before the last day fixed for filing proofs of claims against the assets of the insurer. *Id.* at \*3. The *Integrity* court explained that IBNR claims are actuarial estimates and are, therefore, not absolute, and thus, IBNR claims cannot share in the assets of the estate. *Id.*

Assuming that an estimation plan is lawful, 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 (IRMA Section 611 I).

b. Claims in a Life/Health Insolvency

Few receivership statutes directly address the issue of valuing life and annuity claims. Fortunately, there is a well-developed body of case law on the subject. In any event, it often will be necessary to gauge the scope of policyholder claims in order to evaluate whether groups of policyholders are being fairly treated in any rehabilitation, liquidation or assumption reinsurance transaction.

i. 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 the going concern company, centering around 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.

ii. Immature Claims

Somewhat greater challenges 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, since the policyholder usually has significant rights at the liquidation date, including surrender rights or rights to unearned premium. Court cases, 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 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 his or her 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, since 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 which, 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 all or a portion of the filed proofs of claim, the claimants should be advised of the 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, IRMA Section 703 B 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 (IRMA Section 703 C). IRMA allows the liquidator to accelerate the allowance of claims by obtaining waivers of objections (IRMA Section 703 C). 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 (IRMA Section 703 B). 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 (IRMA Section 707 B). However, there is case law supporting the proposition that the commissioner 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 (IRMA Section 708). 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 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 (IRMA Section 707 C). 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 (i) the time and date of the hearing, (ii) the procedure to be followed at the hearing, (iii) the amount claimed, (iv) the relevant priority status of the disputed claim(s), (v) the reason for the denial or priority status assigned, and (vi) 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 (IRMA Section 707 D).

#### 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 (review of applicable law on this point is essential), 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. 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.

IRMA Section 105 E recognizes the propriety of arbitration to resolve reinsurance disputes. (See Chapter 7 VII.)

## F. Reserving

The establishment of appropriate reserves is 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 property/casualty 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 or not 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 which 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 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 accident and health 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. Adjustments

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, proofs of claim are being amended after the bar date or the supervising court extends the claims filing deadline. Such adjustments typically affect the amount of a letter of credit 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**



On a national level, there is an increase in the number of claim assignments that are presented to receivers. One of the many regulator consumer protection duties to be fulfilled on behalf of the policyholder is to make certain that claims assignments are being carried out. Some states have developed policies for managing the assignment of claims and the Receivership Technology and Administration (E) Working Group provided a forum to draw upon the experience of those states as well as those of other state regulators and other interested parties to a receivership to develop guidance of how to address claims assignment issues. Keeping consumer protection in mind, each state should review its state statutes and regulations regarding the access to information that potential claim buyers have and whether there are any legal privacy issues at the state and federal levels.

## 1. Cost of Receivership of Claims Assignments

### a. Explanation of the issue

Each state is going to have different issues addressing the specific cost of claims assignments contingent upon their specific state laws pertaining to claims assignments, and their own rules that apply to verify and process such assignments. Some specific costs are noted below.

### b. Considerations

- i. Developing and maintaining the proper infrastructure to record a claims assignment. The Liquidator must maintain the original claim, and record the claim assignee as the new proper claim beneficiary.
- ii. Processing the request. Some form of external notice must be generated to initiate a claim assignment. How is it received and recorded?
- iii. Due diligence. The liquidation must verify whether the assignor is the appropriate party to execute the assignment.
- iv. The disparity of knowledge between the claim seller and the claim buyer regarding the claim assignment process can be significant. This results in increased communication demands from buyers on the Liquidator.

### c. Recommendations

- i. Provide additional court filings with required listings of all approved claims on a quarterly basis.
- ii. Establish a specified time frame to respond to a claims assignment request irrespective of the quality of information submitted in the request.
- iii. Revise the existing database to record whether the creditor was eligible to have the personal data of his claim published or not.
- iv. Research all open states, provide listings of creditor information and obtain consent from all creditors for the release of a personal claims data.
- v. Require the Liquidator to make a good faith effort to predict when distributions would occur and estimate pay out percentages for the distribution.

## 2. Difficulty Associated With Verifying Claims

### a. Explanation of the Issue

- i. Some companies placed in liquidation have poor records (e.g., accounting, policy, claim and reinsurance records). Records have to be reconstructed by estate staff before basic policy information can be verified (e.g., in-force coverage at time of loss, policy terms, deductibles and exclusionary endorsements). This information is necessary for the estate and guaranty funds to verify coverage and appropriately handle asserted claims against the estate.
    - ii. Some estates have switched to a paperless environment (i.e., record-only system). If these record-only systems are not maintained properly or kept current, the estate is unable to transition complete and accurate records or to access pertinent supporting documents. See. 2.a.i above for reconstructing estate records.
    - iii. Claimants do not keep estate informed of changed information (e.g., corporate name change, merger of company into another entity, change of address, name change due to divorce and death of claimant). Lack of updated claimant information slows down the verification process.
  - b. Considerations
    - i. The estate and guaranty funds require accurate information to verify coverage and to appropriately handle asserted claims against the estate.
    - ii. The issue of the estate utilizing resources in order to handle inquiries concerning the claims assignment process. Additional pressures exerted on estate staff to finish verification process quickly by third-party vendors.
    - iii. Possibility that the estate may have to retain legal counsel to assist the estate in complex claim assignment issues.
  - c. Recommendations
    - i. Establish standards, as well as a submission package, for use by all estates for processing of claim assignments with third party vendors.
    - ii. Permit estates to bill third-party vendors for work performed in processing claim assignments (e.g., telephone inquiries, production of reports, verification of assignment from claimant, detailed claims history information and updating estate records).
3. Cut-Off Dates
  - a. Explanation of the Issue
    - i. Establishing a date prior to the issuance of any estate distribution monies where incomplete and/or unverified claim assignments will no longer be processed by the estate. Some estates bulk or batch process its distribution document (e.g., letter, envelopes and distribution checks). Time is needed to close the estate records from any future updates to the distribution documents can be bulk or batch processed.
    - ii. Many third-party vendors are either on the estate's service list or receive notification through other means of pending estate distributions. The number of claim assignment requests increase significantly just prior to a pending estate distribution.
    - iii. Generally, once complete and verified claim assignments are received, estate records can be updated quickly in one or two days.
  - b. Considerations

- i. Sufficient time is needed to close the estate records from any future updates so the distribution documents can be bulk or batch processed. Without establishing a cut-off date, last-minute claim assignments could disrupt the estate distribution process.
- ii. The concern that the third-party vendor (“assignee”) may have more information than is known by the claimant “assignor”). The need to ensure that the assignor has full knowledge of all relevant facts before making the decision to assign the claim to a third party vendor.
- ii. Time needed to verify the accuracy of the claim assignment with the assignor prior to the pending estate distribution.

#### 4. Interpretation of Financial Information

##### a. Explanation of the Issue

Explore options to facilitate the interpretation of financial information by entities and claimants that are interested in buying/selling claims.

##### b. Considerations

- i. Publish financial statements and court information (in the Global Receivership Information Database [GRID] and/or on receivership websites) with no additional interpretation. This is currently available in GRID.
- ii. Develop a consumer guide that would help claimants make an informed decision regarding the potential value of their claim.

##### c. Concerns

- i. Interpretation of financial information varies based on type of financial information made available, which varies from state to state.
- ii. Development of a consumer guide to encompass all types of receiverships.
- iii. Publish in GRID and/or receivership websites a number to call to receive information on when a distribution may be made and possible percentage.
- iv. Publish a good faith estimate or other type of predictive information regarding the timing and amounts of potential distribution with no additional interpretation.
- v. Any combination of the above.

##### d. Recommendations

To close the gap on asymmetric information concerns, it is recommended that receivers publish a consumer guide with a “Frequently Asked Questions” document. However, further discussion is needed to finalize a long-term recommendation regarding other available options.

#### 5. Consumer Protections (Fairness)

##### a. Explanation of the Issue

Basic question: What duty, if any, does the Insurance Commissioner in his capacity of statutory liquidator have to claimants who may wish to sell their claim?

Claims assignment vendors (the entities who purchase creditor claims) who purchase creditor claims in an insurance insolvency proceeding are not regulated. They do not have generally accepted practices applicable to purchasing claims. There is no definition of the due diligence required for identifying the party with the proper legal authority to sell a claim. They have no specific statutory prohibition on what advice they may give the seller of a claim, nor is there any guideline on what they are required to pay for the purchase. There is no statutory requirement that the claims assignment vendor must get a claim purchase approved by the court overseeing the liquidation process.

Conversely, there is statutory authority that requires a liquidator to accept assignments, but there are no regulations regarding what the liquidator may require before it accepts a claim assignment.

Many estates cover several years before a first distribution occurs for the non-Guaranty Association claimants, generally the “little guys” who would be the most likely to benefit from selling a claim for a percentage of its ultimate value and receiving payment for their claim now. The claims assignment vendor then bears whatever risk that unforeseen circumstances may reduce the ability of an estate to make distributions, but the vendor does receive the entirety of the amount which would have been received by the seller whenever distributions are made.

Consumer protection considerations for the Commissioner include the attempt to make sure that all the claimants are treated equitably. This duty appears to be at least twofold— i.e., the claimant harmed by the insurance insolvency should get the fair value of his or her claim at any given time, and the liquidator should not be burdened with a set of rules and regulations that are onerous, which causes the estate to incur expenses that diminish the value of claims of other creditors.

Each state must be conversant with its own, as well as the federal, consumer protection statutes in terms of what information can go into the public domain. For example, do name, address and amount approved for the creditor claim submitted for a court filing constitute any kind of issue for the liquidator? Does it make a difference if the creditor is a corporation versus an individual? Does it make a difference if you add a tax payer ID or an SSN? How about if you post the same information on the liquidator's website instead of within a court filing?

b. Considerations

- i. Should claim assignments require court approval whereby a Judge overseeing the liquidation specifically approves the assignment for “fairness”?
- ii. Should claims assignment vendors be regulated to ensure scrupulous practices, or, should the Liquidator be allowed to create whatever rules deemed appropriate to control the assignment process?
- iii. What constitutes reasonable expense for the Liquidator to make the creditor information available for claims assignment vendor?
- iv. What mechanism allows creditors to find a claims assignment vendor?
- v. In general, individuals are perceived to have more acute needs for immediate money than corporate entities, but they also have more privacy protections afforded. Should the claims assignment process be limited to just businesses?
- vi. Should the liquidator allow all approved creditors the opportunity to opt-in, or to opt-out, of the publication of their name, address, approved claim amount, and Tax-ID or SSN?

vii. Should the liquidator be responsible for having sufficiently simple financial data available on their website to allow relatively unsophisticated creditors to knowledgeably be able to discuss the value of their claim with a probably more sophisticated representative of the claims assignment vendor?

c. Recommendations

Each state should review its current state statutes and requirements to make sure they are compliant.

6. Information Exchange

a. Explanation of the Issue

Explore options to facilitate the exchange of information between entities and claimants that are interested in buying/selling claims.

b. Considerations

i. Provide information through a match-up of willing buyers and willing sellers.

a) Identify willing sellers through an “opt in” process and a forum for willing buyers and sellers to communicate.

b) Concerns:

i) Limiting the exchange of information to a subset of claimants willing to sell their claims may not pass public records scrutiny.

ii) Providing a forum for buyers and sellers to exchange information will add additional cost to the receivership.

iii) The creation of a receiver-sponsored forum will create potential issues regarding the implied endorsement/recommendation of a particular buyer and may influence the consumer’s ultimate decision to sell a claim.

ii. Provide information by filing claim reports with the receivership court.

iii. Address privacy concerns regarding protected personal information.

iv. Provide non-protected information through claim report court filings.

v. Provide non-protected information through Web postings.

c. Recommendations

To promote efficiency of receivership resources and transparency in providing non-protected information to the public, it is recommended that receiverships provide non-protected information through claims report filing with the receivership court and Web posting of such information as it becomes available.

7. Availability of Receivership Information to the Public and Related Procedures

a. Explanation of the Issue

Consumer privacy concerns (both legal and common sense) advocate identity protection for consumer claimants. However, certain state laws contain requirements regarding identifying information which must be included in receivership proceedings. To the extent permitted by state law, receivership pleadings should accordingly seek to protect specific identifying information of individual consumer claimants. For example, where permitted, receivership pleadings should not combine both names and addresses, or other specific identifying information, for individual consumer claimants.

b. Considerations

- i. Privacy concerns aside the receiver has no fundamental objection to claim assignments.
  - a) Property right
  - b) A fair claim assignment can be good result (time, uncertainty)
  - c) Receiver has sold claims it holds in other receiverships
- ii. Nonetheless, assignments have consumer protection issues that are Commissioner/Receiver's legitimate concern.
  - a) Fundamentally, consumer protection is key aspect of insurance regulation
  - b) Obligation to have a process that is designed to yield best results for creditors (not a duty to achieve a particular result, but for good process)
- iii. Reasonable measure to protect creditor interest in claims trading are warranted. Areas of concern that these measures address should include:
  - a) Information symmetry/transparency
  - b) Preventing abuse
  - c) No undue administrative burden
  - d) Fraud detection

c. Recommendations

- i. Receiver should develop practical methods for distinguishing individual consumer claims from commercial/corporate creditors in receivership pleadings.
- ii. Contested claim pleadings, where specific identifying information may need to be plead, may require special procedures where appropriate (e.g., filing under seal).
- iii. Receiver believes it has identified a number of protections that, in combination, can give the Commissioner confidence that claims trading on receivership estate claims takes place in a fair environment.
  - a) Convenient publication of better estate information, including publishing allowable corporate claim lists with identifiers.
  - b) Good faith estimates (forward looking statement of intent, typically regarding amount and time of distribution).
  - c) Requiring acknowledgement of information.

- d) Tracking of assignment percentage (price).
  - iv. With these protections in place, the receiver is not, as an initial matter, opposed to a carefully constructed process by which buyers and sellers find each other (whether an information exchange or a publication of claimant identifying information that avoids legal and common sense privacy concerns). The construction and ultimate acceptance and implementation of any such process would involve consideration of many complex issues such as: liability, unintended implicit receiver approval, and use of resources.
8. Federal/ State Privacy of Claimants’ Personal Information
- a. Explanation of the Issue

Information regarding claims is typically reported in a receivership proceeding in accordance with the state receivership laws. Receivership laws vary regarding the information that must be included in a report. Some laws require that each individual claimant must be named. Under certain circumstances, information may be submitted to the court under seal.

Federal privacy laws, such as the federal Gramm-Leach-Bliley Act (GLBA) and the federal Health Insurance Portability and Accountability Act (HIPAA), restrict the disclosure of personal information by insurance companies. In addition, states have adopted privacy statutes and regulations regarding the disclosure of information by insurance companies.

The disclosure requirements in these statutes are summarized in the following Exhibit—Summary of Disclosure Provisions. There are issues regarding the applicability of these laws in a receivership.

- b. Considerations

*GLBA*

The GLBA imposes restrictions on an insurer's disclosure of “non-public personal information” about a consumer. A list of names and addresses derived from personally identifiable financial information is non-public personal information. Subject to certain exceptions, an insurer is prohibited from disclosing to a nonaffiliated third party any non-public personal information, unless the consumer does not “opt out” after proper notice. This prohibition does not apply to disclosures to regulators, or to comply with laws, investigations, subpoenas or other judicial process. The GLBA's privacy requirements do not override state law, except to the extent that a law is inconsistent with the GLBA. A state law is not inconsistent with the GLBA if the protection it affords is greater than the protection provided by the GLBA.

*HIPAA*

HIPAA privacy standards apply to health plans, clearinghouses, and health care providers that transmit health information as defined in the Act. HIPAA protects “individually identifiable health information,” which includes names and geographic subdivisions smaller than a state. HIPAA restricts the disclosure of protected health information without the consent of the individual.

*State Privacy Laws*

The GLBA requires insurance regulators to adopt privacy standards for insurers. The NAIC has adopted the *Privacy of Consumer Financial and Health Information Regulation* (#672). The Model #672 applies to licensed insurers, producers and others required to be licensed. It does not

specify whether it applies to an insurer in receivership. However, a drafting note to Model #672 suggests that a rule could provide an exception for insurers in receivership.

c. Recommendations

A receiver should consider the following:

- i. If a receivership act requires the disclosure to a claimant's name and/or address:
  - a) Is the information regarding the claimant considered publicly available under the GLBA because disclosure is required by state law, or
  - b) Is the requirement to disclose information regarding the claimant pre-empted because it is inconsistent with the GLBA?
- ii. If the GLBA governs the content of a claim report:
  - a) What information may a claim report include if a claimant has opted out? What information may claim report include if a claimant has not opted out?
  - b) To avoid the administrative cost involved in identifying those claims who have opted out, should all claimants be treated as if they opted out?
- iii. Under HIPAA, what information may a claim report include regarding a health insurance claim filed by an individual?
- iv. Is an insurer in receivership a "licensee" under the state privacy law? If there is a conflict between a state's receivership act and privacy act, which law prevails?
- v. If the disclosure of information regarding individuals with insurance claims is prohibited, should a claim report identify other claimants (e.g., corporations or general creditors)? If these claims are reported differently, will this impose an administrative burden on the receivership estate?
- vi. Under what circumstances should a claim report be submitted to the court under seal of *in camera* inspection?
- vii. If a receivership act only requires that a claim report disclose the amount and class of each claim, what information should be provided to identify claims?

9. Exhibit—Summary of Disclosure Provisions

a. Federal Privacy Laws

i. Gramm-Leach-Bliley Act (GLBA)

GLBA imposes requirements on financial institutions to protect the privacy of their customers. *See* 15 U.S.C. Subchapter I, §§ 6801-6809.

*Applicability*

GLBA applies to a "financial institution", which is defined by 15 U.S.C. § 6809 (3) (A) to mean an institution engaging in financial activities as described in 12 USC § 1843 (k). Section 1843(k) provides that activities that are considered to be financial in nature include insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death, or providing and issuing annuities.



15 U.S.C. § 6809(4) defines “non-public personal information” to mean personally identifiable financial information resulting from any transaction with the consumer or any service performed for the consumer, or otherwise obtained by the financial institution. The term specifically includes “any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived using any non-public personal information other than publicly available information”, but excludes “any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any non-public personal information.” Nonpublic personal information does not include “publicly available information”, as defined by regulations prescribed under 15 U.S.C. § 6804.

Non-public personal information is further described by regulations. 16 C.F.R. 313.3 (n) provides examples of non-public personal information, including "any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information (that is not publicly available), such as account numbers." Nonpublic personal information does not include “any list of individuals' names and addresses that contains only publicly available information, is not derived, in whole or in part, using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.”

16 C.F.R. 313.3 (o) (1) defines personally identifiable financial information to mean any information a consumer provides to a financial institution: (i) to obtain a financial product or service; (ii) about a consumer resulting from any transaction involving a financial product or service; or (iii) that a financial institution otherwise obtains about a consumer in connection with providing a financial product or service. Examples of such information include the fact that an individual is or has been a customer, or has obtained a financial product or service from a financial institution, and any information about a consumer that is disclosed in a manner that indicates that the individual is or has been a consumer of a financial institution.

16 C.F.R. 313.3 (p)(1) provides that “publicly available information” means any information that a financial institution has a reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records; widely distributed media; or “disclosures to the general public that are required to be made by federal, state, or local law.”

#### *Restrictions on Disclosure*

GLBA imposes restrictions on a financial institution’s disclosure of non-public personal information provided by a consumer. Subject to certain exceptions, 15 U.S.C. § 6802 prohibits a financial institution from disclosing to a nonaffiliated third party any non-public personal information, unless the financial institution provides the consumer with an “opt out” notice, gives the consumer a reasonable opportunity to opt out, and the consumer does not opt out. Section 6802 (e) (8) provides that this prohibition does not apply to “the disclosure of non-public personal information to comply with federal, state, or local laws, rules, and other applicable legal requirements; to comply with a properly authorized civil, criminal, or regulatory investigation or subpoena or summons by Federal, State, or local authorities; or to respond to judicial process or government regulatory authorities having jurisdiction over the financial institution for examination, compliance, or other purposes as authorized by law.”

#### *Relation to State laws*

15 U.S.C. § 6807 provides that GLBA’s privacy requirements “shall not be construed as superseding, altering, or affecting any statute, regulation, order, or interpretation in effect in any State, except to the extent that such statute, regulation, order, or interpretation is inconsistent with the provisions of this subchapter, and then only to the extent of the

inconsistency.” A state statute, regulation, order, or interpretation is not inconsistent with GLBA if the protection it affords is greater than the protection provided by GLBA.

ii. Health Insurance Portability and Accountability Act (HIPAA)

*Applicability*

The HIPAA Standards for Privacy of Individually Identifiable Health Information apply to health plans, health care clearinghouses, and to any health care provider that transmits health information in electronic form in connection with transactions for which the US Secretary of the Department of Health and Human Services (HHS) has adopted standards under HIPAA.

*Restrictions on Disclosure*

HIPAA protects all “individually identifiable health information” held or transmitted by a covered entity. Under 45 C.F.R. § 164.514 (b), a name and any geographic subdivision smaller than a state, including street address, city, county, precinct, zip code or geocode, is considered an “identifier” of an individual.

45 CFR 164.512 describes the conditions under which protected health information can be disclosed without the consent of the individual. 45 CFR 164.512 (a) provides that a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. A covered entity must meet the requirements described in § 164.512 (c) [relating to disclosures about victims of abuse, neglect or domestic violence]; (e) [relating to disclosures for judicial and administrative proceedings]; or (f) [relating to disclosures for law enforcement purposes].

b. State Privacy Laws

Title V of GLBA requires state insurance regulators to adopt standards relating to the privacy and disclosure of non-public personal financial information applicable to the insurance industry. States have adopted statutes or regulations based on the *NAIC Privacy of Consumer Financial and Health Information Regulation* (#672).

*Applicability*

The Model #672 applies to “licensees”, which is defined as “all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the Insurance Law of this state, [and health maintenance organizations].” It does not specify whether it applies to an insurer in receivership. However, a drafting note to the Model states: “Because the notice requirements of this regulation could be a financial burden on a company in liquidation or receivership and negatively impact the ability of the liquidator or receiver to pay claims, regulators may want to consider adding an additional exception providing that licensees in liquidation or receivership are not subject to the notice provisions of this regulation.”

*Restrictions on Disclosure*

The Model #672 defines “non-public personal financial information” to include personally identifiable financial information, and any list, description or other grouping of consumers (and publicly available information pertaining to them) derived using personally identifiable financial information that is not publicly available. “Personally identifiable financial information” as defined in Model #672 includes “[t]he fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee”.

An example of non-public personal financial information given in the Model #672 is a list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers. In contrast, a list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution, is not considered to be non-public personal financial information.

The Model #672 defines “publicly available information” to mean any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law.

c. State Receivership Laws

The contents of a claim report are typically described in the state receivership act. The act may also specify notice requirements for matters submitted to the court (*See* IRMA § 107). Under IRMA § 107 B (1), if the Receiver determines that any documents supporting the application are confidential, they may be submitted to the court under seal for *in camera* inspection.

## 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 IRMA Article VIII.

### A. Priority of Distribution in Receiverships

All state receivership statutes and IRMA Section 801 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; for example, 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 IRMA Section 801. Secured creditors and special deposit claimants are outside the scheme of priorities established by Section 801. Secured creditors are covered by IRMA Section 710, and special deposit claimants are covered by IRMA Section 1002C.

#### 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 for the disposition of specific types of secured claims, i.e., claims involving surety bonds or undertaking, and obligees or completion contractors. (See IRMA Section 710 B.)

## 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 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 of a limited class or classes of persons (*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, IRMA Section 801 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 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 property/casualty guaranty association, in Class 2 (i.e., after administrative expenses of the receiver). The second alternative places the defense and cost containment expenses of property/casualty 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 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 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 ("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: IRMA Section 712, the *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) and, National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act (NCIGF Model). Individual state statutes

based on the NCI GF Model or Guideline #1980 may differ from IRMA Section 712 in certain respects.

b. Previous Guaranty Association Payments

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 usually 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 bar date 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

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 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 vs. 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 letters of credit 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 (IRMA Section 801). (But see *Weingarten v. Gross*, 563 S.E.2d 771 (Va. 2002). Here, 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

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 bar date (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 IRMA Section 701 B and C). 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 through 11 if the liquidator proposes and the court approves a plan to pay interest (IRMA Section 801 K). 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 (*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 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 IRMA 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 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) also maintains a listing of values for the purpose of assessing *ad valorem* (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, and 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 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 (IRMA Section 802 A). Under IRMA, however, the liquidator is authorized 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 (IRMA Section 802 D). (See also Chapter 6—Guaranty Associations.) IRMA also requires the liquidator to make early access payments to guaranty associations from distributable assets of the liquidation estate (IRMA Section 803). (See Chapter 6—Guaranty Associations.)

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 (IRMA Section 802 B). But see 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 (IRMA Section 802 C).

### **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 trust, the receivership is closed, and then the trustee (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 (IRMA Section 804).

## 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 bar date 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 (*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. RECEIVERSHIPS INVOLVING FEDERAL HOME LOAN BANK AGREEMENTS

## A. Overview of Federal Home Loan Banks

Insurance companies are increasingly likely to be members of, and have a borrowing relationship with, one of the 12 Federal Home Loan Banks (each, an “FHLBank”). The FHLBanks are federally chartered cooperatives under the Federal Home Loan Bank Act (the “FHLBank Act”), regulated by the Federal Housing Finance Agency (the “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.<sup>3</sup>

### 1. Definitions Specific to FHLBank Transactions

The following are common terms that a receiver is likely to encounter when dealing with an FHLBank, and may be more specifically defined in FHLBank documents:

- a. “Advance” means a secured loan from the FHLBank to its member in accordance with such terms and conditions as are applicable to such loan under an Advances Agreement, and includes without limitation a funding agreement executed under an Advances Agreement.
- b. “Advances Agreement” means one or more written agreements, including any written, document, policy, or procedure of the FHLBank and incorporated by reference into such written agreements between the FHLBank and its members pursuant to which the FHLBank makes or agrees to make advances and provide other extensions of credit or other benefits to the member and the member, among other things, grants to the FHLBank a security interest in certain collateral.
- c. “AHP” means the Affordable Housing Program of the FHLBank.
- d. “Assuming Insurer” means an Insurer that has entered into a purchase and assumption agreement with the Insurance Department by which the Assuming Insurer has agreed to assume some or all Obligations of a member.

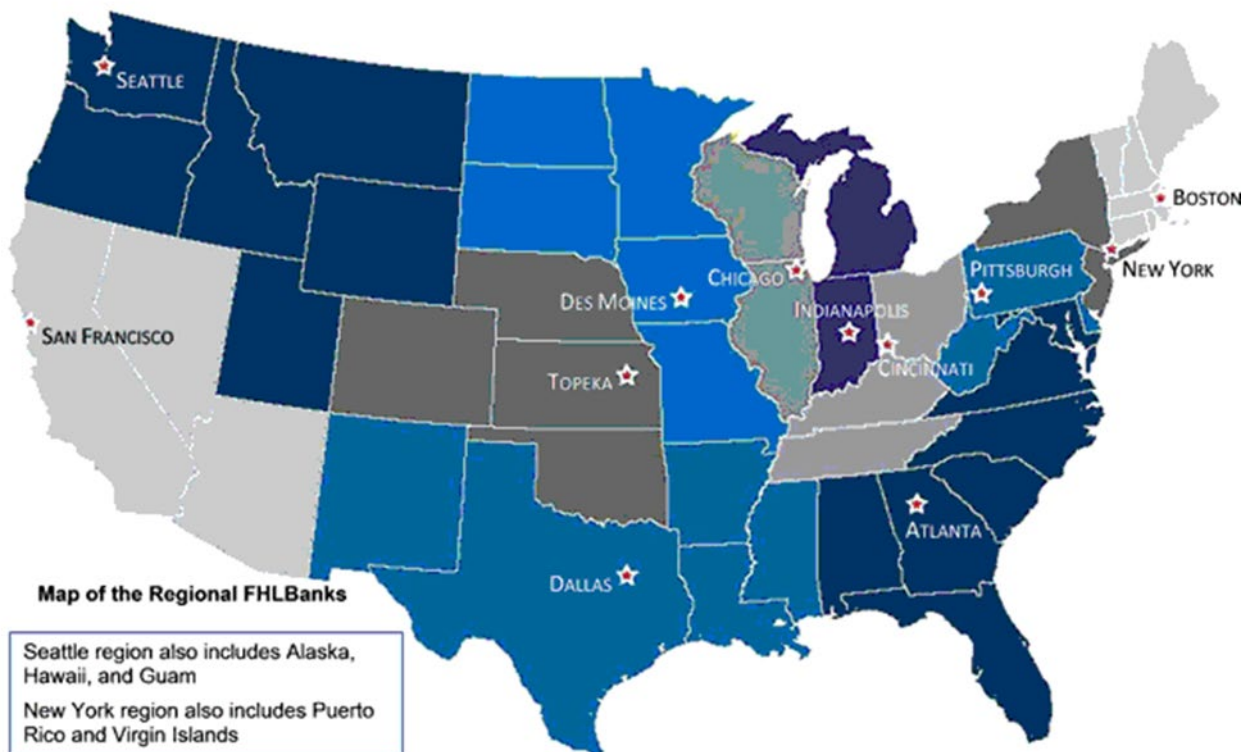
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<sup>3</sup> For additional information regarding the mission and purpose of the FHLBanks, [http://www.fhlbanks.com/overview\\_whyfhlb.htm](http://www.fhlbanks.com/overview_whyfhlb.htm)

- e. "Member" means an insurer that is a member of an FHLBank. Such member will own FHLBank capital stock and may from time to time have outstanding advances or other obligations to the FHLBank, which have not been satisfied in full, or have not expired or been terminated.
- f. "Capital Stock" means all capital stock of the FHLBank owned by a member. Each FHLBank has its own capital plan (which is published on the FHLBank's website), with its own specific capital stock requirements and policies, but generally, each FHLBank requires a member to purchase membership stock (calculated annually) and activity-based stock (required amount fluctuates with the amount of a member's advances or other obligations outstanding). By statute, Capital Stock is Collateral for a member's Obligations to the FHLBank.
- g. "Collateral" means all property, real, personal, and mixed, in which either a member, or an affiliate of the member, has granted a security interest to the FHLBank or the FHLBank has otherwise acquired a security interest. Each FHLBank has its own policies regarding collateral that the FHLBank will accept to secure advances and other obligations, the minimum amount of collateral required, and how the value of such collateral is calculated for purposes of pledging to the FHLBank.
- h. "Obligations" are any and all indebtedness, obligations and liabilities of the member to the FHLBank pursuant to the terms and conditions of the Advance Agreement or any other agreement between the member and the FHLBank, subject to applicable law.

## 2. Geographical Map of FHLBank Districts and FHLBank Contact Information for Receivers

The following is a geographical map of the FHLBank districts and list of FHLBank contact information (as of 2013). 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.



<b>FHLBank</b>	<b>Title/Department</b>	<b>Phone</b>
FHLBank Atlanta	Member Support Operations	mergers@fhlbatl.com
FHLBank Boston	Director of Credit	617-292-9705
FHLBank Chicago	General Counsel	312-565-5805
FHLBank Cincinnati	Vice President, Credit Risk Management	513-852-7525
FHLBank Dallas	Chief Banking Operations Officer	214-441-8546
FHLBank Des Moines	VP/Credit Risk Officer	515-281-1054
FHLBank Indianapolis	Chief Credit and Marketing Officer	317-465-0459
FHLBank New York	General Counsel	212-441-6822
FHLBank Pittsburgh	Chief Credit Officer	412-288-3425
FHLBank San Francisco	Chief Credit Officer	415-616-1000
FHLBank Seattle	Chief Counsel	206-340-2300
FHLBank Topeka	Chief Credit Officer	785-438-6055

## **B. Coordination of Efforts with a FHLBank**

The relationship between an insurance receiver and a lender to the insurer in receivership that is a member of the FHLBank system can present a number of unique issues.

There is no prescribed order of steps for managing a troubled insurer’s obligations to an FHLBank. The following may facilitate the process:

### **1. Gain an Understanding of the History and the Current Status of the FHLBank Program<sup>4</sup>**

It is imperative that the receiver understand fully the history and components of the program. Important aspects of this basic information include:

#### **a. Contacts**

Who are the individuals at the bank (including outside counsel and advisors) who manage the bank’s role with the insurer and how can they be reached, especially if contact on short notice becomes necessary. Similarly, who will be “point” for the receiver in managing the ongoing relationship? Providing the bank a contact person upon inception of delinquency proceedings will temper the possibility that the bank will take summary protective action for lack of information.

#### **b. Complete Documentation**

The receiver should strive to obtain and review carefully all of the documents governing the relationship, including the initial documents establishing the relationship and those related to subsequent advances and repayments.

#### **c. Inception Date and Terms**

The terms on which the relationship was established are likely to govern all subsequent advances and repayments. Not only is the formal agreement important, but so are emails and other

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<sup>4</sup> The guidance in sections B.1, B.8, B.9, and B.10 are intended only to offer practical suggestions for managing the relationship between the receiver and the FHLBank based on the experience of the Shenandoah Life Insurance Company in receivership, related discussions and circumstances as existed generally at the time of this writing. It is important to note that every situation has its own characteristics and circumstances and that the relationship between one insurer and one FHLBank is likely to differ materially from any other such relationship. Further, no effort is made in this guidance to explore the legal or policy bases for the parties’ rights and liabilities, nor to evaluate suggested legislative or regulatory improvements

communications that may provide a more complete understanding of the parties' actual expectations and concerns. Whether or not legally sufficient to alter the formal agreement, course of conduct may be critical guidance on how transactions actually were to be conducted.

d. History of Advances and Repayments

The relationship may have been in place for years and involved a number of advances and repayments. It is important that the receiver gain a thorough understanding of this history to determine whether certain remedial steps (such as stock redemption or release of excess collateral) are indicated immediately.

e. History of Collateral

For similar and other reasons, the collateral requirements upon which the parties agreed when the relationship was established, and how the posting and release of that collateral has evolved over time, are very important factors in understanding what company assets are properly hypothecated or pledged to the FHLBank (and therefore unavailable to pay other claims or expenses), and which assets may be so identified on the company's records but may in fact be eligible for release from such FHLBank claims. Note that the agreement(s) with the FHLBank may require that the insurer post collateral of a stated value in excess of outstanding advances and may also prescribe a reduction in the value assigned to that collateral (the "haircut"), with the combined effect of leaving the bank over-collateralized. It may be possible to negotiate some relief from the over-collateralization of outstanding advances.

f. History of Acquisition and Redemption or Disposition of Bank Stock

As a condition of becoming a member of the FHLBank system, and therefore eligible for advances, the insurer will likely have been required to purchase a certain amount of "membership" stock in the FHLBank. There is typically no independent market on which that stock can be sold and the only way in which the insurer can dispose of it is to sell it back to the FHLBank on redemption terms established by the parties' agreement. Normally the agreement requires that the insurer retain the membership stock so long as the agreement remains in place and advances remain outstanding.

Further, with each advance, the insurer may have been required to purchase additional bank stock as "activity stock", typically in quantities constituting a small percentage of each advance. As with "membership" stock, there is no independent market on which activity stock can be sold, and the only way in which the insurer can dispose of it is to sell it back to the FHLBank on redemption terms established by the FHLBank's capital plan and the parties' agreement. The agreements or explicit terms and conditions of the stock may give the FHLBank discretion to postpone the redemption of membership and activity stock.

Because the stock is illiquid and therefore of little value to the receiver in managing the rehabilitation or liquidation, exploring prompt redemption of outstanding stock may be prudent.

g. Investment of Advances

It is important to determine whether the collateral obligations created by advances have resulted in the hypothecation of other assets of the insurer in a way that may have resulted in asset-liability mismatches and potential liquidity problems. It is not unusual to find a disproportionate share of the insurer's high-grade, liquid, assets pledged as collateral for advances the proceeds of which were instead invested to potentially create beneficial leverage or interest rate arbitrage. Over time, and with deteriorating conditions in the capital market, this can create serious challenges for the receiver. The potential substitution of collateral should be explored with the

FHLBank to ameliorate these challenges. However, an FHLBank is limited by regulation on the types of collateral it may accept.

h. Performance in Relation to Repayment Obligations

By design, the FHLBank program is structured so that the FHLBank does not take on much risk in connection with advances to members, including insurers. The pricing (interest rates charged) for the advances do not typically contemplate material risk of default, and collateral requirements are intended to all but eliminate such risk. The receiver should familiarize himself or herself with the history of the relationship to determine whether there are outstanding concerns for the bank that should be addressed promptly so that the bank does not feel compelled to exercise its rights to the collateral in a manner that might prove disruptive to the receivership. Outstanding defaults or near-defaults should be identified and remedied to preserve the collateral.

i. Current Balance of Advances

Obviously, the amount of outstanding advances and resulting repayment obligations must be understood well by the receiver, particularly in relation to collateral pledges. The records of troubled insurers may not be sufficiently complete or accurate to allow for proper monitoring of these outstanding balances and efforts should be made to reconcile the insurer's records to those of the bank.

j. Repayment Due Dates and Segregated Cash Account Balance

Advances are made with specific repayment obligations. These obligations will address both interest and principal payment obligations, with specific dates established for both. It is common for segregated-cash-account requirements to be imposed from which the bank can draw some or all of these payments. The receiver needs to identify how much cash the insurer is required to maintain in specified accounts by the agreement(s) and the dates and amounts of required interest and principal payments. Plans should be made to assure liquidity and the ability to comply with these requirements or to make other payment arrangements. If forbearance or accommodations become necessary or desirable, those should be negotiated promptly, if the bank has the ability to provide them.

k. Excess Cash

If the insurer finds itself with more cash than required in the specified account(s), discussions should be undertaken with the FHLBank, and without prejudice to the receiver's right to seek a court ordered release, to obtain release of excess cash collateral to the receiver, recognizing that cash held by the FHLBank is a portion of the Collateral for the insurer's obligations.

l. Prepayment Fees

Typically the agreements discourage early repayment of advances because such repayments may be inconsistent with hedges and other arrangements made by the bank in connection with the advances to the insurer. Prepayment may therefore trigger prepayment charges or fees owed by the insurer. However, the bank's need to charge those prepayment fees may be reduced or eliminated by changing circumstances affecting the hedges or other arrangements made by the bank. The receiver should therefore consider whether prepayment may be advantageous (for example because of associated collateral release or stock redemption). If prepayment would be helpful to the receiver's strategy, discussions with the bank should ensue to determine the most optimal prepayment timing that will result in the lowest applicable prepayment fees.

m. Cash Required

As noted, the agreements typically require the insurer to maintain specified liquidity, likely in segregated accounts at the bank, for the protection of the bank. The receiver will need to address these requirements.

2. Notice of Receivership to the FHLBank

a. Notify FHLBank of Receivership

Immediately following the establishment of the receivership, the receiver should contact the FHLBank (see initial FHLBank contact information above) to inform the FHLBank that the Insurer has been placed into receivership.

b. Identify Authorized Individuals

The receiver should forward electronically to the FHLBank all legal agreements, court orders, and/or notices that evidence the appointment of the receiver and a delegation of authority designating individuals authorized to transact business on behalf of the receiver in a mutually satisfactory form. To protect the receiver, the FHLBank may place the account of the member "on hold," prohibiting any additional member/receiver-initiated activity until the required agreements and authority delegations are received.

c. Schedule Initial Conference Call or Meeting

The receiver and the FHLBank should schedule a mutually convenient time to hold a conference call meeting following the establishment of receivership.

3. Considerations for the Initial conference Call or Meeting with the FHLBank

a. Identify Contact Person(s)

The FHLBank, the receiver, and the Assuming Insurer, if applicable, should each identify their primary contact person(s) and business activity coordinator(s). The receiver should also provide to the FHLBank a key point person(s) who will remain involved with the disposition of all residual issues pertaining to the receivership through completion.

b. Identify Outstanding Obligations, Pledged Collateral, and Capital Stock

During the initial conference call meeting, the receiver should request that the FHLBank identify all outstanding advances and any other outstanding obligations of the member, including AHP subsidy exposures, letters of credit, and correspondent services exposures. Furthermore, the receiver should request that the FHLBank provide information regarding the amount and nature of collateral pledged the balance of any member cash accounts or safekeeping accounts, and the member's capital stock.

c. Establish Receivership Timeline

During or prior to the initial conference call meeting, the receiver should inform the FHLBank of the planned receivership timeline; and the identity of any other parties involved in the receivership process.

d. Discuss Payment of Obligations and Collateral Releases

The FHLBank will need to know what the receiver's intentions are with respect to the obligations and if it desires to retain continued correspondent services activities during the receivership. Depending on the facts and circumstances, and subject to renegotiation with the receiver, FHLBank may allow the receiver to:



- Level the obligations outstanding in accordance with their existing terms and conditions, including scheduled interest and principal payment dates and collateral requirements;
- Prepay the obligations, subject to FHLBank policies and procedures regarding prepayments; or
- Transfer the obligations to an Assuming Insurer acceptable to all parties.

The receiver should request that the FHLBank discuss the process and timing for release of any collateral once all or any part of the outstanding obligations have been satisfied, assumed, or secured with other collateral. If a court ordered or statutory stay is in effect, the receiver and the FHLBank may need to execute an agreement detailing the agreed upon payment of obligations and treatment of collateral.

e. Prepayments

If the receiver wants to pay down advances prior to the scheduled maturity date, the receiver should contact the FHLBank and request that the FHLBank calculate an estimation of the final payment due as of that agreed upon prepayment date. The requested estimation should include outstanding principal, accrued interest up to the date of prepayment, and applicable prepayment/settlement fees.

f. Assuming Insurer

If the Obligations of the member are expected to be transferred to an Assuming Insurer, such transfer is subject to the approval of the receiver, the FHLBank and the receivership court. If approved, the FHLBank likely will require that the Assuming Insurer execute <sup>5</sup>an assumption agreement, and such agreement will stipulate that the Assuming Insurer is responsible for the timely payment of assumed Obligations, direct or contingent, in accordance with the terms and conditions of the Advances Agreement and any other agreements in effect between the member and the FHLBank.

g. Summary of Call

Following the initial conference call, the receiver should request that the FHLBank provide a detailed closing statement for the receiver along with a summary of other matters discussed and agreed upon during the call. The summary of the call could provide the framework for the development of a Memorandum of Understanding between the parties.

4. Disposition of Obligations

The FHLBank will expect payment from the receiver in the event Obligations are outstanding unless the Obligations have been purchased by or assigned to an acceptable Assuming Insurer.

With the approval of the receiver, FHLBank, and the receivership court, the obligations may be transferred to an Assuming Insurer through the execution of an Assumption Agreement that will be provided by the FHLBank. Such Obligations will be required to be collateralized in a manner acceptable to the FHLBank prior to any release of collateral pledged by the failed member. Such collateral requirements may differ from the requirements the Assuming Insurer may be accustomed to if it is a member of another Federal Home Loan Bank.

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<sup>5</sup> If the assumption is consummated during a receivership proceeding, then the receivership court would have to approve the transaction and if the assuming insurer is a US insurer, then the domiciliary insurance department would also have to approve the transaction.

Obligations that the receiver has decided not to resolve immediately will need to remain collateralized in accordance with the Advances Agreement.

## 5. Release of Collateral

(Assuming all member obligations have either been satisfied or assumed and fully collateralized by the assignee)

If mortgages have been listed and/or delivered to the FHLBank or to a third-party custodian, the FHLBank will initiate the delivery of those mortgages to the receiver or the receiver's designee in a timely manner and the FHLBank will file a UCC-3 termination statement<sup>6</sup> upon request.

If cash or securities have been pledged by the member, the FHLBank's interest in those assets will be promptly released and the assets will be delivered to the receiver or receiver's designee based on instructions provided.

Partial payment of obligations may allow for partial release of collateral in accordance with the FHLBank's collateral release practices.

## 6. Capital Stock

Typically, Capital Stock holdings of the member may be retained by the receiver or transferred to an Assuming Insurer, if such Assuming Insurer is a current member of the FHLBank. If the Assuming Insurer is not a member of the FHLBank, then the Capital Stock may be repurchased if permissible under applicable laws, regulations, regulatory obligations, and the FHLBank's capital plan and the proceeds of the Capital Stock transferred to the Assuming Insurer or receiver as long as the proceeds of the capital stock are not required to be retained by the FHLBank as collateral or as capital required against remaining outstanding business activity, in accordance with the FHLBank's policies, procedures, or practices.

Treatment of Capital Stock and any payment of dividends are subject to the provisions and restrictions set forth under applicable laws, regulations, regulatory obligations, and the FHLBank's capital plan.

## 7. Other Matters

If the member was a participant in other FHLBank programs such as AHP or letters of credit, collateral will be required to support all obligations that continue to exist past the life of the member. The receiver should request that the FHLBank provide a detailed account of all other programs the member participated in and the term of exposure and the amount and type of collateral required.

The receiver and the FHLBank should determine an appropriate frequency of follow-up correspondence throughout the receivership process.

## 8. Areas of Possible Agreement

The receiver seeks to maximize the value of the estate and to protect policyholders, claimants and beneficiaries of the insurer. To this end, the receiver takes all appropriate steps to marshal and preserve assets for distribution in a liquidation or to facilitate rehabilitation or other resolution of the impaired or insolvent insurer. Apart from maximizing the value of the estate, liquidity is important to both the on-going operation of the estate and more timely distributions. While more formal means to accomplish the purposes of the receivership are always available and should be pursued if necessary,

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<sup>6</sup> When a secured lender obtains a lien on collateral pledged to it, the lender files a UCC -1 so that there is a public record putting other creditors on notice of the lien. A UCC-3 is a termination statement filed by a secured lender to update the UCC record to reflect the lien has been released.

money and other resources ought not to be devoted to that pursuit unless good faith attempts to reach consensual resolution with the FHLBank have failed. In particular, receivers may seek agreement with the FHLBank in the following areas:

a. Release of Excess Cash

As noted, the history of the relationship may have resulted in the insurer porting more cash than required by the agreement in accounts accessible solely by the bank and unavailable to the receiver for other purposes. Release of this excess cash to the general assets of the receivership should be pursued promptly.

b. Release of excess Collateral

Over time the insurer may have caused more collateral to be pledged to the bank than is required by the agreements (for example because repayments may not have resulted in full release of the associated collateral or because of the appreciation of the collateral). In addition, because of the deteriorating condition of the insurer the bank may have had the right to require that the insurer post additional collateral (sometimes as much 25% over the amount of outstanding advances). It may be possible to convince the bank to release some of this excess collateral so that it can be used for other receivership purposes. This is particularly true if the bank can be assured that reducing collateral will not unduly endanger the probability for full repayment when due.

c. Reduction of Haircut and Excess Collateral Requirements

If the formula for determining excess collateral and haircuts applied to collateral values no longer reflect economic reality, the receiver should work with the FHLBank to recalculate these in the light of current conditions, again resulting in the release of some collateral.

d. Repurchase of Excess Stock

Over time, the insurer may have accumulated more bank stock, especially activity stock, than is required by outstanding advances (i.e. “excess stock”), for example because the bank may have been slow in repurchasing stock following repayment of advances. Although the bank cannot be required to redeem excess stock upon demand by the receiver, except after expiration of a redemption period (typically five years), if the bank’s financial condition is not an issue, and barring any statutory or regulatory prohibition, the receiver might seek waiver of the redemption period in order to negotiate the repurchase of excess stock, converting it into liquid assets available for receivership purposes.

9. Managing the Relationship<sup>7</sup>

Apart from seeking accommodations, the receiver should manage the ongoing relationship.

a. Evaluate Pre-Payment

The receivership should consider when it would be optimal to repay outstanding advances and plan accordingly in cooperation with the bank.

b. Evaluate Need for Extensions

It may be necessary or appropriate to renegotiate the repayment schedule with the bank and to evaluate the cost of doing so.

c. Evaluate Substitution of Collateral

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<sup>7</sup> See Footnote 3

Due to asset liability matching considerations or for other reasons, it may be helpful to explore the possibility of substituting collateral posted against outstanding advances.

d. Determine Desirability of Maintaining the FHLBank Program

The FHLBank program typically provides the insurer a facility for financing or access to liquidity on desirable terms. The receiver should consider whether continuation of the program may play a useful role in rehabilitation or liquidation plans. If sale of the company is being considered, preservation of the program may add value to potential buyers, making the insurer that much more attractive.

e. Develop Exit Strategy if Desirable

Conversely, the receiver may conclude that terminating the FHLBank program is the best option. In that case a thoughtful program for concluding the relationship in cooperation with the bank should be developed and implemented.

10. Share Experience with the NAIC<sup>8</sup>

In any case, because this is a relatively new development in the world of insurance receiverships, sharing the receiver's experience with the NAIC and other receivers is indicated provided that appropriate confidentiality can be maintained under applicable law. Developing a body of knowledge will facilitate the management of these programs by banks and receivers involved in subsequent cases.

## **VIII. SPECIAL ISSUES IN LIFE/HEALTH INSOLVENCIES**

While the preceding sections of this chapter apply to all types of insurance company receiverships, the specific claims-handling guidelines are most appropriate for the typical property and casualty receivership or life/health receiverships where policyholder claims become the subject of the claim filing and processing procedures.

However, 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 National Organization of Life and Health Guaranty Associations (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.

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.

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 none the less enjoy the same tax benefits. Generally, periodic payments are excludable from the

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<sup>8</sup> See Footnote 3

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.

Finally, as structured settlement annuities are typically issued to fund the settlement of underlying tort actions, the amounts of these annuities tend to be fairly large, reflective of the seriousness of the injuries sustained by the beneficiaries. As such, consideration should be given to specific and appropriate notices to these beneficiaries as these structured payments tend to be life sustaining in nature to a very sympathetic group of claimants.

## **IX. BEST PRACTICES FOR SUCCESSFUL BILLING AND COLLECTION OF LARGE DEDUCTIBLE PROGRAMS IN LIQUIDATION**

### **A. Overview of Large Deductible Workers' Compensation**

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 which provides services to small and 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*.

### **B. Administration of Large Deductible Plans**

The administration of large deductible plans is impacted 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:

- (a) *Insurer Receivership Model Act* (Model #555—IRMA) Section 712 Administration of Loss Reimbursement Policies;
- (b) *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980); or,
- (c) National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act (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. IRMA § 712 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.

### **C. Communication and Reporting Between the Liquidator, Policyholders and Guaranty Associations, Including Administration of Self-Funded Policyholder Programs**

#### 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, those that permit direct payment by the policyholder, and 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 or 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 guaranty associations, including an allowance for adverse development and incurred but not reported liability to ensure that collateral remains adequate throughout the administration of the program.

#### 2. Agreements between 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.

#### 3. 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 up-front 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 utilize a letter of credit 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.

4. Large deductible billing by 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.

5. Annual collateral review by 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 incurred but not reported, 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 non-performing 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.

## **D. 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 IRMA 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.

Guideline #1980 subsection (F) 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].

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.

### **E. 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 policies 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; or
- (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 which 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 loss adjustment expenses, 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, letters of credit, 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.”

#### **F. Responsible Party for Collection of Large Deductible Reimbursements**

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.

#### **G. 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.”<sup>9</sup> 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 letters of credit or surety bonds), but state law could provide additional rights,<sup>10</sup> and will specify what the receiver may do when the documents are silent, incomplete, or missing.

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<sup>9</sup> IRMA § 104(V)(1).

<sup>10</sup> For example, IRMA § 712(D) specifically provides that the relevant provisions of the policy are not controlling “where the loss reimbursement policy conflicts with this section.”

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 a letter of credit (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 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.<sup>11</sup> Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral,<sup>12</sup> 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,<sup>13</sup> 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.

## **H. 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.<sup>14</sup> 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

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<sup>11</sup> Compare IRMA § 712(C)(3) with Guideline #1980 § (C) and NCIGF Model § 712(C).

<sup>12</sup> See Guideline #1980 § (E)(3) and NCIGF Model § 712(E)(3).

<sup>13</sup> See, e.g., Guideline #1980 § (E)(4) and NCIGF Model § 712(E)(5).

<sup>14</sup> See Property and Casualty Insurance Guaranty Association Model Act, (# 540 ), § 8(A)(1)(a)(i). 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.

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.

1. 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.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup> 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 IRMA 712, 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.

2. 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.”<sup>18</sup> However, some states have enacted explicit language further clarifying that there is no guaranty association coverage for amounts within a policy’s deductible or self-

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<sup>15</sup> Model 540, § 13.

<sup>16</sup> 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.

<sup>17</sup> Model 540, § 13(B)(2) Alternative 2.

<sup>18</sup> Model 540 § 8(A)(1)(b). *Compare Life and Health Insurance Guaranty Association Model Act* (#520), § 3(B)(2)(a), 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.”

insured retention.<sup>19</sup> 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 property and casualty guaranty association.<sup>20</sup> 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.<sup>21</sup> 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).<sup>22</sup> 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.<sup>23</sup>

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.<sup>24</sup> 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 cases permit the insured to “self-fund” its claims with an account in the possession of the TPA which 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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<sup>19</sup> 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.

<sup>20</sup> Minn. Stat. § 60C.09(2)(4).

<sup>21</sup> *Terminal Transport v. Minnesota Ins. Guar. Ass’n*, 862 N.W.2d 487 (Minn. App. 2015), *review denied* June 30, 2015.

<sup>22</sup> Minn. Stat. § 60C.09(3).

<sup>23</sup> 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.

<sup>24</sup> 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.

**X. EXHIBITS**

*Exhibit 5-1: Linear Summary of Claims Administration*

*Exhibit 5-2: Claimant Notice via Postcard*

**Exhibit 5-1: Linear Summary of Claims Administration**

LINEAR SUMMARY OF CLAIMS ADMINISTRATION

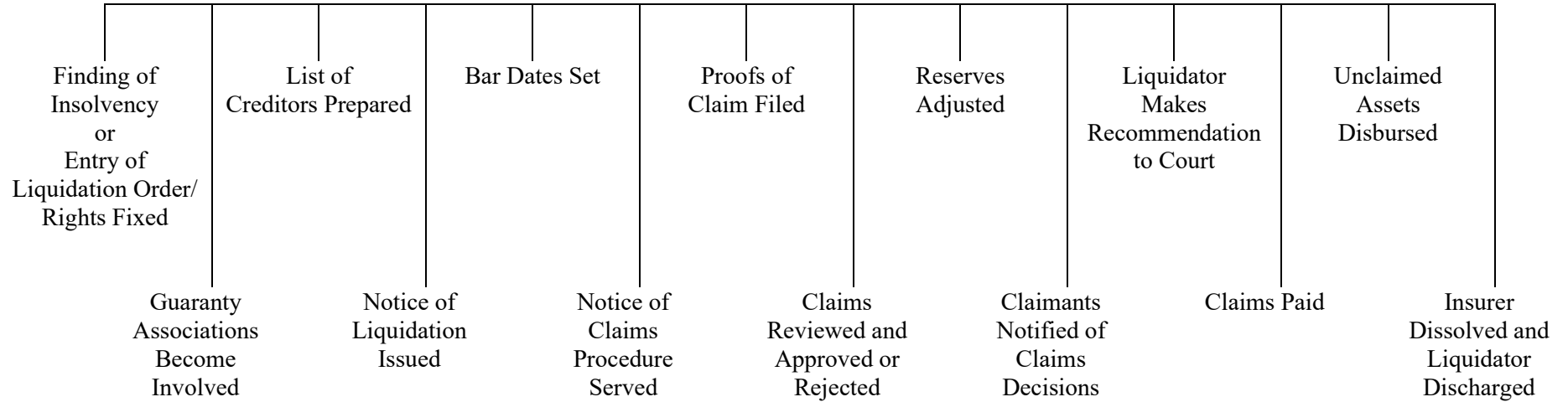


Exhibit 5-2: Claimant Notice via Postcard

CLAIMANT NOTICE VIA POSTCARD

Florida Department of Financial Services  
Division of Rehabilitation and Liquidation  
Post Office Box (insert box number)  
Tallahassee, FL 32302-(insert 4-digits)

PRESORT  
FIRST CLASS  
U.S. MAIL  
PAID  
Tallahassee, FL  
Permit #108

ID BARCODE  
RCN <Company code>-<ID Number>-<Suffix>  
<Claimant Type> <Reference #> >  
<First Name> <Middle Initial> <Last Name>  
<Address 1>  
<Address 2>  
<City>, <State> <Zip Code>  
POSTAL BAR CODE

(insert company name), in Receivership

label

postcard

front side of postcard

**IMPORTANT CLAIMANT NOTICE**  
Department of Financial Services  
Receiver for (insert company name)  
Toll-Free Consumer Hotline (800) 882-3054

The Florida Department of Financial Services (as Receiver) has been directed by Court Order to liquidate the above company. You have been identified as someone who might have a claim against this company. If you have no claim, please ignore this Claimant Notice. **If you have a claim, you must complete and submit a claim for each Claimant Notice (postcard) received.** Failure to complete and submit your claim(s) to the Receiver by the claim filing deadline shown below may result in your claim being denied in full or in part.

**CLAIM FILING DEADLINE: (insert claims filing deadline here)**

- To file a claim please go to the following website: **(insert web address here)**
- If you do not have access to the Internet, please place an "X" in **one** of the boxes below and return this Claimant Notice in an envelope to the return address on the front of this postcard:
  - Please mail me a proof of claim form and instructions
  - Please mail a proof of claim form to the updated address below **(print your information)**:  
Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State and Zip Code: \_\_\_\_\_

back side of postcard

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**CHAPTER 6 – GUARANTY FUNDS / ASSOCIATIONS**

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## I. INTRODUCTION

This chapter provides an overview of the operation of state insurance guaranty funds and associations and their relationship to a receivership. All 50 states, Puerto Rico, the United States Virgin Islands (property/casualty only) and the District of Columbia have a guaranty mechanism<sup>1</sup> 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 associations, 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 by assessing solvent members of the insurance industry, albeit assessments are subject to certain annual limitations. 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 not feasible because many life/health contracts are issued on a level premium basis. The burden of the assessments on solvent insurers is mitigated somewhat, 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 9G of the NAIC Life and Health Insurance Guaranty Association Model Act (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. The Life Model Act also contains optional Section 13, which permits an offset against premium, franchise or income taxes for amounts paid by life/health insurers to meet their assessment obligations.

Guaranty associations in most states are overseen by a board of directors composed of representatives from the insurance industry. Some guaranty association boards also include public members. A minority of guaranty associations also have representatives of state departments of insurance sitting on the fund's board. Many guaranty associations employ a manager 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 payment, the fund must be "triggered" with respect to the particular insolvency. The statutory provisions specifying when coverage is triggered differ from state to state. These provisions should be reviewed for each state before the receiver prepares an order of rehabilitation or liquidation. This will ensure that guaranty associations are triggered when intended. Care should be taken that the associations are not triggered prematurely or inadvertently.

The guaranty associations and the receiver have different statutory duties to protect policyholders of the insolvent insurer. The duties of the guaranty funds and associations are limited to covered policies or claims as set forth in state guaranty fund statutes. The guaranty funds can be very helpful, if not critical, to the receivership process. In a life/health insolvency, for example, a plan for liquidation will generally require the guaranty associations to help fund the transfer of policies to a solvent insurer. Maintaining open communication and cooperation between the guaranty associations and the receiver throughout the course of the receivership from prior to inception through the winding down of the insolvent estate 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

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<sup>1</sup> The terms "guaranty fund" and "guaranty association," for the purposes of this handbook, are synonymous.

Most property/casualty guaranty fund enabling acts are based on the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act (Model Act). Although the 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 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 NCIGF Web site (See the Guaranty Fund Laws tab 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.

## **B. Triggering Fund Liability**

### **1. General Statutory Activation Requirements**

Previously, the 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 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 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.<sup>2</sup>

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. 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 once put in motion. Judicial review is perceived to be an effective safeguard against arbitrariness and ambiguity.

The current version of the 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 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 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 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 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 Guaranty Fund Laws tab on the NCIGF Web site at <http://www.ncigf.org>).

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<sup>2</sup> 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.

### **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.

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.

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.<sup>3</sup>

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 restrictions 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 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 Model Act. Because of the

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<sup>3</sup> In Arkansas and Indiana, the coverage limit also applies to workers’ compensation claims.

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 the 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

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.

### 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 by Section 11(3) of the 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 (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.

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. 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 insure 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 § 405 of IRMA):

- 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; and
- Such other information as may be needed by the guaranty funds.

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, 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.

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. Receivers and guaranty funds should consider entering into agreements as to ownership, return of files, auditing rights, inventory controls and reporting.

Claim files sometimes are delivered to the wrong guaranty fund. In this situation, the preferable course of action is for the guaranty fund to forward the file to the appropriate guaranty fund, with a copy of the transmittal letter going to the receiver for control purposes.

In large multi-state insolvencies, receivers and guaranty funds have found it useful to develop "file shipping" instructions which specifically set out protocols for determining where a particular claim file should be shipped and shipping addresses for each involved fund. This is a wise practice in any case and is particularly important when company files have been serviced by various third party administrators. Consideration should also be given to the fact that some insurance companies are going "paperless," so that most, if not all, of its claim and underwriting files are electronic. Obviously, this will affect shipping instructions and costs. For instance, electronic files can be uploaded, or downloaded, from a receiver's Web site.

## **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 immediate 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 Uniform Data Standards (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.

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 National Conference of Insurance Guaranty Funds (NCIGF) Web site at <http://www.ncigf.org> at the Uniform Data Standards tab.

There is a desire for a secure process for transferring UDS data from the property and casualty insurance guaranty associations to insurance receivers. The concept proposed by the California Liquidation Office in 2005 and the process advanced by the NCIGF in 2007, known as SUDS (Secure Uniform Data Standards Process), utilizes 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. SUDS is available at no charge to insurance receivers or the guaranty associations.

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 has simplified the aforementioned receivers' requirements. The formats were designed and approved by a group of receivers and guaranty funds, and approved by the NAIC.

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 limited, read-only access to their claims database.

## **H. Claims Exceeding Guaranty Fund Limits and Aggregate Claims**

### **1. Claims Exceeding Guaranty Fund Limits or Claims Excluded from Guaranty Fund Coverage**

Under the 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 Model Act may not exceed \$300,000 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.

## 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. Section 706 D of IRMA 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;
- 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 ear mark 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. In recent insolvencies, early access distributions from receivers to guaranty funds have averted capacity shortfalls that could have resulted in the need for pro rata payment of covered claims. 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.

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 Section 803 F of IRMA 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. However, IRMA obviates the need for an agreement by incorporating the key provisions of a typical agreement in the statute. 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 §803 F of IRMA;
- 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 §803 B of IRMA; 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.

Samples of an early access plan and agreement are attached as Exhibits 6-1 through 6-3.

#### 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 §803 A(2)(c) of IRMA.

## 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 § 803 G of IRMA.

## 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.

## **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 liquidation 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 associations 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) 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.

#### **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.<sup>4</sup>

### **III. LIFE AND HEALTH GUARANTY ASSOCIATIONS**

#### **A. Introduction**

In 1970, the NAIC adopted the Life and Health Insurance Guaranty Association Model Act (the Life Model Act). Since 1970, the Life Model Act has undergone several major revisions. The most recent revisions to the Life Model Act were made in 1999.<sup>5</sup> All 50 states, the District of Columbia and Puerto Rico have enacted legislation either the same as or similar to a version of the Life Model Act (for summaries of the provisions in each state's guaranty association laws see the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) Web site at <http://www.nolhga.com/stateinformation/main.cfm>).

Life and health insurance guaranty associations were created to protect policyholders, certificate holders under group policies, annuitants and their beneficiaries from loss due to the insolvency or impairment of an insurer licensed to do business in the state where the claimant resides. Life/health guaranty associations pay benefits and continue coverage, subject to statutory limitations, either directly or through a third party. They can provide prompt service to claimants if they can engage early in the process in a

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<sup>4</sup> A copy of this White Paper may be obtained from the NAIC at: [http://www.naic.org/store\\_home.htm](http://www.naic.org/store_home.htm)  
Phone: 816.783.8300; Fax: 816.460.7593; E-mail: [prodserv@naic.org](mailto:prodserv@naic.org)

<sup>5</sup> All references in this chapter to the "Life Model Act" are to the 1999 version, unless otherwise specified. At the time of writing, an amendment to The Life Model Act was under consideration by the NAIC. It is especially important, however, to check individual state statutes for variations from the Life Model Act in actual cases.

cooperative venture with the receiver to coordinate plans for payment of claims and continuation of covered policies. Early coordination between the receiver and the associations will help minimize confusion, avoid duplication of effort and lead to greater administrative efficiency and lower costs for both the receiver and the 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, 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 prior to the entry of a liquidation order (e.g., during rehabilitation). NOLHGA can be reached at:

National Organization of Life and Health  
Insurance Guaranty Associations  
13873 Park Center Rd., Suite 329  
Herndon, VA 20171  
Phone: (703) 481-5206  
Facsimile: (703) 481-5209  
Web Site: <http://www.nolhga.com>

## **B. Triggering Fund Liability**

### 1. "Insolvent" Insurers

Under the Life Model Act, a guaranty association is triggered when a member insurer is determined to be "insolvent," 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 as "any insurer licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under the local guaranty association act, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn." Certain types of insurers are excluded from the definition.

### 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. An insurer is "impaired" if it has not been declared insolvent but is under a court order of rehabilitation or conservation. In such situations, associations may take measures to cover the impaired insurer's policyholder obligations. The primary purpose of the guaranty associations is to protect policyholders, however, not to bail out impaired or insolvent insurers. Guaranty associations, therefore, have traditionally been extremely reluctant to provide funding before liquidation.

Complexities in life/health insolvencies can be reduced by developing coordinated plans with guaranty association representatives and NOLHGA (if a multistate insolvency), as early as possible before a petition for receivership is filed. Because of the variations in state guaranty association triggering provisions, receivers should seek legal assistance and work with NOLHGA in preparing the order of liquidation or rehabilitation. Early development of information requirements, procedures for the transfer of policy obligations, interim servicing arrangements and early access agreements serve to minimize confusion and the disruption of claims payments, preserve the value of the business

and reduce costs. For individual state provisions, see the NOLHGA Web site (<http://www.nolhga.com/stateinformation/main.cfm>).

## C. Scope of Coverage

### 1. Covered Policies and Limits of Coverage

Guaranty associations were created to provide limited, but substantial, coverage for less sophisticated policyholders who are ill-equipped to fend for themselves in connection with their decision to purchase and retain their policies. Under the Life Model Act, the following coverages are provided:

- 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 life insurance, however, overall benefit coverage is capped at \$5,000,000 per owner.
- Health insurance: \$500,000 in benefits for basic hospital, medical and surgical insurance and for major medical insurance; \$300,000 in benefits for disability insurance; and \$100,000 for other health policies. All limits are applied per life.<sup>6</sup>
- Ordinary individual (allocated) annuities: \$100,000 in present value of annuity benefits, including net cash surrender and withdrawal values, per life.<sup>7</sup>
- Structured settlement annuities: \$100,000 in present value of annuity benefits, per payee or beneficiary. See Chapter 3 for a discussion of structured settlements.<sup>8</sup>
- Unallocated annuities: Coverage varies in accordance with the type of arrangement involved. If the annuity is held by a trust for the benefit of a single private plan sponsor, coverage is \$5,000,000 per plan sponsor. If the plan is a governmental plan, coverage is \$100,000 in present value of annuity benefits per plan participant.<sup>9</sup> If the annuity is held as part of a pool of investments formed by an intermediary and if it is issued in connection with a specific employee benefit plan, coverage is capped at \$5,000,000 per pool. There has been much litigation over the meaning of the term “unallocated annuity.” Generally speaking, where the insolvent insurer has no record of individual participant accounts, the contract will be presumed by most guaranty associations to be unallocated. The exact wording of the contract and how the contract has been administered will be important factors in making a definitive determination as to coverage in most states. The usual type of contract where the issue has been contested is the so-called “guaranteed interest contract” or “GIC.” The law is split among states that clearly cover these contracts, states that clearly do not cover them and states where annuities are covered without a distinction between allocated and unallocated annuities. If an insolvent insurer has issued a substantial number of GICs, the receiver, early in the process, should discuss with NOLHGA alternatives for handling these contracts in ways that minimize the possibility that hostile GIC holders will attempt to delay or derail the plan that is ultimately developed.

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<sup>6</sup> The treatment of long term care policies varies from state to state; they may either be included in healthcare coverage or treated separately. The receiver should consult NOLHGA or their local guaranty association.

<sup>7</sup> At the time of writing, an amendment to The Life Model Act was under consideration by the NAIC which would increase individual allocated annuity limits to \$250,000.

<sup>8</sup> At the time of writing, an amendment to The Life Model Act was under consideration by the NAIC which would increase guaranty association coverage of structured settlement annuities to \$250,000.

<sup>9</sup> At the time of writing, an amendment to The Life Model Act was under consideration by the NAIC which would increase governmental plan annuity limits to \$250,000.

- Aggregate limits across policy types: Aggregate benefits covered with respect to any one life for life insurance, individual annuities, and health insurance (other than basic hospital, medical and surgical insurance and major medical insurance) are capped at \$300,000.<sup>10</sup>

## 2. Exclusions

Under the Life Model Act, those policies or portions of policies under which the risk is borne by the policyholder or that are not guaranteed by the insurer are excluded from guaranty association protection. This encompasses products such as variable annuities and variable life insurance. Also excluded are policies issued by entities that are not regulated under the standards applicable to legal reserve carriers. Insurance exchanges, assessment companies, fraternal, health maintenance organizations (HMO) and hospital or medical service corporations are excluded, although in a few states special HMO guaranty associations have been established under separate law. Hospital or medical service corporations that are members of the Blue Cross/Blue Shield Association are 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. Self-funded employer-provided welfare benefit plans are also excluded, as are unallocated annuity contracts issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation. Reinsurance is also specifically excluded unless assumption certificates have been issued.

## 3. Residency Requirements

The Life Model Act provides for coverage of policyholders and contract holders who are residents of the state, as well as their beneficiaries, regardless of where the beneficiaries reside. It also provides coverage for pension plan owners of unallocated annuities if the plan sponsor has its principal place of business in the state. Residence is determined at the time coverage is triggered, usually on an order of liquidation. However, an order of liquidation may not be entered until several months or years after the receiver has been appointed. During this time, contract holders and beneficiaries may relocate, which could affect the situs of coverage.

Nonresident policyholders and contract holders may be covered under 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 policyholder is not eligible for coverage there because the insurer was never licensed there. An example of such a situation would be a New York resident who owns a policy of the XYZ Life Insurance Company, domiciled in California, and never licensed in New York. New York residents will be covered by the California law, not New York's, because the company was not licensed to do business in New York.

### **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 arrange for claims processing, premium billing and auditing. Where possible, the MPC also arranges for the transfer of the insolvent insurer's future policy obligations to a solvent insurer.

For each insolvency, NOLHGA appoints a guaranty association task force that includes representatives from the domestic guaranty association and other associations most affected by the insolvency.

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<sup>10</sup> At the time of writing, an amendment to The Life Model Act was under consideration by the NAIC which would create a separate category of coverage for long-term care insurance with a limit of \$300,000.

## 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. 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 by line of business;
- A list of third-party administrators and administrative offices, identifying the policies, claims and group policyholders they served;
- Actuarial evaluations of the insurer’s business;
- Copies of policy and contract forms;
- Copies of reinsurance contracts, assuming or ceding;
- Drafts of notices to policyholders, including 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; or
- 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 notify claimants and other interested persons of the existence of the guaranty associations and their role in the receivership. Several notices may be necessary over the course of the receivership. Because of the special nature of life/health guaranty association obligations, the receiver and the guaranty associations should collaborate closely on the contents of all notices to claimants that involve guaranty association obligations. Normally, the notices should:

- Explain the concept of 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, and provide information regarding the status of efforts undertaken by NOLHGA and the receiver;
- Provide instructions on filing claims and remitting future premiums;
- 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 the claims bar date and explain its legal significance under the continuation of coverage requirements of the relevant guaranty association statutes;
- Describe the receiver's handling of claims in excess of guaranty association statutory maximums; and
- Describe the receiver's handling of claims that are ineligible for coverage.

### 3. Notice to Guaranty Associations

In many states, the receiver is also 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 notify all interested guaranty associations and NOLHGA as a matter of courtesy to facilitate the coordination that will be necessary for a successful receivership. That notice should include a copy of the notice being issued by the receiver to the claimants, along with copies of the receivership order and 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 assumed by a reinsurer, 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 receiver should deliver files and records to the appropriate guaranty association or its designated servicing agent as soon as possible to avoid interrupting claim payments for health and disability income claimants and annuitants.

### 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 the guaranty association to ensure the policyholder payment and guaranty association collection of premiums post-liquidation without interruption. 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 right of subrogation, allowing them to recover from the estate to the extent they pay covered claims. These subrogation claims are accorded the same priority as policyholder claims, and are taken into account in the calculation of association benefits as part of a rehabilitation or liquidation plan. The guaranty associations’ administrative costs and subrogation claims together often make the guaranty associations the largest claimants against the estate.<sup>11</sup> In recognition of this fact, most state laws provide for the guaranty associations’ “early access” to payments from the estate. See §803 of IRMA. Early access is typically accomplished by specific agreement, which should include a provision that the guaranty associations will return excess funds (sample Early Access Agreements are attached as Exhibits 6-1 through 6-3).

### **F. Claim Reporting**

Guaranty associations should make timely reports to receivers of their costs for policy transfers, claim payments and administrative expenses. In multi-state insolvencies, NOLHGA will collect the necessary data from the affected guaranty associations and report to the receiver on their behalf.

### **G. Guaranty Association Obligations During the Formulation of a Rehabilitation or Liquidation Plan**

The successful creation and implementation of a plan to protect policyholders depends on the cooperative efforts of the guaranty associations and the receiver.

It may be necessary to restructure life insurance policies or annuity contracts to make a plan work. Policyholders and contract holders may question restructurings that may reduce accumulated cash values or delay access to their funds. Guaranty associations take the position that minimum original contract guarantees (or their equivalent) must be maintained for them to fulfill their statutory obligations. Any restructuring needs to be carefully considered in light of applicable statutory requirements.

### **H. Reinsurance**

The guaranty associations may find it advantageous to keep in-force reinsurance treaties that the insolvent insurer had in place on covered blocks of business. Accordingly, the receiver should not cancel contracts with reinsurers or stop paying premium to reinsurers without consulting NOLHGA or their state’s guaranty association. The existence of a 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 Section 612 of IRMA, which provide that the guaranty association(s) may elect to succeed to the rights and obligations of the insolvent insurer under indemnity reinsurance agreements.

### **I. Special Issues**

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<sup>11</sup> 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.

Under the Life Model Act, guaranty associations have the power to “guarantee, assume or reinsure . . . the policies or contracts of the impaired [or insolvent] insurer.” Relying on this authority, guaranty associations in one instance acted collectively to establish an insurance company to assume all covered life insurance and annuity obligations. The company was able to manage the assets of the insolvent insurer over a longer period of time, leading to better returns to the estate than would have been realized had the assets been disposed of in a “fire sale.” Whether a similar arrangement may be appropriate in another insolvency depends entirely on the circumstances.

#### **J. Guaranty Association Procedures for Collective Action**

Receivers must expect to deal with many guaranty associations in a multistate insolvency. Simply communicating with multiple guaranty associations can be a difficult task for a receiver's staff. Therefore, the receiver should work closely with NOLHGA, through its appointed task force, to coordinate communication. 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, tested in actual insolvencies, provide a useful mechanism for entering into binding contracts among the guaranty associations and third parties.

### **IV. RECEIVERS' EXPECTATIONS FOR GUARANTY FUND/ASSOCIATION DUES AND EXPENSES**

#### **A. Introduction**

In 2015, the Receivership & Insolvency (E) Task Force adopted the following principles regarding expenses claimed in insurance receiverships by Guaranty Funds<sup>12</sup>. These principles are intended to assist insurance commissioners as receivers (“Receivers”), and Guaranty Fund Administrators, in fulfilling their duties dealing with troubled companies. They are intended to further the objective of Receivers and Guaranty Funds working more closely together in addition to the pre-liquidation planning and other areas of cooperation and coordination presently being done.

A Receiver has a fiduciary responsibility to all of the receivership estate's creditors and is charged with protecting the interests of insureds, creditors and the public generally. Receivers need to ensure that the overall administrative expenses charged to the receivership estate are reasonable. The Receiver may approve payment of expenses or reject expenses, pursuant to state law. Typically a court will approve the expenses that have been approved by the Receiver. The purpose of the following principles is to provide guidance to Receivers and courts in order to increase consistence in receivership administration.

The guaranty fund system is a statutorily designed “safety net” to cover insolvent insurers' policy obligations, within statutory limits, to policy owners, beneficiaries and third-party claimants. Guaranty Funds are financed by assessments based on member insurers' premiums written on covered lines of business in a state. Because of this design, the guaranty fund safety net exists without regard to an individual receivership estate.

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<sup>12</sup>Note that references to “guaranty funds” in this document refer to both property/casualty guaranty funds and life/health guaranty associations.



Differences exist between the states with regard to guaranty fund and receivership statutes that may impact the handling of certain guaranty fund expenses. Regardless of the variances between state laws, the following principles are intended to promote coordination between Receivers and Guaranty Funds, reduce the cost of receiverships, and promote uniformity of practices which will preserve assets for payment of claims.

## **B. Principles and Expectations**

The following represent Receivers' statement of principles and expectations regarding guaranty fund dues and expense.

1. Principle: Some fixed costs of operating a guaranty fund will be incurred regardless of the existence of pending receiverships including all or a portion of membership dues for the Guaranty Fund's applicable national organization. These baseline costs that are not attributable to a specific receivership should not be charged to receiverships, and should be paid from assessed funds. This will ensure that the allocation of guaranty fund expenses to receiverships remains reasonable, even when the number of receiverships is reduced.

### Expectations:

- a) The allocation of guaranty fund expenses must be reasonable, regardless of the number of receiverships to which expenses are charged. A receivership should not be unduly burdened by allocating fixed costs to a dwindling number of receiverships.
  - b) A Guaranty Fund's fixed operational costs that are not related to receiverships should not be imposed on receiverships. For example, NCIGF and NOLHGA dues expenses should not be included with a Guaranty Fund's claim for administrative and claim handling expenses filed in a receivership estate. If membership dues to a national organization include costs that the Guaranty Fund would incur for a receivership except for the work of the national organization, those portions of the dues could be allocated to the receivership.
2. Principle: Receivers are required to routinely submit financial reports to the receivership court to assist it in monitoring the progress and status of the receivership. The receivership court and the receivership estate's creditors require transparent and consistent financial reporting regarding the overall administration of the receivership estate.

Expectations: With regard to guaranty fund expense classification, detail, methodologies, formulas, and guidelines, to minimize the need for audit, Receivers expect:

- a) Guaranty fund expenses charged to an estate should be properly classified, directly relevant to the specific estate being charged, and reasonable in amount, subject to state law.

Moreover, expenses incurred to represent the guaranty funds interests as a creditor should not be included if the actions are similar to actions that might be taken by other creditors

which would not be reimbursable. This may include for example, legal fees to dispute the Receiver's determination of a guaranty fund's claim against the receivership or legal fees to object to an application filed by the Receiver. This would not include expense necessary for the guaranty fund to fulfill its statutory obligations to process or pay covered claims.

- b) Guaranty fund expenses should be itemized and detail provided with or without a request from the receiver (e.g. expenses should not be grouped into "Other" or "General" expense categories). This will also avoid an inadvertent inclusion of particular expenses that are excluded by statute. (For example, some statutes exclude guaranty fund expenses incurred in detecting and preventing insolvencies.)
  - c) Guaranty Funds should further refine their established expense allocation guidelines to develop more detailed expense reporting directives and then consistently utilize the guidelines when reporting to Receivers. Where not impacted by state statutes, Guaranty Funds should refine the formulas, methodologies and guidelines for expenses that are charged to individual receiverships. (i.e. classifications, types of expenses, levels of expenses, reasonableness standards/analysis, coordination standards) in order to minimize grouping of unrelated expenses.
  - d) Guaranty Funds, in coordination with NCIGF and NOLHGA, should continue to consider solutions to minimize and eliminate administrative expenses to keep expenses reasonable. Examples of such actions that many Guaranty Funds have already taken include, utilizing part-time staff, housing Guaranty Fund offices in other entities (e.g., law firms) and by relying on the national organizations to perform various services (e.g. website and system services). Working with the NAIC in developing Uniform Data Standards is another example.
3. Principle: To ensure that travel expenses billed to a receivership estate are fair, reasonable and consistent, Guaranty Funds should be aware of the Receiver's reimbursement guidelines when submitting travel expenses for reimbursement.

Expectation: Guaranty Funds should limit their claim against the estate for travel expenses to travel expense limits, guidelines and per diems consistent with those used by the applicable state Receiver's office for travel expenses billed to receivership estates in that state. Any travel expenses incurred in excess of such limits should be borne by the Guaranty Funds, and not the receivership estate.

## **V. EXHIBITS**

*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*

**Exhibit 6-1: NOLHGA Sample Early Access Agreement**

**Early Access Agreement**

THIS EARLY ACCESS AGREEMENT (the “Agreement”), is entered into as of the \_ day of \_\_\_\_, 20\_\_ (the “Contract Date”), by and among the National Organization of Life and Health Insurance Guaranty Associations (“NOLHGA”), on behalf of its member state life and health insurance guaranty associations which are or become “Participating Associations” under this Agreement, and \_\_\_\_\_, Commissioner of Insurance for the State of \_\_\_\_\_, as Liquidator (the “Liquidator”) of the \_\_\_\_\_ Insurance Company (the “Company”).

WITNESSETH: RECITALS

WHEREAS, on \_\_\_\_\_ 20\_\_ (the “Liquidation Order Date”), in the \_\_\_\_\_ Court of \_\_\_\_\_ County, State of \_\_\_\_\_ (the “Liquidation Court”) an “Order of Liquidation” (the “Liquidation Order”) was entered as to Company, a \_\_\_\_\_ corporation, in Civil Cause Number \_\_\_\_\_; and

WHEREAS, upon entry of the Liquidation Order, Company had in force certain \_\_\_\_\_ [list policies/policy types] \_\_\_\_\_ (“Policies”).

WHEREAS, in the \_\_#\_\_ jurisdictions where Company was licensed, there are life and health insurance guaranty associations (collectively, the “Affected Guaranty Associations”) that, as a result of the Liquidation Order, have obligations, subject to statutory conditions and limitations on coverage and applicability, to holders of the Policies who reside within the Affected Guaranty Associations’ respective jurisdictions (“Covered Obligations”). In addition, the [domiciliary state guaranty association] in certain cases may have Covered Obligations to holders of the Policies who reside in states and territories where Company was not licensed to do business prior to liquidation.

WHEREAS, the parties hereto desire to facilitate the provision of early access distributions to the Participating Associations.

AGREEMENTS:

NOW, THEREFORE, in consideration of the mutual covenants set forth in this Agreement, Liquidator, NOLHGA and the member state life and health insurance guaranty associations named on the List of Participating Associations (the form of which is attached as Exhibit A) agree as follows:

1. Duties of Liquidator:

- 1.1 The Liquidator shall make pro rata to each Participating Association early access distributions of such assets of Company attributable to policies or contracts giving rise to Covered Obligations, which are not reasonably necessary for use by the Liquidator for (i) expenses of administration of the estate of Company or (ii) as a reserve for claims accorded a higher or equal priority of distribution by \_\_\_\_\_ law.

For purposes of this Agreement, the term “cash assets of Company attributable to policies or contracts giving rise to Covered Obligations” means that proportion of the cash assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies or contracts of insurance written by the Company. The amount of the early access distribution shall be made pursuant to the priority of claims and early access provisions contained in Sections \_\_\_\_\_ and \_\_\_\_\_ of the [domestic state] Insurance Code. The early access distribution each Participating Association shall receive shall be its pro-rata share of the assets reserved for each class in which it has qualifying claims. The early access distribution may not exceed the amount needed to pay each such claim in full for each class of claim.

- 1.2 Each Participating Association will be entitled to participate in and receive early access distributions from Company made by the Liquidator after the entry of an Order of Liquidation of Company in the same manner and to the same extent as may be provided to Participating Associations of other states.
- 1.3 Early access assets shall consist of funds received by the Participating Associations as distributions from the Liquidator classified as early access distributions or from any ancillary receiver or state insurance departments or from statutory or special deposits actually received by the guaranty association; provided such funds in each case are attributable to policies or contracts giving rise to Covered Obligations as defined above.
- 1.4 The reasonable expenses of the Participating Associations will be treated by the Liquidator as administrative expenses of the estate. These expenses will be advanced or reimbursed to the respective Participating Associations by the Liquidator based on the quarterly reporting by each Participating Association in accordance with Section (priority statute) of [domestic state] Insurance Code.

2. Duties of Participating Associations:

- 2.1 Each Participating Association, consistent with an accounting having been filed by the Liquidator and approved by the Court, will return within thirty days of Court approval to the Liquidator (or within 90 days if an assessment is required), (a) any amounts in excess of the amount ultimately determined by the Liquidation Court to be due the Participating Association, or (b) any amounts representing the proportional share of the assets disbursed by the Liquidator which may be required to make equivalent distribution to creditors of the same priority class as policyholders in the event that the Participating Association may have received a policyholder level disbursement of assets (including early access distributions) in excess of that available to pay all creditors of the insolvent insurer in the same class of priority as policyholders.
- 2.2 Each Participating Association will file a proof of claim either for itself or through NOLHGA as supplemented from time to time and in a form mutually agreed to by the Liquidator and the Participating Association, for all obligations of such Participating Association which are paid or otherwise discharged.
- 2.3 In addition to the accounting and reports required herein, each Participating Association will respond in good faith to reasonable requests for information from the Liquidator concerning the receipt and disbursement of all assets transferred under this Agreement.

3. Duties of NOLHGA:

NOLHGA will advise the Liquidator within 30 days after the execution of this Agreement of the identities of the Participating Associations, as the same shall be determined pursuant to the rules, regulations and bylaws of NOLHGA, by preparation and delivery to the Liquidator of a list of Participating Associations, the form of which is attached as Exhibit A. Each Affected Guaranty Association not listed by NOLHGA as a Participating Association may elect to become a Participating Association at a later date by informing NOLHGA of its decision and by NOLHGA supplementing its list of Participating Associations.

4. Access to Records and Information:

Liquidator, NOLHGA and the Participating Associations mutually agree to provide each other with reasonable access to certain business records and information, as follows:

4.1 Liquidator will provide NOLHGA and the Participating Associations with reasonable access, during normal business hours, to the books, records and files of Company under the control of Liquidator and will respond affirmatively and in good faith to all reasonable requests from NOLHGA or the Participating Associations for information, files and documents pertaining to insurance coverage underwritten or reinsured by Company.

4.2 NOLHGA or its Participating Associations as appropriate will provide Liquidator with reasonable access, during normal business hours, to the books, records and files of Company, under the control of NOLHGA or the Participating Associations and will respond affirmatively and in good faith to all reasonable requests from Liquidator for information, files and documents pertaining to the adjudication, administration and payment of Covered Obligations.

4.3 On a quarterly basis, and within 45 days of the end of each calendar quarter, the Liquidator shall provide to NOLHGA or its Participating Associations a balance sheet and an income statement of Company which shall disclose the Liquidator's best estimate of the nature and amount of all remaining assets, the nature and amount of all known liabilities and classify these liabilities by priority classification, and the nature and amount of all income and disbursements for the quarter.

4.4 On a quarterly basis, and within 45 days of receiving the Company's balance sheet and income statement from the Liquidator, each Participating Association shall provide Liquidator a written report in a form mutually acceptable to Liquidator and such Participating Association, disclosing the status of the following items to the extent relevant during the reporting period: claims received and adjudicated; benefit payments made; open claim benefit payment reserve; subrogation recoveries, if any; and such other items as may reasonably be required by Liquidator. Reports shall be sent by each Participating Association to Liquidator physically or electronically at the address set forth in Section 7 of this Agreement or to such other address as Liquidator may from time-to-time designate in writing.

4.5 Liquidator shall give NOLHGA and its Participating Associations reasonable prior written notice of any hearing before the Liquidation Court requested by the Liquidator in connection with the liquidation of the Company. Said notice shall be considered supplemental to, and not in lieu of, the rights of NOLHGA and/or the Participating Associations to intervene or make an appearance.

5. Premiums:

Premiums due for coverage for periods after the Liquidation Order Date shall belong to and be payable at the direction of each Participating Association, and shall not constitute early access distributions. Premiums due for coverage for periods prior to the Liquidation Order Date shall be assets of the estate, subject to the provisions of this Agreement and applicable law.

6. Audit:

The Liquidator shall, prior to and in connection with the final distribution of assets of this liquidation, be authorized to audit the financial accounts and records of the Participating Associations with respect to receipt of assets and early access distributions, and with respect to the payment or discharge of Covered Obligations.

7. Notice:

Any notice required or permitted under the terms of this Agreement to be given to the parties shall be deemed given if provided in writing and (i) if actually received by the intended recipient by facsimile or hand delivery or (ii) if posted by prepaid first class mail, or (iii) if consigned to and received by a commercial delivery service and addressed as follows:

i. If to Liquidator:

The \_\_\_\_\_ Insurance Company in Liquidation

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attention: \_\_\_\_\_, Special Deputy Liquidator

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

With a copy to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

ii. If to NOLHGA:

National Organization of Life and Health  
Insurance Guaranty Associations  
13873 Park Center Road, Suite 329  
Herndon, VA 20171

**Exhibit 6-1**

Attention: Mr. Peter Gallanis, President

Telephone: 703-481-5206

Fax: 703-481-5209

E-mail: \_\_\_\_\_

7.3 If to Participating Associations:

For the address of each Participating Association, see Exhibit A.

7.4 Each Party shall be responsible for promptly notifying the others of any change of address or addressee which change shall become effective upon notice given in accordance with the terms of this Section 7.

iii. Merger and Choice of Law:

This Agreement merges all prior offers and agreements among the parties with respect to the subject matter herein and expresses the full and final intent of the parties. This Agreement shall be construed in accordance with the laws of \_\_\_\_\_ and shall not be modified except by an instrument in writing, executed by the authorized representatives of all the parties. In the event of any dispute between Liquidator, NOLHGA or any of the Participating Associations over (i) the legal obligations of the parties to each other under this Agreement or (ii) the construction of any term or provision of this Agreement, the parties hereby consent to the *in personam* jurisdiction of the Liquidation Court for the limited purpose of adjudicating said issues. This consent shall not extend to matters other than those expressly referenced in the previous sentence, nor to any creditor, policy owner, contract holder, or beneficiary of Company nor to any party who may be deemed a third party beneficiary of this Agreement.

This section shall not be construed to confer jurisdiction on the Liquidation Court to resolve coverage disputes between guaranty associations and those asserting claims against them resulting from the initiation of a receivership proceeding.

9. Termination:

This Agreement may be terminated by each Participating Association, with respect to that Participating Association only, by giving written notice in accordance with Section 7 to the Liquidator, with a copy to NOLHGA, and by returning to the Liquidator all assets, together with actual interest earned thereon, previously advanced to the Participating Association by the Liquidator under this Agreement.

10. Effective Date:

The effective date of this Agreement shall be the Contract Date.

IN WITNESS WHEREOF, this Agreement has been executed by the parties as of the first date written above.

NATIONAL ORGANIZATION OF LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATIONS

By. \_\_\_\_\_  
Peter Gallanis, President

ATTEST:

(Print) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_, COMMISSIONER OF INSURANCE FOR THE STATE OF  
\_\_\_\_\_, As Liquidator of the \_\_\_\_\_ Insurance Company.

By (Sign): \_\_\_\_\_  
\_\_\_\_\_  
Special Deputy Liquidator

ATTEST:

(Print) \_\_\_\_\_  
\_\_\_\_\_



**EXHIBIT A**

PARTICIPATING ASSOCIATIONS

(As of \_\_\_\_\_, 20.)

in the

EARLY ACCESS AGREEMENT

By and between the

NATIONAL ORGANIZATION OF LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATIONS

And its Participating Member Guaranty Associations

And

The \_\_\_\_\_ Commissioner of Insurance As Liquidator of the  
\_\_\_\_\_ Insurance Company in Liquidation  
\_\_\_\_\_ (Liquidator)

The National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) represents that, in accordance with its rules, regulations and bylaws, it is authorized to designate the following state life and health insurance guaranty associations as Participating Associations under that certain Early Access Agreement (Agreement) entered into with \_\_\_\_\_, Commissioner of Insurance for the State \_\_\_\_\_, as Liquidator of the \_\_\_\_\_ Insurance Company in Liquidation; and that any notice required or permitted to be given under the Agreement to the Participating Associations shall be deemed to be given if delivered to the Participating Associations at the following addresses, in accordance with the requirements of Section 7 of the Agreement:

\_\_\_\_\_

**LIQUIDATOR'S PROPOSAL TO DISBURSE ASSETS**

TO THE HONORABLE, THE JUDGES OF SAID COURT:

Petitioner, [NAME], Insurance Commissioner of [JURISDICTION], in her capacity as Liquidator ("Liquidator") of [INSOLVENT INSURER] (COMPANY) by her attorney, respectfully represents and proposes as follows:

1. By order dated [DATE], and effective [DATE], COMPANY was ordered liquidated, and the Insurance Commissioner of [JURISDICTION] and her successors in office were directed to take possession of the COMPANY'S property and to liquidate its business and affairs.
2. The Liquidator makes this proposal in accordance with the provisions of Section \_\_\_ of the [STATUTORY REFERENCE] ("Act").
3. The purpose of this proposal is to provide to the guaranty associations and funds of the states and other jurisdictions (hereinafter "SGAs") prompt access to the assets of the COMPANY pursuant to the Act.
4. The Liquidator shall determine the market value of available liquid assets marshaled at the time of a proposed disbursement. Available liquid assets include cash; short-term investments, including without limitation U.S. Treasury bills and notes; and any other securities which are readily marketable and in the opinion of the Liquidator could be liquidated for a price deemed reasonable, and without material adverse economic impact. Available liquid assets do not include any amounts in the custody of an ancillary receiver in another jurisdiction, or any other amounts held on deposit in another jurisdiction. The Liquidator will continue to pursue reasonable efforts to marshal the assets of the COMPANY, and to invest the proceeds in a prudent manner in assets which shall constitute available liquid assets.

[WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING] The liquid assets available as of [DATE] total \$\_\_\_\_\_.

5. The Liquidator shall reserve amounts for the payment in full of the estimated expenses of administration through conclusion of the liquidation of the COMPANY. To the extent deemed feasible and reasonably prudent by the Liquidator, a portion of such reserves may be provided for out of non-liquid assets. [WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING]. Such reserves as of [DATE] are \$\_\_\_\_\_ of which \$\_\_\_\_\_ constitutes non-liquid assets.

6. The Liquidator shall reserve amounts for the payment in full of claims falling within the priorities established in Section \_\_\_\_ of the Act for claims higher than the priority for policyholder claims. To the extent deemed feasible and reasonably prudent by the Liquidator, a portion of such reserve may be provided for out of non-liquid assets. [WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING]. Such reserves as of [DATE] are \$\_\_\_\_\_ of which \$\_\_\_\_\_ constitutes non-liquid assets.

7. The Liquidator shall reserve amounts for the payment of the estimated percentage distribution on claims falling within the priority established by Section \_\_\_\_ of the Act for policy claims, other than amounts for the payment of claims of SGAs. To the extent deemed feasible and reasonably prudent, a portion of such reserves may be provided for out of non-liquid assets. [WHERE INITIAL DISBURSEMENT IS CONTEMPLATED, INSERT THE FOLLOWING]. Such reserves as of [DATE] are \$\_\_\_\_\_ of which \$\_\_\_\_\_ constitutes non-liquid assets.

8. The Liquidator shall disburse to SGAs amounts equal to the payments made or to be made by the SGAs for which the SGAs could assert claims against the Liquidator, including claims on account of claims payments and administrative expenses, provided that if assets available for disbursement to SGAs from time to time do not equal the amounts of such payments made or to be made by the SGAs, then disbursements shall be in the amount of liquid assets available after providing for reserves pursuant to Sections 5, 6 and 7 above. The Liquidator proposes to make an initial disbursement to SGAs on or about [DATE]. The Liquidator shall make additional disbursements to SGAs from time to time as assets become available but not less frequently than annually.

9. The amount determined pursuant to Section 8 above shall be disbursed among the SGAs as follows:

- I. Administrative expense payments reported by each SGA to the liquidator will be paid in full.
- II. The amount to be disbursed pursuant to Section 9 i. Above shall be deducted from the amount determined pursuant to Section 8 above, and the balance shall be disbursed as follows:
  - i. The total amount of loss payments reported to the Liquidator by the SGAs shall be determined.
  - ii. The loss payments reported to the Liquidator by each SGA shall be determined.
  - iii. From the amounts reported in Section 9 II.ii. above shall be subtracted any amounts recovered (or projected to be recovered) by such SGA from salvage, subrogation and second injury funds, attributable to the payments reported in Section 9 II.ii. above.

- iv. From the amounts determined in Section 9 II.ii. above shall be subtracted any amounts previously paid to such SGA from the liquidation of deposits or other assets of the COMPANY located in the jurisdiction of such SGA.
- v. A distribution percentage will be determined for each SGA by dividing:
  - (x) the excess (if any) of the amount in Section 9 II.ii. over the amounts in Sections 9 II.iii. and 9 II.iv. for each SGA, by
  - (y) the sum of the amounts determined in (x) above for all SGAs.
- vi. Each SGA’s share of the disbursement shall be determined by applying the percentages expressed in Section 9 II.v. above, to the amount calculated in Section 8 above.

10. Prior to receiving any disbursement from the Liquidator, an SGA will be required to execute a refunding agreement in the form of Exhibit A hereto agreeing to return to the Liquidator any funds received as described above in Section 9 in excess of such SGA’s share of the assets of the COMPANY under the Act as finally determined. WHEREFORE, the Liquidator prays your Honorable Court that:

- 1. The SGAs in and the Commissioner of Insurance of each of the states be served with notice of this Liquidator’s Proposal to Disburse Assets and attached Refunding Agreement.

2. The Court set a date more than \_\_\_ days after the date of this petition for a hearing on this petition and that after such hearing the Court approve the Liquidator's Proposal and attached Refunding Agreement.
  
3. The Liquidator be authorized to distribute [amount] to the SGAs pursuant to the Liquidator's Proposal To Disburse Assets upon the execution of a Refunding Agreement by the SGA receiving a disbursement.

Respectfully submitted,

\_\_\_\_\_  
Liquidator of \_\_\_\_\_

*Exhibit 6-3: NCIGF Sample Refunding Agreement*

**REFUNDING AGREEMENT**

This Refunding Agreement (“Agreement”) is entered into this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by and between \_\_\_\_\_, Insurance Commissioner of [JURISDICTION] (the “Commissioner”) in her capacity as Liquidator (the “Liquidator”) of \_\_\_\_\_ (“COMPANY”) and the undersigned insurance guaranty association or fund (hereinafter “SGA”):

**RECITALS**

A. On \_\_\_\_\_, the \_\_\_\_\_ court (the “court”) entered an order of liquidation (the “liquidation order”) of the COMPANY declaring the COMPANY insolvent and directing that the COMPANY be liquidated. The Court also appointed the commissioner and her successors in office, the liquidator of the COMPANY.

B. By reason of the Liquidation Order subject to the provisions of the statute under which it is organized, the SGA has certain obligations with respect to certain claims arising under certain policies issued by the COMPANY.

C. On \_\_\_\_\_, the Liquidator filed with the court her proposal to disburse assets (“Liquidator’s Proposal”), which contained the Liquidator’s request for authorization to make disbursements to various state insurance guaranty associations and funds from assets of the COMPANY. This form of Agreement was referenced in the Liquidator’s Proposal. The Liquidator’s Proposal and this form of Agreement were approved by the court on \_\_\_\_\_.

**AGREEMENTS**

The Liquidator and the SGA, in consideration of the mutual benefits and promises received by the parties hereto and the mutual covenants and agreements contained herein, and intending to be legally bound hereby agree that the recitals set forth above are hereby adopted and made a part of this Agreement and further agree to the following terms and conditions:

1. Any disbursements made by the Liquidator pursuant to the Liquidator's Proposal will be treated as disbursements to the SGA in accordance with Section \_\_\_ of the Act.
2. The SGA will be entitled to receive in accordance with Section \_\_\_ of the Act, any disbursement from the COMPANY'S assets made by the Liquidator in the same manner and to the same extent as may be provided to insurance guaranty associations or funds of other jurisdictions, provided, however, that nothing in this paragraph 2 shall be construed to indicate that a subrogation collection or deductible reimbursement amount related to a covered claim paid by the SGA is a disbursement pursuant to such Section.
3. The Liquidator and the SGA agree to provide each other with reasonable access to certain business records and information, as follows:

The Liquidator will provide the SGA with access, during normal business hours, to the books, records and files of the COMPANY held by the Liquidator and will respond affirmatively and in good faith to all reasonable requests from the SGA for information, files and documents pertaining to the SGA's performance of its statutory obligations including information, files and documents pertaining to insurance coverages issued by the COMPANY, claims against the COMPANY and unearned premiums on each in-force policy of the COMPANY.



The SGA will provide the Liquidator with access, during normal business hours, to the books, records and files of the COMPANY held by the SGA and will respond affirmatively and in good faith to all reasonable requests from the Liquidator for information, files and documents pertaining to the adjudication, administration and payment of covered claims by the SGA. At least once each quarter, the SGA will provide the Liquidator with management reports in accordance with the UDS reporting format and such other information as may reasonably be requested by the Liquidator. Reports shall be provided by the SGA to the Liquidator at the address set forth in section 10 of this Agreement or to such other address as the Liquidator may from time to time designate in writing.

4. All rights of the COMPANY in net salvage and subrogation recovery and collection in connection with losses paid by the SGA to the extent such rights exist, will be retained and accounted for by the SGA. Any portion of salvage and subrogation received by the SGA in connection with losses paid by the COMPANY prior to the date of the Liquidation Order shall be sent by the SGA to the Liquidator on a quarterly basis.

5. The SGA will, within 30 days after receipt of a written request from the Liquidator, or within ninety (90) days after such request is made if it is necessary for the SGA to make an assessment, return to the Liquidator any disbursements made pursuant to the Liquidator's Proposal (a) in excess of the amount finally determined to be due the SGA from the assets of the COMPANY, (b) if necessary to pay claims of secured creditors or claims of a higher priority than or equal to the SGA's claims under Section \_\_\_\_ of the Act.

6. The SGA will be permitted to file with the Liquidator an omnibus proof of claim, as supplemented from time to time and in a form mutually agreed to by the Liquidator and the SGA, for all amounts paid or to be paid by the SGA.

7. The Liquidator and the SGA shall cooperate in making arrangement for the final disposition of the information, files and documents received by the SGA from the COMPANY or the Liquidator.

8. This Agreement shall be governed by and construed in accordance with the law of [JURISDICTION], but without regard to its choice of law rules. The SGA agrees to submit to the exclusive jurisdiction of the court solely with respect to the enforcement of this Agreement or any issue or dispute arising out of this Agreement. However, nothing in this Agreement or the Liquidator's Proposal is intended to affect the proper venue or forum for any action arising out of or relating to any other matter or controversy, nor shall the fact that the SGA agreed to the Liquidator's Proposal or executed this Agreement be used for purposes of arguing the proper venue or forum of any such action.

9. Any notices and all other matters of communications from the Liquidator to the SGA concerning this Agreement shall be sent by first-class United States mail, postage prepaid, or by overnight delivery service or facsimile transmission to the SGA addressed as follows:

[address]

10. Any notices and all other matters of communication from the SGA to the Liquidator concerning this Agreement shall be sent by first-class United States mail, postage prepaid, or by overnight delivery service or by facsimile transmission to the Liquidator addressed as follows:

[address]

11. Each party shall pay all of its own costs, fees and expenses incurred in negotiating and preparing this Agreement and in closing and carrying out the transactions contemplated by this Agreement, provided, however, that the expenses of the SGA shall be treated by the Liquidator as administrative expenses.

12. This Agreement merges all prior offers and agreements of every kind and expresses the full and final intent of the parties. This Agreement shall not be modified except by an instrument in writing, executed by the authorized representatives of each of the parties.

13. The execution of this Agreement by the SGA, and the acceptance by the SGA of any amount distributed pursuant to the Liquidator’s Proposal, shall be without prejudice to the SGA’s rights with respect to final or other distributions from the estate of the COMPANY. Without limiting the generality of the foregoing, the SGA reserves its rights to assert whatever claim the SGA deems appropriate with respect to the composition of and priority to be afforded to the SGA’s claim for its payment of losses, expenses or other amounts, and its rights with respect to any issues relating to what assets constitute the assets of the estate or otherwise relating to the COMPANY.

WHEREFORE, this Agreement is executed by the parties’ duly authorized representatives as of the day first written above.

\_\_\_\_\_  
[Liquidator]

By: \_\_\_\_\_

\_\_\_\_\_  
SGA

By: \_\_\_\_\_

## LARGE DEDUCTIBLE—SAMPLE STATE CODES

*Please note, these examples were current at the time of writing this Handbook. As codes are constantly changing, you should confirm the current version.*

### Illinois Insurance Code

REGULATION ... CHAPTER 215 INSURANCE ... ACT 5. ILLINOIS INSURANCE CODE

Article XIII—REHABILITATION, LIQUIDATION, CONSERVATION AND DISSOLUTION OF COMPANIES

215 ILCS 5/205.1

Policyholder collateral, deductible reimbursements and other policyholder obligations.

(a) Any collateral held by, for the benefit of, or assigned to the insurer or the Director as rehabilitator or liquidator to secure the obligations of a policyholder under a deductible agreement shall not be considered an asset of the estate and shall be maintained and administered by the Director as rehabilitator or liquidator as provided in this Section and notwithstanding any other provision of law or contract to the contrary.

(b) If the collateral is being held by, for the benefit of, or assigned to the insurer or subsequently the Director as rehabilitator or liquidator to secure obligations under a deductible agreement with a policyholder, subject to the provisions of this Section, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association or the Illinois Insurance Guaranty Fund and the policyholder is unwilling or unable to take over the handling and payment of the noncovered claims, the Director as rehabilitator or liquidator shall adjust and pay the noncovered claims utilizing the collateral but only to the extent the available collateral after allocation under subsection (d), is sufficient to pay all outstanding and anticipated claims. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all reasonable means of collection against the insured have been exhausted, the Director's obligation to pay such claims from the collateral as the rehabilitator or liquidator terminates, and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions in this Article for the filing and allowance of such claims. When the liquidator determines that the collateral is insufficient to pay all additional and anticipated claims, the liquidator may file a plan for equitably allocating the collateral among claimants, subject to court approval.

(d) To the extent that the Director as rehabilitator or liquidator is holding collateral provided by a policyholder that was obtained to secure a deductible agreement and to secure other obligations of the policyholder to pay the insurer directly or indirectly, amounts that become assets of the estate, such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the Director as rehabilitator or liquidator shall equitably allocate the collateral among such obligations and administer the collateral allocated to the deductible agreement pursuant to this Section. With respect to the collateral allocated to obligations under the deductible agreement, if the

collateral secured reimbursement obligations under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The Director as rehabilitator or liquidator shall inform the guaranty association or the Illinois Insurance Guaranty Fund that is or may be obligated for claims against the insurer of the method and details of all the foregoing allocations.

(e) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement, either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third party administrator who administers the claims, the Director as rehabilitator or liquidator shall allow such funding arrangement to continue and, where applicable, will enforce such arrangements to the fullest extent possible. The funding of such claims by the policyholder within the deductible amount will act as a bar to any claim for such amount in the liquidation proceeding, including, but not limited to, any such claim by the policyholder or the third party claimant. The funding will extinguish both the obligation, if any, of any guaranty association or the Illinois Insurance Guaranty Fund to pay such claims within the deductible amount, as well as the obligations, if any, of the policyholder or third party administrator to reimburse the guaranty association or the Illinois Insurance Guaranty Fund. No charge of any kind shall be made by the Director as rehabilitator or liquidator against any guaranty association or the Illinois Insurance Guaranty Fund on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subsection.

(f) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association or the Illinois Insurance Guaranty Fund is required by applicable state law to pay any claims for which the insurer would be or would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by a policyholder or third party, the Director as rehabilitator or liquidator shall promptly bill the policyholder for such reimbursement and the policyholder will be obligated to pay such amount to the Director as rehabilitator or liquidator for the benefit of the guaranty association or the Illinois Insurance Guaranty Fund that paid such claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, shall be a defense to the policyholder's reimbursement obligation under the deductible agreement. When the policyholder reimbursements are collected, the Director as rehabilitator or liquidator shall promptly reimburse the guaranty association or the Illinois Insurance Guaranty Fund for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within 60 days after such bill for such reimbursements is due, the Director as rehabilitator or liquidator shall use the collateral to the extent necessary to reimburse the guaranty association or the Illinois Insurance Guaranty Fund, and at the same time, may pursue other collections efforts against the policyholder. If more than one guaranty association or the Illinois Insurance Guaranty Fund has a claim against the same collateral and the available collateral (after allocation under subsection (d)), along with billing and collection efforts, are together insufficient to pay each guaranty association or the Illinois Insurance Guaranty Fund in full, then the Director as rehabilitator or liquidator will pro-rate payments to each guaranty association or the Illinois Insurance Guaranty Fund based upon the relationship the amount of claims each guaranty association or the Illinois Insurance Guaranty Fund has paid bears to the total of all claims paid by such guaranty association or the Illinois Insurance Guaranty Fund.

(g) Director's duties and powers as rehabilitator or liquidator.

(1) The Director as rehabilitator or liquidator is entitled to deduct from reimbursements owed to guaranty associations or the Illinois Insurance Guaranty Fund or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this provision, not to exceed 3% of the collateral or the total deductible reimbursements actually collected by the Director as rehabilitator or liquidator.

(2) With respect to claim payments made by any guaranty association or the Illinois Insurance Guaranty Fund, the Director as rehabilitator or liquidator shall promptly provide the court with a copy of the guaranty associations, or the Illinois Insurance Guaranty Fund with a complete report of the Director's deductible billing and collection activities as rehabilitator or liquidator including copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each policyholder and any proration of payments when it occurs. If the Director as rehabilitator or liquidator fails to make a good faith effort within 120 days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations or the Illinois Insurance Guaranty Fund, then after such 120 day period such guaranty associations or the Illinois Insurance Guaranty Fund may pursue collection from the policyholders directly on the same basis as the Director as rehabilitator or liquidator, and with the same rights and remedies, and will report any amounts so collected from each policyholder to the Director as rehabilitator, liquidator, or conservator. To the extent that guaranty associations or the Illinois Insurance Guaranty Fund pay claims within the deductible amount, but are not reimbursed by either the Director as rehabilitator, liquidator, or conservator under this Section or by policyholder payments from the guaranty associations' or the Illinois Insurance Guaranty Fund's own collection efforts, the guaranty association or the Illinois Insurance Guaranty Fund shall have a claim in the insolvent insurer's estate for such unreimbursed claims payments.

(3) The Director as rehabilitator or liquidator shall periodically adjust the collateral being held as the claims subject to the deductible agreement are run-off, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and the Director as rehabilitator or liquidator shall not be required to adjust the collateral more than once a year. The guaranty associations or the Illinois Insurance Guaranty Fund shall be informed of all such collateral reviews including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the Director as rehabilitator or liquidator is satisfied that no new claims can be presented, the Director as rehabilitator or liquidator will release any remaining collateral to the policyholder.

(h) The Illinois Circuit Court having jurisdiction over the liquidation proceedings shall have jurisdiction to resolve disputes arising under this provision.

(i) Nothing in this section is intended to limit or adversely affect any right the guaranty associations or the Illinois Insurance Guaranty Fund may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by such guaranty associations or the Illinois Insurance Guaranty Fund under policies of the insolvent insurer, or for related expenses that the guaranty associations or the Illinois Insurance Guaranty Fund incur.

***Exhibit 6-4***

(j) This section applies to all receivership proceedings under Article XIII\* that either (1) commence on or after the effective date of this amendatory Act of the 93rd General Assembly or (2) are on file or open on the effective date of this amendatory Act of the 93rd General Assembly and in which an Order of Liquidation is entered on or after May 1, 2004. However, this Section applies to rehabilitation proceedings only to the extent that guaranty associations are required to pay claims and does not apply to receivership proceedings in which an order of conservation has been entered.

(k) For purposes of this section, a "deductible agreement" is any combination of one or more policies, endorsements, contracts, or security agreements, which provide for the policyholder to bear the risk of loss within a specified amount per claim or occurrence covered under a policy of insurance, and may be subject to the aggregate limit of policyholder reimbursement obligations. This section shall not apply to first party claims, or to claims funded by a guaranty association or the Illinois Insurance Guaranty Fund in excess of the deductible unless subsection (e) above applies. The term "non-covered claim" shall mean a claim that is subject to a deductible agreement and is not covered by a guaranty association or the Illinois Insurance Guaranty Fund.

\*215 ILCS 5/187 et seq.

## Pennsylvania Insurance Code

BOOK I. UNCONSOLIDATED STATUTES ... TITLE 40—INSURANCE ... Chapter 11—  
REHABILITATION AND LIQUIDATION ... Part 4. Formal Proceedings: Liquidation—Powers and  
Duties of Liquidators and Others

40-11-405.1

Deductible reimbursement agreements; collateral; obligations of policyholders and receivers

(a) Collateral shall not be considered an asset of the estate and shall be maintained and administered by the receiver as provided in this section, notwithstanding any other provision of law or contract to the contrary.

(b) Subject to the provisions of this section, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association and the policyholder is unwilling or unable to take over the handling and payment of the non-covered claims, the receiver shall adjust and pay the non-covered claims utilizing the collateral but only to the extent the available collateral, after allocation under subsection (d), is sufficient to pay all outstanding and anticipated claims. A claim against the collateral by a third-party claimant is not a claim against the insolvent insurer's estate for the purposes of releasing the policyholder to the extent of applicable policy coverage. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all collection means against the insured have been exhausted, the receiver's obligation to pay such claims from the collateral terminates and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions of this article for the filing and allowance of claims. When the liquidator determines that the collateral provided by the insured is insufficient to pay all additional and anticipated claims against the insured, the liquidator may file a plan for equitably allocating the collateral among claimants of the insured which provided the collateral, subject to court approval.

(d) To the extent that the receiver is holding collateral that secures other obligations of the policyholder to pay the insurer directly or indirectly amounts that will become assets of the estate, such as reinsurance obligations under a captive reinsurance program or premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the receiver shall equitably allocate the collateral among such obligations and administer the collateral allocated to the deductible agreement pursuant to this section. With respect to the collateral allocated to obligations under the deductible agreement, if the collateral secured reimbursement obligations are under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The receiver shall inform the guaranty associations of the method and details of all the foregoing allocations.

(e) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement, either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third party administrator who administers the claims, the receiver shall allow such funding arrangement to continue and, where applicable, will enforce such arrangements to the fullest



extent possible. The funding of such claims by the policyholder within the deductible amount will act as a bar to a claim for such amount in the liquidation proceeding including, but not limited to, a claim by the policyholder or the third party claimant. The funding will extinguish both the obligation, if any, of any guaranty association to pay such claims within the deductible amount, as well as the obligation, if any, of the policyholder or the third-party administrator to reimburse the guaranty association. No charge of any kind shall be made against a guaranty association on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subsection.

(f) (1) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall promptly bill the policyholder for such reimbursement and the policyholder will be obligated to pay such amount to the receiver for the benefit of the guaranty associations who paid such claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, shall be a defense to the policyholder's reimbursements obligation under the deductible agreement. When the policyholder reimbursements are collected, the receiver shall promptly reimburse such guaranty association for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within 60 days after such bill for reimbursements is due, the receiver shall use the collateral to the extent necessary to reimburse the guaranty association, and, at the same time, may pursue other collections efforts against the policyholder. If the policyholder reimbursements are not collected due to the reduction in such reimbursements as provided in paragraph (2), the receiver shall nonetheless reimburse such guaranty association as if such reimbursements had been collected. The receiver will obtain funds to reimburse a guaranty association claim affected by paragraph (2) by subtracting from funds collected by the receiver for other policyholder claim reimbursements under this paragraph amounts sufficient to reimburse the guaranty association affected by the application of paragraph (2). Subtraction of funds shall be made against all guaranty associations, including the guaranty association affected by paragraph (2) on the basis of the ratio stated in paragraph (3). If more than one guaranty association has a claim against the same collateral and the available collateral, after allocation under subsection (d), along with billing and collection efforts, are together insufficient to pay each guaranty association in full, then the receiver will prorate payments to each guaranty association based upon the proportion of the amount of claims each guaranty association has paid bears to the total of all claims paid by such guaranty associations.

(2) The obligation of a policyholder arising solely from a deductible agreement to reimburse the receiver for the benefit of one or more guaranty associations under paragraph (1) for losses paid by one or more guaranty associations shall be reduced by the amount of premium paid by or on behalf of the policyholder for one or more policies issued by a wholly owned affiliate or subsidiary of the insurer, which affiliate or subsidiary was either licensed to do business in this Commonwealth or was an eligible surplus lines insurer under Article XVI of the act of May 17, 1921 (P.L. 682, No. 284), known as "The Insurance Company Law of 1921," at the time of the issuance of such policies, where such policies were purchased to fund the policyholder's obligation to reimburse the insurer for deductibles under the deductible agreement, but in no event shall the reduction in liability be less than 90% of the total premiums paid to the insurer

*Exhibit 6-4*

and such affiliate or subsidiary for such policies and coverage provided under the related deductible agreement, provided that the policyholder's reimbursement obligation shall be reduced only if: (i) the wholly owned affiliate or subsidiary was merged into the insurer that was a party to the deductible agreement before the entry of a liquidation order against the insurer; (ii) the merger was approved by the commissioner; and (iii) the merger took place before the enactment of this section.

(3) The reduction as a result of paragraph (2) in the amount of deductible reimbursements that one or more guaranty associations would have been entitled to claim from a policyholder of the insurer under paragraph (1) shall be allocated by the receiver pursuant to this paragraph pro rata among all guaranty associations receiving deductible reimbursements under paragraph (1). The pro rata allocation among guaranty associations shall be based upon the ratio of:

(i) claims paid and to be paid as estimated by each guaranty association that are referred to in paragraph (1) to (ii) the total amount of claims paid and to be paid estimated by all the guaranty associations that are referred to in paragraph (1). Amounts used for the pro rata allocation shall be determined after giving effect to the provisions referred to in subsection (k) relating to insured net worth.

(4) Any claim of the policyholder under one or more policies issued by the affiliate or subsidiary as described in paragraph (2) is hereby waived except for those claims under policies that are not paid by a guaranty association as a covered claim or amounts the policyholder has reimbursed a guaranty association under Article XVIII of "The Insurance Company Law of 1921" or similar laws in other states.

(g) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall first make a good faith attempt to recover reimbursements or collateral under the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall be payable to the guaranty associations to the extent of claims paid within the deductible. To the extent the receiver is unable in whole or in part to recover first under the deductible reimbursement policy for claims paid by the guaranty associations, the receiver shall promptly bill the policyholder for the reimbursement and the policyholder will be obligated to pay the amount to the receiver for the benefit of the guaranty associations who paid the claims. The policyholder shall retain any and all defenses that may be asserted in connection with the receiver's efforts to collect reimbursements from the policyholder.

(h) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present and if a guaranty association is not paying claims for any reason for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy, to the extent claims covered under a deductible reimbursement policy have been paid by the policyholder and sufficient information on the payments has been provided by the policyholder to the receiver for purposes of billing under the deductible reimbursement policy, the receiver shall make a good faith attempt to recover reimbursements or collateral under the deductible

***Exhibit 6-4***

reimbursement policy from the insurer of the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall be payable to the policyholder.

(i) Receiver's duties and powers:

(1) The receiver is entitled to deduct from reimbursements owed to guaranty associations and/or policyholders under this section or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this provision, not to exceed three per centum of the collateral or the total deductible reimbursements actually collected by the receiver.

(2) With respect to claim payments made by any guaranty associations, the receiver shall promptly provide the guaranty associations with a complete accounting of the receiver's deductible billing and collection activities, including, but not limited to, copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each account, and any proration of payments when it occurs. The receiver's costs of accounting shall be included with expenses referred to under this subsection and, together with other reasonable actual expenses, be subject to the overall limit called for by this subsection. If the receiver fails to make a good faith effort within one hundred twenty days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations, then after such one hundred twenty day period such guaranty associations may pursue collection from the policyholders directly on the same basis as the receiver, and with the same rights and remedies, and will report any amounts so collected from each policyholder to the receiver. To the extent that guaranty associations pay claims within the deductible amount, but are not reimbursed by either the receiver under this section or by policyholder payments from the guaranty association's own collection efforts, the guaranty association shall have a claim in the insolvent insurer's estate for such unreimbursed claims payments.

(3) The receiver shall periodically adjust the collateral being held while the claims subject to the deductible agreement are run off, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and the receiver shall not be required to adjust the collateral more than once a year. The guaranty associations and the policyholder shall be informed of all such collateral reviews, including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims can be presented, the receiver will release any remaining collateral to the policyholder.

(j) The Commonwealth Court shall have jurisdiction to resolve disputes arising under this section.

(k) Nothing in this section is intended to limit or adversely affect any right the guaranty associations may have under applicable State law to obtain reimbursement from certain classes of policyholders for claims payments made by such guaranty associations under policies of the insolvent insurer, or for related expenses the guaranty associations incur.

(l) This provision will apply to all delinquency proceedings which are open and pending as of the effective date of this provision.

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(m) This section shall not apply to first party claims, or to claims funded by a guaranty association net of the deductible unless subsection (e) applies.

(n) For purposes of this section, the following terms shall have the meanings given to them in this subsection:

"Collateral" shall mean collateral held by, for the benefit of or assigned to the insurer or subsequently to the receiver in order to secure the obligations of a policyholder under a deductible agreement and also any collateral recovered or held by the receiver that secured the obligations of a policyholder under a deductible reimbursement policy.

"Deductible agreement" shall include any combination of one or more policies, endorsements, contracts or security agreements which provide for the policyholder to bear the risk of loss within a specified amount per each claim or occurrence covered under a policy of insurance and may be subject to aggregate limit of policyholder reimbursement obligations as set forth in an endorsement to a policy or in a program agreement.

"Deductible reimbursement policy" shall mean a policy other than one referred to in subsection (f)(2), purchased by the policyholder to secure the policyholder's obligation to reimburse the insurer for deductibles under the deductible agreement.

"Non-covered claims" shall mean a claim that is subject to a deductible agreement, may be secured by collateral and is not covered by a guaranty association.

**California Insurance Code**

1033.5. (a) The purpose of this section is to clarify the rights and obligations of policyholders, claimants, guaranty funds, including the California Insurance Guarantee Association, and the liquidator with respect to a deductible agreement entered into between a policyholder and an insurer subject to liquidation proceedings under this article. These arrangements are commonly referred to as "large deductible" policies or programs, even though the actual amount of the deductible can vary significantly and may not be in fact large in amount. Deductible amounts under these arrangements may vary from as little as \$5,000 to as much as \$1,000,000 or more. This section shall be construed such that the claim payment obligations of the guaranty associations, including the California Insurance Guarantee Association, in total arising from deductible agreements will be substantially equivalent to those of the insurer, except as provided otherwise in each guaranty association's enabling statute, including that of the California Insurance Guarantee Association, had the insurer continued in business and not become subject to a liquidation proceeding.

(b) Notwithstanding any other provision of law or contract to the contrary, any collateral held by or for the benefit of, or assigned to, the insurer or the liquidator to secure the obligations of a policyholder under a deductible agreement and any reimbursement payments to the liquidator under a deductible agreement shall be considered property of the liquidated company, but shall not be general assets of the liquidated company. The liquidator shall maintain, administer and distribute all such collateral and deductible reimbursement payments only as provided in this section.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by a guaranty association or the California Insurance Guarantee Association and the policyholder is unwilling or unable to take over the handling and payment of the noncovered claims, the liquidator shall adjust and pay the noncovered claims utilizing the collateral, but only to the extent the available collateral, after allocation under subdivision (d), is sufficient to pay all outstanding and anticipated claims. If the collateral is exhausted and the policyholder is not able to provide funds to pay the remaining claims within the deductible after all reasonable means of collection against the policyholder have been exhausted, the remaining claims shall be claims against the insurer's estate, subject to the other provisions of this article regarding the filing and allowance of claims. When the liquidator determines that the collateral is insufficient to pay all additional and anticipated claims, the liquidator may file a plan for equitably allocating the collateral among claimants, subject to court approval.

(d) (1) To the extent that the liquidator holds collateral provided by a policyholder that was obtained to secure a deductible agreement and to secure other obligations of the policyholder to pay the insurer, directly or indirectly, amounts that become assets of the estate, such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy or where the premium due is subject to adjustment based upon actual loss experience, the liquidator shall equitably allocate the collateral among those obligations and administer the collateral allocated to the deductible agreement pursuant to this section.

(2) With respect to the collateral allocated to obligations under the deductible agreement, if the collateral secured reimbursement obligations under more than one line of insurance, then the

collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line.

(3) The liquidator shall inform the guaranty associations or the California Insurance Guarantee Association that is or may be obligated for claims against the insurer of the method and details of each allocation made pursuant to this subdivision.

(4) The liquidator shall be entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements under this section.

(e) (1) Regardless of whether there is collateral, if the insolvent insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement, either through the policyholder's own administration of its claims or through its provision of funds directly to a third-party administrator who administers the claims, the liquidator shall allow the funding arrangement to continue and, where applicable, shall enforce the arrangement to the fullest extent possible. The funding of any of these claims by the policyholder within the deductible amount, including, but not limited to, any of these claims by the policyholder or the third-party claimant, shall bar a claim for that amount in the liquidation proceeding.

(2) The funding of claims pursuant to paragraph (1) shall extinguish the obligation, if any, of a guaranty association or the California Insurance Guarantee Association to pay the claims within the deductible amount, as well as the obligation, if any, of the policyholder or third-party administrator to reimburse the guaranty association or the California Insurance Guarantee Association. No charge of any kind shall be made by the liquidator against any guaranty association or the California Insurance Guarantee Association on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subdivision. The funding of these claims by the policyholders shall not limit or prejudice any right the guaranty association or the California Insurance Guarantee Association may have with respect to these claims under state law. Any policyholder that funds its own claims under the provisions of this subdivision shall provide to the guaranty association or to the California Insurance Guarantee Association all relevant information concerning the claim whenever the policyholder's reserved liability for the claim equals or exceeds 50 percent of the deductible amount on the claim.

(f) (1) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association or the California Insurance Guarantee Association is required by applicable state law to pay any claims for which the insurer would be or would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement, and to the extent the claims have not been paid by a policyholder or third party, the liquidator shall promptly bill the policyholder for the reimbursement. The policyholder shall pay that amount to the liquidator for the benefit of the California Insurance Guarantee Association or the guaranty association that paid the claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, shall be a defense to the policyholder's reimbursement obligation under the deductible agreement.

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(2) When the policyholder reimbursements pursuant to paragraph (1) are collected, the liquidator shall promptly reimburse the guaranty association or the California Insurance Guarantee Association for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within 60 days after the bill for the reimbursements is due, the liquidator shall use the collateral to the extent necessary to reimburse the guaranty association or the California Insurance Guarantee Association, and, at the same time, may pursue other collections efforts against the policyholder. If more than one guaranty association or the California Insurance Guarantee Association has a claim against the same collateral, and the available collateral, after allocation under subdivision (d), along with billing and collection efforts, are together insufficient to pay each guaranty association or the California Insurance Guarantee Association in full, then the liquidator shall prorate payments to each guaranty association or the California Insurance Guarantee Association based upon the relationship the amount of claims each guaranty association or the California Insurance Guarantee Association has paid bears to the total of all claims paid by the guaranty association or the California Insurance Guarantee Association.

(g) (1) With respect to claim payments made by any guaranty association or the California Insurance Guarantee Association, the liquidator shall promptly provide the court with a copy to the guaranty association or the California Insurance Guarantee Association, with a complete report of the liquidator's deductible billing and collection activities, including copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each policyholder and any proration of payments when it occurs. If the liquidator fails to make a good faith effort, within 120 days of receiving a claims payment report, to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations or the California Insurance Guarantee Association, then the guaranty association or the California Insurance Guarantee Association may pursue collection from the policyholders directly on the same basis as the liquidator, and with the same rights and remedies, and shall report any amounts so collected from each policyholder to the liquidator. To the extent that the guaranty association or the California Insurance Guarantee Association pays claims within the deductible amount, but is not reimbursed by the liquidator under this section or by policyholder payments from the collection efforts of the guaranty association or the California Insurance Guarantee Association, the guaranty association or the California Insurance Guarantee Association shall have a claim against the insolvent insurer's estate for the unreimbursed claims payments.

(2) The liquidator shall periodically adjust the collateral being held as the claims subject to the deductible agreement are satisfied, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and provided further that the liquidator shall not be required to adjust the collateral more than once a year. The guaranty associations or the California Insurance Guarantee Association shall be informed of any collateral adjustment, including but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the liquidator is satisfied that no new claims can be presented, the liquidator shall release any remaining collateral to the policyholder.

(h) The court having jurisdiction over the liquidation proceedings shall have jurisdiction to resolve disputes arising under this provision.

(i) Nothing in this section is intended to limit or adversely affect any right a guaranty association or the California Insurance Guarantee Association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association or the California Insurance Guarantee Association under policies of the insolvent insurer, or for related expenses the guaranty association or the California Insurance Guarantee Association incur.

(j) This section shall apply only with respect to insolvencies occurring on or after January 1, 2006.

(k) For purposes of this section, the following definitions apply:

(1) "Collateral" means any form of security held to secure the obligations of a policyholder under a deductible agreement with an insurer subject to an order of liquidation under this article.

(2) "Deductible agreement" means any policy, endorsement, contract, or security agreement, or a combination of any of those items, that provides for the policyholder to bear the risk of loss within a specified amount per claim or occurrence covered under a policy of insurance, and may be subject to the aggregate limit of policyholder reimbursement obligations.

(3) "Noncovered claim" means a claim that is subject to a deductible agreement and is not covered by a guaranty association or the California Insurance Guarantee Association.

(l) This section shall apply to claims funded by a guaranty association or the California Insurance Guarantee Association in excess of the deductible only if subdivision (e) is applicable.



**Texas Insurance Code**

§ 443.213. Administration of Deductible Agreements and Policyholder Collateral

(a) Any collateral held to secure the obligations of a policyholder under a deductible agreement with an insurer subject to a delinquency proceeding under this chapter must be maintained and administered as provided in this section. For purposes of this section, a "deductible agreement" is any combination of one or more policies, endorsements, contracts, or security agreements that:

(1) provide for the policyholder to bear the risk of loss within a specified amount per claim or occurrence covered under a policy of insurance; and

(2) may be subject to an aggregate limit of policyholder reimbursement obligations.

(b) This section applies to any collateral described by Subsection (a), regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer under a deductible agreement. The collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payments within the agreed deductible amount, subject to this section.

(c) If the contract between the policyholder and the insurer allows the policyholder to fund claims within the deductible amount through a third-party administrator or otherwise, the receiver shall allow that funding arrangement to continue, except as prohibited by Title 5, Labor Code. If a policyholder funds claims within the deductible amount, the receiver or any guaranty association has no obligation to pay claims for the amount funded by the policyholder, and the policyholder or its third-party administrator is not obligated to reimburse a guaranty association for any amount funded. A charge of any kind may not be made against a guaranty association based on the funding of claims payments by a policyholder under this subsection.

(d) If the receiver is holding collateral provided by a policyholder to secure both a deductible agreement and other obligations of the policyholder, the receiver shall:

(1) allocate the collateral among these obligations in accordance with the deductible agreement; or

(2) in the absence of an allocation provision in the deductible agreement and with the approval of the receivership court, allocate the collateral equitably among these obligations.

(e) If, under Subsection (d), the collateral secures reimbursement obligations under more than one line of insurance, the receiver shall equitably allocate the collateral among the various lines based on the estimated ultimate exposure within the deductible amount for each line.

(f) If a guaranty association is obligated to pay claims under a policy under Subsection (d), the receiver shall give notice to the guaranty associations of any allocation under this section.

(g) Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims may be presented, the receiver shall release any remaining collateral to the policyholder in accordance with the provisions of the contract and of this chapter.

(h) To the extent a guaranty association is required by applicable law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder, the following provisions apply:

(1) The receiver shall promptly invoice the policyholder for the reimbursement due under the agreement, and the policyholder is obligated to pay the amount invoiced to the receiver for the benefit of the guaranty associations that paid the claims. Neither the insolvency of the insurer nor the insurer's inability to perform any obligations under the deductible agreement is a defense to the policyholder's reimbursement obligation under the deductible agreement. At the time the policyholder reimbursements are collected, the receiver shall promptly forward those amounts to the guaranty association, based on the claims paid by the guaranty association that were subject to the deductible.

(2) If the collateral is insufficient to reimburse the guaranty association for claims paid within the deductible, the receiver shall use any existing collateral to make a partial reimbursement to the guaranty association, subject to any allocation under Subsection (d), (e), or (f). If more than one guaranty association has a claim against the same collateral, the receiver shall prorate payments to each guaranty association based on the amount of the claims each guaranty association has paid.

(3) The receiver is entitled to deduct from reimbursements owed to a guaranty association or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the receiver's responsibilities under this section. Expenses incurred to collect reimbursements for the benefit of a guaranty association are subject to the approval of the guaranty association. Any remaining expenses that are not deducted from the reimbursements are payable subject to Section 443.015.

(4) The receiver shall provide any affected guaranty associations with a complete accounting of the receiver's deductible billing and collection activities on a quarterly basis, or at other intervals as may be agreed to between the receiver and the guaranty associations. Accountings under this subdivision must include copies of the policyholder billings, the reimbursements collected, the available amounts and use of collateral for each account, and any prorating of payments.

(5) If the receiver fails to make a good faith effort to collect reimbursements due from a policyholder under a deductible agreement within 120 days of receipt of claims payment reports from a guaranty association, the guaranty association may, after notice to the receiver, collect the reimbursements that are due, and, in so doing, the guaranty association shall have the same rights and remedies as the receiver. A guaranty association shall report any amounts collected under this subdivision and expenses incurred in collecting those amounts to the receiver.

(6) The receiver shall periodically adjust the collateral held as the claims subject to the deductible agreement are paid, provided that adequate collateral is maintained. The receiver is not required to adjust the collateral more than once a year. The receiver shall inform the guaranty associations of all collateral reviews, including the basis for the adjustment.

(7) Reimbursements received or collected by a guaranty association under this section may not be considered a distribution of the insurer's assets. A guaranty association shall provide the receiver with an accounting of any amounts it has received or collected under this section and any expenses incurred in connection with that receipt or collection. The amounts received, net of any expenses incurred in connection with collection of the amounts, must be set off against the guaranty association's claim filed under Section 443.251 for the payments that were reimbursed.

(8) To the extent that a guaranty association pays a claim within the deductible amount that is not reimbursed by either the receiver or by policyholder payments, the guaranty association has a claim for those amounts in the delinquency proceeding in accordance with Section 443.251.

(9) Nothing in this section limits any rights of a guaranty association under applicable law to obtain reimbursement for claims payments made by the guaranty association under policies of the insurer or for the association's related expenses.

(i) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association, the following provisions apply:

(1) The receiver is entitled to retain as an asset of the estate any collateral or deductible reimbursements obtained by the receiver.

(2) If a policyholder fails to assume an obligation under a deductible agreement to pay a claim, the receiver shall use the collateral to adjust and pay the claim to the extent that the available collateral, after any allocation under Subsection (d), (e), or (f), is sufficient to pay all outstanding and anticipated claims within the deductible. If the collateral is exhausted and all reasonable means of collection against the insured have been exhausted, the remaining claims shall be subject to the provisions of Sections 443.251 and 443.301.

(3) The receiver is entitled to deduct from collateral reasonable actual expenses incurred in fulfilling the receiver's responsibilities under this section. Any remaining expenses that are not deducted from the reimbursements are payable subject to Section 443.0.

## Michigan Insurance Code

§ 500.8133a. Deductible agreement; collateral as asset maintained and administered by receiver; jurisdiction of circuit court; rights of guaranty association or foreign guaranty association; applicability to delinquency proceedings; applicability to first party claims; definitions.

Sec. 8133a. (1) Notwithstanding any other law or contract to the contrary, any collateral held by or for the benefit of or assigned to the insurer or subsequently the receiver in order to secure the obligations of a policyholder under a deductible agreement shall not be considered an asset of the estate and shall be maintained and administered by the receiver as provided in this section.

(2) If collateral is being held by or for the benefit of or assigned to the insurer or subsequently the receiver to secure obligations under a deductible agreement with a policyholder, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount as provided in this section.

(3) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association or foreign guaranty association and the policyholder is unwilling or unable to take over the handling and payment of the noncovered claims, the receiver shall adjust and pay the noncovered claims using the collateral but only to the extent the available collateral after allocation under subsection (4) is sufficient to pay all outstanding and anticipated claims. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all reasonable means of collection against the insured have been exhausted, the receiver's obligation to pay the claims from the collateral terminates and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions in this chapter for the filing and allowance of those claims. If the liquidator determines that the collateral is insufficient to pay all additional and anticipated claims, the liquidator may file a plan, subject to court approval, for equitably allocating the collateral among claimants.

(4) To the extent that the receiver is holding collateral provided by a policyholder that was obtained to secure a deductible agreement and to secure other obligations of the policyholder to pay the insurer directly or indirectly amounts that become assets of the estate, such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the receiver shall equitably allocate the collateral among those obligations and administer the collateral allocated to the deductible agreement as provided in this section. For collateral allocated to obligations under the deductible agreement, if the collateral secured reimbursement obligation under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The receiver shall inform the guaranty associations and foreign guaranty associations of the method and details of all the foregoing allocations.

(5) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible

agreement, either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third party administrator who administers the claims, the receiver shall allow this funding arrangement to continue and, where applicable, will enforce the arrangement to the fullest extent possible. The funding of these claims by the policyholder within the deductible amount will act as a bar to any claim for such amount in the liquidation proceeding, including, but not limited to, any claim by the policyholder or the third party claimant. This funding arrangement extinguishes both the obligation, if any, of any guaranty association to pay those claims within the deductible amount, as well as the obligations, if any, of the policyholder or third party administrator to reimburse the guaranty association. If a policyholder has entered into an agreement to which this subsection applies and is prevented from funding its own claims due to any proceeding under 11 USC 101 to 1330 and 1501 to 1532, then the guaranty funds that would otherwise be obligated to pay the claims shall pay the claims to the extent required by applicable state law and, in addition to any other rights of recovery arising from payment of the claims, shall have the full benefit of all collateral and other rights of reimbursement and recovery under this section from the bankruptcy court, liquidator, or receiver. No charge of any kind shall be made against any guaranty association on the basis of the policyholder funding of claim payments made pursuant to an arrangement described in this subsection.

(6) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association or foreign guaranty association is required by applicable state law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by a policyholder or third party, the receiver shall promptly bill the policyholder for reimbursement and the policyholder is obligated to pay the reimbursement amount to the receiver for the benefit of the guaranty association or foreign guaranty associations who paid the claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, is a defense to the policyholder's reimbursement obligation under the deductible agreement. The receiver shall promptly reimburse the guaranty association or foreign guaranty association for claims paid that were subject to the deductible when the policyholder reimbursements are collected. If the policyholder fails to pay the amounts due within 60 days after the bill for the reimbursement is due, the receiver shall use the collateral to the extent necessary to reimburse the guaranty association or foreign guaranty associations, and, at the same time, may pursue other collections efforts against the policyholder. If more than one guaranty association or foreign guaranty association has a claim against the same collateral and the available collateral, after allocation under subsection (4), along with billing and collection efforts, are together insufficient to pay each guaranty association and foreign guaranty association in full, then the receiver will prorate payments to each guaranty association and foreign guaranty association based upon the relationship the amount of claims each guaranty association and foreign guaranty association has paid bears to the total of all claims paid by the guaranty association and foreign guaranty associations.

(7) The receiver is entitled to deduct from reimbursements owed to a guaranty association or foreign guaranty association or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this section, not to exceed 3% of the

*Exhibit 6-4*

collateral or the total deductible reimbursements actually collected by the receiver. For claim payments made by a guaranty association or foreign guaranty association, the receiver shall promptly provide the guaranty association or foreign guaranty association with a complete accounting of the receiver's deductible billing and collection activities, including copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each account, and any proration of payments when it occurs. If the receiver fails to make a good faith effort within 120 days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by the guaranty association or foreign guaranty association, the guaranty association or foreign guaranty association may pursue collection from the policyholders directly on the same basis as the receiver, and with the same rights and remedies, and shall report any amounts collected from each policyholder to the receiver. To the extent that a guaranty association or foreign guaranty association pays claims within the deductible amount, but is not reimbursed by either the receiver under this section or by policyholder payments from the guaranty association's or foreign guaranty association's own collection efforts, the guaranty association or foreign guaranty association shall have a claim in the insolvent insurer's estate for unreimbursed claims payments.

(8) The receiver shall adjust the collateral being held as the claims subject to the deductible agreement are run off, so long as adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor. The receiver shall make these adjustments periodically, but is not required to adjust the collateral more than once a year. The guaranty association and any foreign guaranty association shall be informed of all such collateral reviews, including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims can be presented, the receiver will release any remaining collateral to the policyholder.

(9) The Ingham county circuit court having jurisdiction over the liquidation proceedings shall have jurisdiction to resolve disputes arising under this section.

(10) This section does not limit or adversely affect any right a guaranty association or foreign guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association or foreign guaranty association under policies of the insolvent insurer or for related expenses the guaranty association or foreign guaranty association incurs.

(11) This section applies to all delinquency proceedings that are open and pending on the effective date of this section.

(12) This section does not apply to first party claims or to claims funded by a guaranty association or foreign guaranty association net of the deductible unless subsection (5) applies.

(13) As used in this section:

(a) "Deductible agreement" means any combination of one or more policies, endorsements, contracts, or security agreements that provide for the policyholder to bear the risk

*Exhibit 6-4*

of loss within a specified amount per claim or occurrence covered under a policy of insurance and may be subject to aggregate limit of policyholder reimbursement obligations.

(b) "Noncovered claim" means a claim that is subject to a deductible agreement, may be secured by collateral, and is not covered by a guaranty association or foreign guaranty association.

**Utah Insurance Code**

31A-27a-612. Administration of deductible policies and insured collateral.

(1) As used in this section:

(a) "Collateral" means any of the following that secures an insured's obligation to pay or to reimburse the insurer for deductible claim payments and to reimburse or pay to the insurer other secured obligations:

- (i) cash;
- (ii) a letter of credit of the insured;
- (iii) a surety bond posted by the insured; or
- (iv) any other form of security posted by the insured.

(b) "Deductible claim" means a claim, including a loss or allocated loss adjustment expense, under a deductible policy within the insured's obligation to pay a portion of a claim or claim expense that the insurer is obligated to pay to a person other than the insured by the deductible policy or by operation of law.

(c) (i) "Deductible limit" means a limit on an amount to be paid or reimbursed by the insured under a deductible policy that is equal to or greater than \$5,000.

(ii) A deductible limit may be any amount of the risk exposure before the insurer agrees to become liable for the insurance risk without a right of recoupment from the insured for the insurer's payment of claims or expenses related to a claim under the deductible policy.

(d) (i) "Deductible policy" means any combination of one or more policies, endorsements, contracts, or security agreements in which the insured agrees with the insurer to:

(A) pay directly:

(I) the initial portion of a claim under the policy, endorsement, contract, or agreement up to a specified dollar amount; or

(II) the expenses related to a claim; or

(B) reimburse the insurer for the insurer's payment of:

(I) a claim under the policy, endorsement, contract, or agreement up to a specified dollar amount; or

(II) the expenses related to a claim.



(ii) "Deductible policy" includes a policy, endorsement, contract, or agreement that contains an aggregate limit on the insured's liability for all deductible claims in addition to a deductible limit for each claim.

(iii) "Deductible policy" does not include:

(A) a policy, endorsement, contract, or agreement that provides that the initial portion of a covered claim shall be self-insured and the insurer has no payment obligation within the self-insured retention;

(B) a policy, endorsement, contract, or agreement that provides for retrospectively rated premium payments by the insured; or

(C) a reinsurance arrangement or agreement.

(e) "Other secured obligation" means an obligation, such as a reinsurance or retrospective premium obligation, that is:

(i) payable by the insured to the insurer; and

(ii) secured by collateral that also secures a deductible obligation.

(f) "Uncovered claim" means a deductible claim that is secured by collateral but that:

(i) is not defined as a covered claim under any relevant guaranty association statute;

(ii) the insured fails to fund or pay; and

(iii) is filed with the receiver pursuant to the receivership proof of claim process.

(2) (a) If an insurer agrees to allow an insured to fund or pay deductible claims directly or through a third party administrator, except as prohibited by applicable workers' compensation insurance law:

(i) the insured shall fulfill the insured's obligations notwithstanding a delinquency proceeding; and

(ii) the receiver shall allow the funding or payment agreements to continue notwithstanding a delinquency proceeding.

(b) To the extent the insured funds or pays a deductible claim, the insured's funding or payment of a deductible claim:

(i) bars any deductible claim in a delinquency proceeding including a claim by the insured or third party claimant; and

- (ii) extinguishes the obligation, if any, of the receiver or an affected guaranty association to pay the deductible claim.
  - (c) The insured is responsible for providing timely notice to the receiver and to all affected guaranty associations for any claim that may exceed the deductible limit.
  - (d) A charge of any kind may not be made against a receiver or an affected guaranty association on the basis of an insured's funding or payment of a deductible claim.
  - (e) The failure of an insured to fulfill the insured's obligation pursuant to a funding agreement entitles the following to the full benefit of all collateral and other rights of recovery and reimbursement under the other provisions of this section:
    - (i) the receiver that pays a deductible claim; or
    - (ii) pursuant to Subsection (6)(b), an affected guaranty association that pays a deductible claim.
- (3) Any reimbursement owed to an insurer under a deductible policy issued by an insurer subject to a delinquency proceeding shall be administered as follows:
- (a) (i) A reimbursement from an insured for the payment of a deductible claim is a general asset of the estate to the extent that:
    - (A) the insolvent insurer is owed reimbursement for deductible payments made before the entry of a final order of liquidation; or
    - (B) the receiver is owed reimbursement for a deductible payment.
  - (ii) The receiver shall determine if a reimbursement is a general asset of the estate in accordance with this section.
  - (b) The receiver shall bill an insured for reimbursement of a deductible claim:
    - (i) paid by the insurer before the commencement of delinquency proceedings;
    - (ii) paid by an affected guaranty association upon receipt of notice of a reimbursable payment; or
    - (iii) paid or allowed by the receiver.
  - (c) The receiver may take all commercially reasonable actions necessary to collect a reimbursement owed if the insured does not make payment within:
    - (i) the time specified in the deductible policy; or
    - (ii) within 60 days after the day of billing if no time is specified in the deductible policy.

***Exhibit 6-4***

(d) The following is not a defense to the insured's reimbursement obligation under a deductible policy:

(i) the insolvency of the insurer;

(ii) the insurer's inability to perform any of the insurer's obligations under a deductible policy; or

(iii) an allegation of improper handling or payment of a deductible claim by:

(A) the insurer;

(B) the receiver;

(C) an affected guaranty association; or

(D) any combination of Subsections (3)(d)(iii)(A) through (C).

(4) The receiver shall adjust and pay uncovered claims as provided in Subsection (5). The receiver's obligation under this Subsection (4) terminates once all available collateral is exhausted. Once all available collateral is exhausted, any unpaid uncovered claims shall continue to be handled as a proof of claim in the receivership estate.

(5) (a) (i) Except where a deductible policy or other agreement conflicts with this section, any collateral held by an insurer subject to a delinquency proceeding under this chapter held under a deductible policy issued by the insurer, held for other secured obligations, or held under both shall be maintained and administered in accordance with:

(A) the deductible policy;

(B) any applicable security agreement;

(C) any agreement regarding other secured obligations; or

(D) any applicable combination of the deductible policy and other agreement.

(ii) This Subsection (5) applies to collateral regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer under a deductible policy, agreement, or other secured obligation.

(b) (i) Subject to this Subsection (5), collateral shall be used to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations under Subsection (8).

(ii) Collateral shall be considered as property of the receivership estate solely for the purpose of the receiver administering and handling the collateral.

**Exhibit 6-4**

(iii) Collateral may not be considered as a general asset of the estate, except as provided in Subsections (5)(c) and (8).

(c) (i) Subject to Subsection (5)(c)(ii), collateral held to secure the insured's performance of obligations is a general asset of the estate to the extent that:

(A) the insurer pays or has paid a deductible claim before the day on which a final order of liquidation is entered and the deductible is not reimbursed by the insured;

(B) the receiver pays or has paid a deductible claim; or

(C) the insured fails to pay or reimburse to the insurer other secured obligations to the extent the payment or reimbursement is due or payable before the day on which a final order of liquidation is entered and remains unpaid.

(ii) The receiver shall determine the extent that collateral described in this Subsection (5)(c) is a general asset.

(d) The receiver shall draw down collateral to the extent necessary if the insured fails to:

(i) perform the insured's funding or payment obligations under any deductible policy;

(ii) pay deductible reimbursements within:

(A) the time specified in the deductible policy; or

(B) 60 days after the date of the billing if no time is specified in the deductible policy;

(iii) timely fund any other secured obligation; or

(iv) timely pay expenses defined in Subsection (8).

(e) (i) The receiver shall first apply or reserve collateral to the insured's obligations referenced in Subsections (5)(c)(i)(A) and (C).

(ii) The receiver shall use any collateral remaining after the application of Subsection (5)(e)(i) to:

(A) reimburse deductible claims submitted by an affected guaranty association;

(B) adjust and pay uncovered claims allowed by the liquidator;

***Exhibit 6-4***

- (C) pay other secured obligations of the insured that become due and payable after the date of liquidation; or
- (D) pay expenses as defined in Subsection (8).

(iii) The receiver shall:

(A) use collateral under Subsection (5)(e)(ii) in the order that the deductible claims or charges against the collateral listed in Subsection (5)(e)(ii) are received and accepted by the receiver; and

(B) continue until all valid deductible claims or charges are fully reimbursed or paid or the collateral is exhausted.

(iv) If there are amounts payable or reimbursable under this Subsection (5)(e) and the receiver for any reason has been precluded from drawing the collateral, the receiver may establish a reserve against the collateral for those amounts. Only the collateral exceeding the reserve shall be considered remaining collateral under this Subsection (5)(e).

(f) Once all claims, other secured obligations, or expenses under Subsection (8) covered by collateral have been paid and the receiver is satisfied that no new claims, other secured obligations, or expenses under Subsection (5)(e) may be presented, the receiver shall release any remaining collateral to the insured in accordance with the deductible policy or agreement relating to other secured obligations.

(6) To the extent an affected guaranty association pays a deductible claim for which the insurer would have been entitled to reimbursement from the insured, the following provisions apply:

(a) (i) When an affected guaranty association pays a deductible claim, the affected guaranty association shall report the claim to the receiver.

(ii) The receiver shall collect from the insured all deductible amounts due as reimbursement. Subject to Subsection (8), when the insured reimbursements are collected, the receiver shall reimburse the affected guaranty association for deductible claims.

(iii) A reimbursement paid to the affected guaranty association pursuant to this Subsection (6)(a) may not be treated as a distribution under Section 31A-27a-703 or as an early access payment under Section 31A-27a-704.

(iv) If an affected guaranty association pays a deductible claim that is also subject to reimbursement under statutory net worth provisions, the affected guaranty association shall:

(A) bill the insured directly;

(B) notify the insurer of the payment; and

**Exhibit 6-4**

(C) notify the receiver of any receipt of a reimbursement under net worth provisions, which shall be credited against the insured's deductible reimbursement obligations to the extent that the reimbursement applies to deductible claims.

(b) (i) This Subsection (6)(b) applies if:

(A) the receiver declines to seek reimbursement from the insured or from any available collateral;

(B) the receiver is unsuccessful in obtaining reimbursement from the insured or from any available collateral; or

(C) the receiver fails to take available commercially reasonable actions to collect a reimbursement owed.

(ii) The receiver shall notify an affected guaranty association if the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured or from any available collateral.

(iii) If a condition described in Subsection (6)(b)(i) exists, notwithstanding whether the affected guaranty association receives the notice required by Subsection (6)(b)(ii), an affected guaranty association:

(A) may, after notice to the receiver, collect a reimbursement due from the insured for the deductible claims the affected guaranty association has paid:

(I) on the same basis as the receiver; and

(II) with the same rights and remedies; and

(B) shall report any amounts collected under Subsection (6)(b)(iii)(A) from each insured to the receiver.

(iv) The receiver shall provide an affected guaranty association with available information needed to collect a reimbursement due from the insured.

(v) When an affected guaranty association undertakes to collect reimbursements from the insured, the affected guaranty association shall notify all other guaranty associations who have paid deductible claims on behalf of the same insured that this action is being taken.

(vi) An amount collected by the affected guaranty association pursuant to this Subsection (6)(b) may not be treated as a distribution under Section 31A-27a-703 or as an early access payment under Section 31A-27a-704.

(vii) An affected guaranty association may net an expense incurred in collecting a reimbursement against that reimbursement.

***Exhibit 6-4***

(c) The receiver shall provide any affected guaranty associations with periodic reports concerning the receiver's activities in discharging responsibilities under this section, which shall include an accounting for the receiver's deductible billing and collection activities.

(d) To the extent that an affected guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, the affected guaranty association has a claim for those amounts in the delinquency proceeding. Any claim by an affected guaranty association shall be reduced by reimbursed or unreimbursed expenses described in Subsection (8) incurred by the receiver.

(e) (i) If any collateral is held under a deductible policy at the time the receiver files an application to terminate the delinquency proceeding, and it appears that an additional deductible claim may be payable by an affected guaranty association under the deductible policy, the receiver shall:

(A) transfer to an affected guaranty association the portion of the collateral that is reasonably estimated to be necessary to pay the deductible claim; and

(B) release any remaining portion of the collateral to the insured.

(ii) An affected guaranty association shall handle any collateral transferred from the receiver as provided in this section.

(f) Nothing in this Subsection (6) limits any rights of the receiver or an affected guaranty association under applicable statutory law to obtain reimbursement from an insured for a claims payment made by the affected guaranty association under a policy of the insurer or for the affected guaranty association's related expenses.

(7) (a) The receiver shall periodically adjust the collateral being held using accepted actuarial principles and practices.

(b) The receiver may impose a discretionary safety margin for collateral maintained.

(c) The receiver may not be required to review collateral more than once a year.

(d) The receiver shall inform any affected guaranty association and the insured of any collateral reviews, including the basis for any proposed adjustment.

(8) The receiver may do the following in relation to reasonable expenses incurred in fulfilling the receiver's responsibilities under this section:

(a) deduct the expense from reimbursements;

(b) deduct the expense from the collateral; or

(c) recover the expense through billings to the insured.

**Exhibit 6-4**

(9) (a) A receiver shall meet the receiver's obligations under this section in a timely manner.

(b) If an affected guaranty association believes that a receiver is not meeting an obligation under this section in a timely manner, upon motion by an affected guaranty association, a receivership court may grant relief to the affected guaranty association if the receivership court finds that the receiver is not meeting an obligation under this section in a timely manner.

(10) This section modifies Subsection 31A-22-1010(2)(b) to the extent necessary to permit an insured to participate in the payment of the insurance claims and losses by reimbursement of a receiver or affected guaranty association as provided in this section.



**CHAPTER 7—REINSURANCE**

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**I. INTRODUCTION**

Reinsurance is insurance for insurance companies, and it is separate and distinct from the insurance relationship existing between a policyholder and its insurer. With respect to property/casualty reinsurance, the direct (primary 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, the reinsurer has no 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 a property/casualty insurer’s assets. Understanding reinsurance is critical to the efficient collection of this important asset. Generally, ceded reinsurance agreements should be continued.

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.
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	A guarantee by the reinsurer to a party that is not in privity with the reinsurance contract 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.
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 the risk from the cedent.
Retention	The amount of the risk kept 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 the risk that it has assumed from the cedent to another reinsurer.
Retrocessionnaire	A reinsurer that assumed the 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.

Additional definitions may be found in the NAIC’s Credit for Reinsurance Model Act, Credit for Reinsurance Model Regulation, Special Purpose Reinsurance Model Act, Life and Health Reinsurance Agreement Model Act, and Assumption Reinsurance Model Act. Glossaries can be found at various Web sites.

## **II. REINSURANCE BASICS**

There are several reinsurance arrangements that one might expect to find in an insurer’s reinsurance program.

### **A. Reinsurance Arrangements**

A reinsurance program can be extremely complex and may consist of multiple interacting arrangements, all responsive to the same loss recovery. Furthermore, an insurer’s net retention, after applying prevailing 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 insurers and then transfers its own liability to the 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. In 1995, the NAIC adopted a revision to Schedule F to require ceding companies to disclose whether they have contracts ceding 75 percent of direct written premiums.

A cut-through is 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 endorsement. The general market effect of the existence of cut-throughs is to encourage competition among insurers by ensuring that additional insurers can compete for business. Some clients require insurers to obtain a cut-through or face the possibility of losing business to a larger or non-domestic 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.

Reinsurance programs and participants vary from year to year. Programs written prior to the early 1980s are likely to have more of a proportional content, with excess of loss reinsurance filling out capacity, and catastrophe reinsurance protecting the net line. Recent programs are more likely to consist of excess layers, with a higher retention by the ceding insurer and more aggregate caps on pro rata proportional reinsurance.

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.

## 2. Facultative Reinsurance

Facultative reinsurance is reinsurance of individual risks by offer and acceptance wherein the reinsurer retains the ability to accept or reject each risk offered by the ceding company.

There are two principal categories of facultative reinsurance: facultative obligatory and semi-automatic facultative.

- **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.
- **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.

## 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.

### 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 circles, 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 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 insured. 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. 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.

## 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 significant 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 ( $\$150,000 + 4 \times \$150,000 + 2 \times \$150,000$ ) 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. 75—Reinsurance Deposit Accounting – An Amendment to SSAP No. 62, Property and Casualty Reinsurance, and SSAP No.61—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 61 for Life and SSAP 62 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 their 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. 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 the ceding 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.

### **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 to Intermediary shall be deemed to constitute payment to Insurer only to the extent that such payments are actually received by Insurer.<sup>1</sup>

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.

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 known as an “Interests and Liabilities” Statement (I&L), binding them to the formal contract. More recently, many brokers and direct reinsurers have been moving toward contract at

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<sup>1</sup> 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.

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, although the reinsurance intermediary clauses of more recent treaties may deem payment as having been made only upon actual receipt by the cedent. For an example, see the NAIC Reinsurance Intermediary Model Act and New York Regulation 98.

## **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.

## **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 (loss portfolio) 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. As of October 1994, under a “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 62 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 those cash flows.

Paragraph 12 of SSAP 62 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 75.

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 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. 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.

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.

### 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 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. 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 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
- 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 range from a simple manual system to an elaborate, mainframe electronic system. In a few cases, there may be a limited accounting systems or no system at all. 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 treaty wording
- Reinsurance slips (if a formal treaty has not been finalized)
- Signed interest and liability endorsements 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 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 Interests & Liabilities), 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 insurers 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. The receiver needs to coordinate with the reinsurer and any affected guaranty funds as to how the audit should be conducted.

### 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 treaty, 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 and reviewed.

Documentation on hand should include the most recent experience reports on the program. Investigation should be made into significant deviations from normal business trends. If desired, a comparison to similar programs with other cedents may also be made.

Comparison of these 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 visiting the cedent's offices, 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:

- 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 (treaty 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 of 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 claims manual, 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, attorneys and others
  - claim control log
  - claim registers, including aged listing of outstanding claims and salvage and subrogation registers
  - claim files and related policy files
  - cash records applicable to claim and expense payments

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:
  - determination of adequacy of file documentation, including notice of loss, adjusters' reports, attorneys' reports,<sup>2</sup> 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)

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<sup>2</sup> 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.

- 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 the 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.

### 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 nor disrupts the receiver's own efforts to manage claims and assets.

#### 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 the affected 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 affected 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 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.

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.

The receiver may 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 low 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.

Second, 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 cedent 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.
- 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.
- 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:

- 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 only after the cedent pays the 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 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. 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



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. Receivers should be aware of case law regarding the legal effect of providing late notice of claims to reinsurers. 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.

### V. TERMINATION OF REINSURANCE RELATIONSHIP

The purpose of this section is to outline the four principal methods for terminating a reinsurance relationship: commutation, cancellation, novation and rescission. 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.

##### 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.

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 and raises questions of priorities or preferences to creditors. Commutation of an insolvent insurer's ceded business should involve consideration of the factors as discussed 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 (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 before attempting a commutation.

The receiver of a reinsurer is largely dependent on information provided by the ceding insurers. As a result, the receiver should consider conducting an on-site review 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 for the calculation. Three basic steps are involved:

- Project reported outstanding and IBNR losses to ultimate incurred.
- 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 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. Cancellation, however, does not usually end the reinsurance relationship, which continues until all claims are submitted and paid.

Non-life business in force at the date of receivership, including assumed reinsurance, is usually terminated within 30 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.

## 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. 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 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 may be a primary reason for novations.

### 3. Practical Difficulties

Traditionally, a novation requires the consent of all parties to the contract, the insured, the original insurer and the reinsurer. 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.

## **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 or by a party that has been injured by acts of the other. Generally, reinsurance agreement rescissions occur because a party contends it has been 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.

## **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 domiciliary state's law.

### **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, which are discussed in Chapter 9—Legal Considerations.

### **C. Procedural Steps in Administering Setoffs**

The receiver should review the domiciliary 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 resolved, the receiver should consider mediation, partial or total rejection of a proof of claim, or appropriate legal action.

### **D. Priority of Distribution Statutes**

Virtually every state liquidation law contains provisions that establish creditor classifications and assign priorities to each classification. Lower priority creditors will not be paid until the superior priority creditors have been paid in full. These distribution schemes invariably favor policyholder claims over those of general creditors. Assumed reinsurance obligations of the insolvent insurer are considered to be general creditor claims. With respect to life insurance company receiverships, the receiver’s desire to continue the business of the insurer generally will motivate the receiver to continue the reinsurance. As a result, reinsurance premiums will be an administrative expense of operating the estate, which will be assigned a higher priority.

### **E. 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.<sup>3</sup>

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.

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<sup>3</sup> This is a very cursory discussion—please refer to the Legal Chapter for a detailed analysis of this subject.

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.<sup>4</sup> 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.

Arbitration rights within reinsurance agreements are enforceable under Section 105E of the NAIC Insurer Receivership Model Act. 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 frequently issued by the bank at the request of a third party, called the account party (the reinsurer), in furtherance of a separate agreement between the account party and the beneficiary. Reinsurers may also be beneficiaries of LOCs provided by cedents to collateralize future premium payment obligations.

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 generally permitted under credit for reinsurance statutes similar to the NAIC Model Law on Credit for Reinsurance.

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**

While state laws differ, most requirements track closely the NAIC Model Regulation on Credit for Reinsurance. LOCs supporting unauthorized reinsurance should be clean, 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 generally 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

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<sup>4</sup> As of January 2007, only New York and Ohio courts have held that receivers are not required to arbitrate, despite arbitration clauses in reinsurance agreements.

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. Each state's insurance law contains relevant standards for an issuing bank. Many states require issuing or confirming banks to be members of the Federal Reserve System. Other states require that the LOC be issued or confirmed by either a domestic bank, a foreign bank licensed in the United States or an unlicensed foreign bank, which is either on the NAIC Securities Valuation Office (SVO) list or a member of the Federal Reserve System.

### **C. What Should a Receiver Know About LOCs?**

#### **1. Cedent in Receivership**

When a cedent is in receivership, the receiver must 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.

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 to the greatest degree possible. 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.

## **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 NAIC Model Regulation on Credit for Reinsurance contains minimum standards for how a trust should be established and operated.

In reinsurance, trust funds serve as an alternative to LOCs. 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.

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.

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 the 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<sup>5</sup> 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 or liquidation. 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.

## **XII. EXHIBITS**

*Exhibit 7-1: Treaty Master Abstract*

*Exhibit 7-2: Reinsurance Matrix*

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<sup>5</sup> Also known as alien reinsurers.

TREATY MASTER ABSTRACT

Ceding Co.: \_\_\_\_\_ Source Co/MGA: \_\_\_\_\_  
 Title: \_\_\_\_\_ Date: \_\_\_\_\_  
 Status:  New  Renew  Endorse  Cancellation  Reactive

Treaty No.: \_\_\_\_\_

Binder Change (Status "New")  
 Activity No.: \_\_\_\_\_

Assuming Co: \_\_\_\_\_

Contract Type \_\_\_\_\_ Ceding Co. \_\_\_\_\_ Broker Code: \_\_\_\_\_ Source \_\_\_\_\_ Proportional Co.: \_\_\_\_\_ Non-Proportional

Participation %: \_\_\_\_\_ Broker Reference No.: \_\_\_\_\_

Dates

Contract Eff: \_\_\_ / \_\_\_ / \_\_\_ Contract Exp: \_\_\_ / \_\_\_ / \_\_\_ Cont (Y/N): \_\_\_ / \_\_\_ / \_\_\_

Anniversary: \_\_\_ / \_\_\_ / \_\_\_ Review Mos: \_\_\_ / \_\_\_ / \_\_\_ Endorsement: \_\_\_ / \_\_\_ / \_\_\_

Actual Can Date: \_\_\_ / \_\_\_ / \_\_\_ Basis: \_\_\_\_\_ Provisions: \_\_\_\_\_

Territory of Risk: \_\_\_\_\_ Underwriter: \_\_\_\_\_

			Line of Business		
ASL	%	%	%	%	
_____	_____	_____	_____	_____	_____

LPC	CUR	%	Limit of Liab	Retention	Comment
_____	_____	100	_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____

Class of Bus: \_\_\_ % Long Tail: \_\_\_\_\_

Risk Attach Method: \_\_\_\_\_ Loss Attach Basis: \_\_\_\_\_ Sub To Cat: \_\_\_\_\_ % Sub  
 Cat \_\_\_\_\_

	EAP Type	Cur	100% Amount
Prem Basis	EAP	_____	_____
G/N ___ W/E ___	Flat	_____	_____
	Min	_____	_____
	Dep	_____	_____
	M&D	_____	_____
	Cur	Provisional	Minimum Flat or Max

Rates: \_\_\_\_\_  
 Subject Prem: \_\_\_\_\_ Cur: \_\_\_\_\_ Amount: \_\_\_\_\_  
 Rating Basis: \_\_\_\_\_ Adjustment (Y/N): \_\_\_\_\_ As Of: \_\_\_ / \_\_\_ / \_\_\_ Due: \_\_\_\_\_  
 Premium Comment: \_\_\_\_\_

Commission % \_\_\_ W/E: \_\_\_\_\_ Brokerage % \_\_\_\_\_ W/E: \_\_\_\_\_ G/N: \_\_\_\_\_

Profit Commission Formula Code: \_\_\_\_\_ % \_\_\_\_\_ MTG%: \_\_\_\_\_

#Yrs Deficit C/F: \_\_\_\_\_ Basis of Adj: \_\_\_\_\_ 1st Calc Day: \_\_\_/\_\_\_/\_\_\_ 1st Due Date: \_\_\_/\_\_\_/\_\_\_

Sliding Scale Commission Minimum %: \_\_\_\_\_ Pro%: \_\_\_\_\_ Max %: \_\_\_\_\_

Loss Ratio — Max: \_\_\_\_\_ Prov: \_\_\_\_\_ Min: \_\_\_\_\_

SSC Basis: \_\_\_\_\_ Adjustment Due Date: \_\_\_/\_\_\_/\_\_\_

# Yrs Carry Forward Credit: \_\_\_\_\_ Deficit: \_\_\_\_\_

Commission Comment: \_\_\_\_\_

Portfolio Premium In (Y/N): \_\_\_\_\_ Out (Y/N): \_\_\_\_\_ Loss In (Y/N): \_\_\_\_\_ Out (N/Y): \_\_\_\_\_

Accounts: Freq \_\_\_\_\_ 1st Pd Start \_\_\_/\_\_\_/\_\_\_ End \_\_\_\_\_ Due \_\_\_\_\_

Report Lag (in days) \_\_\_\_\_ Payment Lag (in days): P \_\_\_ L \_\_\_

Reinstatement: Type Code: \_\_\_\_\_ Brokerage \_\_\_\_\_ Comment \_\_\_\_\_

Loss Exp. Method: \_\_\_\_\_ Cas Loss Amt 100%: \_\_\_\_\_ Cur: \_\_\_\_\_

Type of Bus.: \_\_\_\_\_ Accommodation Bus (Y/N): \_\_\_\_\_

IBNR: \_\_\_\_\_

COMMENTS

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_

Priority	Ceded	Contract Year	Retro%	Start	Stop	W/E	G/N	%O/R
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

QUAKE WIND FLOOD

Zones Cur Amount

PH L	%	1	2	3	4	5	6	7

ABC INSURANCE COMPANY

REINSURANCE MATRIX

LINE OF BUSINESS: PROPERTY AND CASUALTY

LIMITS	4/01/87 - 3/31/88	4/01/88 - 3/31/89	4/01/89 - 3/31/90	LIMITS
100,000	RETENTION	RETENTION	RETENTION	100,000
500,000	Contract 1 1st Multi-Line XOL 400,000 XS 100,000  (Prop & Cas)	Contract 4 1st Multi-Line XOL 400,000 XS 100,000  (Prop & Cas)	Contract 7 1st Multi-Line XOL 400,000 XS 100,000 (1,200,000 Agg Prop Only) 30% Canceled Cut-off (Prop, Cas. Wkrs Comp)	500,000
1,000,000	Contract 2 2nd Multi-Line XOL 500,000 xs 500,000  (Prop & Cas)	Contract 5 2nd Multi-Line XOL 500,000 XS 500,000  (Prop & Cas)	Contract 8 2nd Multi-Line XOL 500,000 XS 500,000 25% Canceled Cut-off (Prop & Cas)	1,000,000
2,000,000	Contract 3 1st Casualty Cat XOL 1,000,000 XS 1,000,000 (2,000,000 Agg) (Casualty)	Contract 6 1st Casualty Cat XOL 1,000,000 XS 1,000,000 (2,000,000 Agg) (Casualty)	Contract 9 1st Casualty Cat XOL 1,500,000 XS 1,000,000 (3,000,000 Agg) (Casualty)	2,000,000 ----- 2,500,000
2,500,000 ----- 3,000,000 ----- 5,000,000	NO REINSURANCE IN PLACE		Contract 10 2nd Casualty Cat XOL 2,500,000 XS 2,500,000 (Casualty)	3,000,000 ----- 5,000,000

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**CHAPTER 8 – SPECIAL RECEIVERSHIPS**

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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).<sup>1</sup> 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;<sup>2</sup>
- (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; and
- (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 (“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 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, section on

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<sup>1</sup> 29 U.S.C. Section 1001, *et seq.*

<sup>2</sup> See, for example, Section 626.902, *Florida Statutes*

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 to 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/nonadmitted) 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.<sup>3</sup> *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.

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

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<sup>3</sup> Chapters 9, 12 and 13 govern adjustment of debts by composition, extension or discharge for municipalities, certain farmers and fishermen, and certain individuals.

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 V.(C) 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 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, IRMA 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 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 persons 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 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.<sup>4</sup> The EBSA also has processes by which advisory opinions concerning multiple employer welfare arrangements (MEWAs)<sup>5</sup> may be requested. Utilizing that process can be of enormous assistance in overcoming jurisdictional objections to the commencement and continuation of a receivership.

### **III. HEALTH MAINTENANCE ORGANIZATIONS**

Financially troubled Health Maintenance Organizations (“HMOs”) pose a particular challenge to receivers for a number of reasons. HMOs and other managed care entities are unique business entities, formed according to state enabling acts for the specific purpose of providing or arranging for the provision of health care services. Their business can be an emotionally charged issue and a political “hot button.” HMOs are an important force in today’s health care market. A successful approach to resolving the financial problems of HMOs depends on a thorough understanding of the HMO’s organization and the complexities of its relations with its providers and clients. Most states do not provide guaranty fund protection for HMOs. Because the applicable laws may vary significantly

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<sup>4</sup> 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/](http://www.dol.gov/ebsa/).

<sup>5</sup> 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

from state to state, the receiver should review the HMO statutes of the affected states, and also have an understanding of different market conditions that may affect the financial structure of HMOs.

While they are generally within the ambit of state insurance codes, HMOs and some other managed care arrangements are different from indemnity companies. In many states, the regulation of HMOs has its roots primarily in health care provider regulation, and HMOs are often not chartered as insurance companies. They are frequently governed exclusively by one or more portions of a state’s insurance code, rather than by its entirety. Therefore, a receiver may not be able to proceed upon all of the same assumptions as he or she would when an indemnity company is the subject of the proceeding.<sup>6</sup>

A significant distinction between indemnity insurers and HMOs or most other types of managed care organizations is that indemnity contracts promise reimbursement for claims incurred or money expended for covered claims by the person insured. In contrast, the subscriber to an HMO pays periodic premiums in return for a promise to furnish, or to make available, health care services. Therefore, the risk-bearing activity of an HMO is different than that of an indemnity insurer. While the insurer collects, retains and invests premium in anticipation of paying future covered claims (as either reimbursement to the insured, or direct payment to the provider), an HMO collects, retains and invests the premium in order to ensure the ability to pay, in some cases, contracted providers at a specified, pre-negotiated rate (and often in advance because of capitation), whether or not the consumer actually uses health care services during the period for which the premium or capitated payment was made.

On the other hand, the lines between HMOs and indemnity insurers might not be as clear as the traditional model suggests. Indemnity insurers may pay providers directly, sometimes even on a capitated or risk-sharing basis, while it is common to see HMOs with a negotiated rate for volume of business and not a capitation arrangement. For example, the HMO may have an agreement with a national hospital chain for a certain fee schedule, but it is based on services actually rendered, not a capitation per subscriber per month.

## A. Types of HMOs

An HMO manages a prepaid or discounted health care delivery or financing system. Generally, an HMO’s enrollees and their dependents receive health care benefits through a network of participating providers, such as physicians, hospitals, specialists and pharmacies, with whom HMOs enter into provider contracts setting forth payment amounts and conditions. Providers may contract to provide health care services and equipment to enrollees and their dependents on a prepaid basis. Those providers who contract on a prepaid basis may bear a portion of the risk when the cost of their services exceeds the capitation or fixed-fee rate paid by the HMO. In this way, capitation may shift the financial risk from the HMO to the providers, thus creating incentives to control costs. Enrollees and members are responsible for co-payments and deductibles as a means of controlling the use of health care services.

### 1. HMO Models

There are different types of HMOs, depending on their relationships with their providers. Some of the differences relate to the number of participating physicians, the degree of utilization management, the reimbursement method for services, provider contract administration and capital requirements. An HMO can be a combination of models, referred to sometimes as a “mixed” model HMO, and new variations are often invented.

#### a. Staff Model

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<sup>6</sup> For example, the Florida Insurance Code provides: Applicability of other laws. “Except as provided in this part, health maintenance organizations shall be governed by the provisions of this part and part III of this chapter and shall be exempt from all other provisions of the Florida Insurance Code except those provisions of the Florida Insurance Code that are explicitly made applicable to health maintenance organizations.” Section 641.201, Florida Statutes.

In the staff model, the HMO employs physicians to provide health care services to the HMO's members. The HMO may own or lease facilities and medical equipment to provide such health care services. The fact that the health care services are rendered at the HMO's facility distinguishes the staff model HMO from other HMO models, where the health care is rendered at the provider's facility and the same provider might contract simultaneously with the HMO's competitors.

b. Independent Physician Association (IPA) Model

In an IPA model, the HMO contracts with a group of physicians, but each physician maintains a separate and distinct practice from others in the group. An IPA may be a primary care physician (PCP) who subcontracts with a specialist who is not a participating provider with the HMO. HMOs generally compensate IPAs on a capitated or fee-for-service basis. IPAs may also be large multi-specialty groups that do not need to subcontract for specialist or other services, or only subcontract on a very limited basis.

c. Network Model

In a network model, the HMO contracts directly with individual providers or small groups of providers. As practiced in some markets, this model may closely resemble the "preferred provider" networks used by many indemnity insurers and self-insurers.

d. Mixed HMO Model

The mixed model HMO combines features of the other models. For example, some HMOs may both employ physicians and contract directly with a group of physicians. The reimbursement arrangement is similar to the IPA model.

The different types of HMO models may impact various liquidation issues. For example, the liquidator may have liquidity issues when attempting to rehabilitate a staff model HMO if many of the assets are invested in buildings, land and medical equipment. The HMO model may also affect the classification of the entity for jurisdictional purposes.

2. Managed Care Organization <sup>7</sup>

HMOs are a type of managed care organization (MCO). An MCO may also be an insurer, a provider, or a group of providers or plans. Whatever form it takes, an MCO proposes to arrange for the provision of health care services to its enrollees and simultaneously controls costs of those services through a variety of strategies, which may include utilization review, pre-certification, capitation programs, deductibles, co-payments, physician gatekeepers, negotiated pricing, and mail-order pharmaceutical programs.

Some states license special MCOs known as limited benefit plans or single service plans. These plans generally offer a single service (e.g., laboratory, vision, medical or equipment) to enrollees on a prepaid basis. Except for their limited range of services, single service plan operations are similar to those of HMOs. In some states, single service plans are licensed and regulated under the HMO statutes, but are allowed to operate with less capital and surplus than is required of full service HMOs.

Preferred provider organizations (PPO) arrange for or provide coverage for health services and equipment to employer groups, individuals and others on a discounted basis. Some PPOs are risk-bearing entities requiring a license or other regulatory approval to operate in a state. Some states also require the licensing of PPOs even if they are not bearing any insurance risk. PPOs also may conduct

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<sup>7</sup> See Peter R. Kongstvedt, 2000, *The Managed Health Care Handbook, Fourth Edition*, Aspen Publishers.



utilization review, including preauthorization, concurrent and retrospective review of necessary and appropriate health care services.

### 3. Point-of-Service (POS) Plans

Traditionally, HMO coverage was limited to services provided by the HMO through its staff or network. However, with the proper state regulatory approval, HMOs may, and in some instances must, offer an out-of-plan benefit, often referred to as point-of-service (POS) plans. Typically, an HMO enrollee using a participating provider or a provider with an approved referral is covered for 100% of the cost of the services received, minus the contractual co-pay or co-insurance. However, a referral is not required under a POS plan. But if the enrollee goes outside the HMO network, the enrollee's out-of-pocket expenses are increased. POS plans thus offer the enrollee additional provider choices in exchange for paying a larger portion of the cost. The POS plans are similar to the more traditional indemnity insurance.

## B. Types of Providers

A typical provider network consists of physicians, hospitals, pharmacies, laboratories and specialists who have agreed by contract ("contract" or "network" providers) to provide medical services or equipment to enrollees at favorable or discounted rates. The health care services may include medical, dental, vision or a combination of services. The receiver should review the plans, contracts and policies to determine the specific benefits provided.

### 1. Network Providers

Enrollees usually choose a primary care provider (PCP) from the physicians within the network. The PCP will be either a contract (participating) provider or directly employed by the HMO. A contract PCP is compensated on a salary, fixed-fee, capitation or partial capitation basis. Under a capitation arrangement, the PCP receives a set amount per enrollee (per member per month, or PMPM) assigned to that physician each month. The HMO may withhold various percentages from the capitation payment until the end of certain periods, when payment may be conditioned on the physician's ability to control certain costs. The practice of using holdbacks has declined significantly across the country. The HMO may also implement a performance payment arrangement for providers who meet certain quality goals (for example, high percentages of immunization for children).

### 2. Out-of-Network Providers

Providers outside the network ("non-contract" or "non-participating" providers) by definition have not entered into contracts with the HMO providing for payment amounts for services rendered to enrollees and are not subject to hold-harmless clauses (see below), utilization requirements, quality assurance programs, or other programs or contract terms developed by the HMO, except through operation of law. Consequently, non-participating providers may charge higher rates for services or equipment, and they may bill the member for amounts not covered by the HMO. In order to minimize these higher costs, the HMO requires the enrollees to obtain proper authorization (also known as a referral) for out-of-network treatment (except for certain open-ended POS programs). In addition, some plans provide that the HMO may "charge back" the fees of the out-of-network provider to the provider who is receiving capitation payments to provide the services, other than for services on an emergency basis. Generally, this health care includes treatment by specialists or out-of-network providers. If an HMO enrollee is directed to an out-of-network provider by the enrollee's PCP, the HMO will only require the enrollee to pay the co-pay, and the HMO will discharge the enrollee's responsibility to pay the prescribed deductible and coinsurance. Therefore, the HMO will reimburse the non-network provider their submitted charges less the enrollee's co-payment. If the enrollee self-directs himself or herself to a non-participating provider, the provider is entitled to full payment, and the enrollee's responsibility may include a co-pay, deductible and co-insurance payment. A more detailed discussion of Medicare implications affecting non-participating providers is set forth below.

### 3. Hospital Reimbursement

Hospitals are reimbursed using a variety of methods: per diem, per case, global capitation and bundled-fee arrangements. A per diem system pays hospitals a prospectively determined rate for each day of inpatient care. A per-case reimbursement pays the hospital a predetermined amount based on the patient's diagnosis or type of service. One type of case reimbursement uses Diagnosis Related Groups (DRGs), which may vary by hospital or geographical area. Under a global-capitation program, the HMO pays a single capitation rate for all services, including primary care, hospital, surgical and other benefits. A bundled-fee arrangement is similar to the global-capitation method, except the method of reimbursement for each class or type of provider is a set fee-for-service amount.

Regardless of the type of receivership proceeding, it is important that the receiver have an understanding of which type of benefits the HMO is at risk for and which risks the HMO has transferred to providers. This is especially true in the claims adjudication area, but also has implications when possible rehabilitation or continuation-of-coverage schemes are being considered.

## **C. Additional Considerations for the Receiver**

There are several additional complications that may confront the receiver of an HMO, either in the form of contracts into which the HMO has entered, or in the form of federal and state regulations to which some HMOs are subject.

### 1. Hold-Harmless Clause

There are two distinct types of hold-harmless clauses. The first, which is discussed in detail in this section, is the hold-harmless clause that is contained in the contract between a health plan 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 co-payments, deductibles or fees for services not covered under the member plan or policy. The HMO, in turn, will include a hold-harmless clause in its provider contracts, prohibiting providers from seeking to recover any amounts from the enrollee that are ultimately the responsibility of the HMO, or amounts that are above and beyond the agreed reimbursement for a given service. These clauses are designed to protect patients not only against overbilling by providers, but also to protect them from the risk that the HMO will go insolvent and fail to pay its providers.

Receivers should seek to have an injunction to enforce hold-harmless clauses against contracted providers (and even non-contracted providers in some instances) included within the petition to rehabilitate or liquidate an HMO. In cases where the receiver has evidence that members have been inappropriately billed, efforts should be made to intercede on behalf of the member and require the return of monies collected by the contracted provider. The receiver should note that claims by a member that represent amounts the member 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. Reinsurance

The HMO may have contracted for reinsurance, which is a useful tool to minimize losses and preserve the financial viability of an HMO. Reinsurance treaties include the following types and coverages:

- Assumption reinsurance, which provides for the transfer of in-force business to another HMO, MCO or insurer.
- Loss portfolio assumption reinsurance, which provides for the transfer of run-off claim liabilities to another HMO, MCO or insurer.
- Aggregate excess of loss reinsurance, which provides for the transfer of claim liabilities in excess of a specified threshold (e.g. typically for per diem inpatient charges) for reinsured business of an HMO.
- Per risk excess of loss reinsurance, which provides for the transfer of a particular claim liability in excess of a specified threshold (e.g. typically for per diem inpatient charges) for reinsured business of an HMO.

A regulator considering whether to take action against a troubled HMO should immediately review any reinsurance contracts for provisions that may come into play in an insolvency situation. Reinsurance contracts typically provide for notice of insolvency to the reinsurers, and, in some instances, the reinsurance coverage terminates immediately upon notice of the company's insolvency or cessation of business. Reinsurance coverage is often provided on a paid claim basis, and claims should be submitted within a six-month period after termination of the (1) existing reinsurance treaty, and/or (2) the anniversary date of the prior reinsurance treaty that was renewed by the existing reinsurance treaty.

The responsibility of preserving or maintaining reinsurance arrangements poses an additional challenge to the receiver, who may not be familiar with the activities of an HMO. Reinsurance issues may also arise because the receiver does not have possession and control of the insolvent HMO's records or the records are incomplete or in disarray. Some reinsurance issues may arise because the HMO has:

- Failed to submit the required reinsurance reports within the required time frames.
- Failed to pay reinsurance premiums when due.
- Failed to make the HMO's books and records available or to have such records in good order when the reinsurer performs a reinsurance audit.
- Failed to recognize certain special exceptions for provider arrangements that may not be covered by the reinsurer (e.g., certain risk pool arrangements with providers or situations where capitation changes to fee-for-service for provider charges above a risk threshold).

Receivers should bear in mind that there is limited coverage afforded to the HMO under the insurance insolvency clause provisions of a reinsurance contract. Collection of the reinsurance may be more difficult if the HMO breached a duty of good faith owed to the reinsurer. A breach of this duty may void or limit the reinsurance coverage.

Receivers attempting to collect and preserve the HMO's reinsurance should be aware that insolvency clause limitations typically provide the following:

- Continuation of coverage for the duration of the contract period for which premium payments have been made by the members (typically such coverage will last until the end of the initial receivership month for the company's plan).
- Coverage for members confined to an inpatient facility on the date of insolvency until the date of the member's discharge from such facility (typically such inpatient coverage will not last for more than one year).

- Coverage for confinement to a skilled nursing or rehabilitation facility on the date of insolvency when treatment is concurrent with and incidental to acute care services (such coverage typically extending until the earlier of 120 days or the date of discharge of the enrolled member from such facility).
- The reinsurance does not typically cover the medical services of affiliated providers or pay claims that may be covered by any guaranty association or insurance insolvency protection plan.
- The reinsurer's reimbursement is subject to the deductible, co-insurance or exclusions contained in the HMO's contract with the eligible member.
- The HMO does not owe any additional premium for the insurance insolvency protection.
- The reinsurer's cost of defending a claim may be chargeable as an expense of the receivership.
- For any members who are Medicare enrollees, the limitations of the insurance insolvency protection will apply, and the coverage will not extend beyond the date that such members may be entitled to coverage under the federal program.
- The reinsurance contracts typically allow conversion coverage for the members, other than for Medicare members, if the enrollees apply for such conversion coverage within a limited time frame (typically within thirty days) of the HMO's insolvency.

This is a brief overview of the reinsurance considerations that may be useful to receivers. Attention should be paid to the unique provisions of each reinsurance contract. The states have not prescribed a standard form or set of conditions for the reinsurance coverages of an HMO. In some cases, HMOs have affiliated reinsurers. In many states, there is a requirement that an HMO be a domestic corporation that can write only in its state of domicile. Therefore, groups may form that consist of several HMOs, each licensed in only one state, under common ownership or control. Typically, in an effort to smooth results for all HMOs within the group, the group may also form a reinsurer to take an aggregate excess of loss coverage for all single-state HMOs within the group. If a receiver is appointed for one HMO, the receiver may be in a position of attempting to recover reinsurance payments from the affiliate controlled by the former officers/directors or shareholders of the HMO that is in receivership.

### 3. Federal Regulations

#### a. Medicare and Medicaid

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

The Centers for Medicare & Medicaid Services (CMS), previously known as the Federal Health Care Financing Administration,<sup>8</sup> guidelines require that non-participating providers with

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<sup>8</sup> The Centers for Medicare & Medicaid Services' Web site is [www.cms.gov/medlearn](http://www.cms.gov/medlearn).

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.

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.

b. ERISA

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

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

4. Health Insurance Portability and Accountability Act (HIPAA)

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

a. Guaranteed Renewability of Coverage by HMO in Receivership

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

products.<sup>9</sup> As with group coverage, nonrenewal is allowed for specified reasons, including carrier market exit.

b. Guaranteed Issue of Coverage by Other Plans

HIPAA requires all carriers serving the small employer market (2 to 50 employees) to accept every small employer that applies for coverage and to accept every eligible individual who applies when they first become eligible (although it should be noted that particularly in the individual market, underwriting requirements, or even the ability of carriers to underwrite at all will vary depending upon whether the state has filed an alternative mechanism or not). Small employers covered by an HMO in receivership will thus be able to move their business to another carrier serving that market without risking loss of coverage or gaps in coverage. The same is generally true for individual subscribers. A carrier offering coverage in the individual market may not decline to offer coverage to, or deny enrollment of, an eligible individual, and may not impose preexisting condition exclusions with respect to the coverage. Exceptions are permitted for insufficient network or financial capacity. HIPAA does not require guarantee issue in the large group market (more than 50 employees), although large group insurers and employer-sponsored plans may not establish rules of eligibility for enrollment based on a health status-related factor. Also, large group plans may not require an individual to pay a premium greater than that charged to a similarly situated individual based on a health status-related factor.

c. Documentation Requirements

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

#### **D. Jurisdictional Issues**

1. Legal Organization and State Regulation of the HMO

An HMO may be organized as an insurance company under a state's insurance statutes or as a conventional corporation under a state's corporation laws. An HMO may be subject to state regulation as an insurer or under special statutes. The nature of an HMO's incorporation is an important factor in determining the forum in which it is liquidated, and who will be responsible for its liquidation. An HMO organized and regulated under the state insurance laws (or, in some cases, under the state's health laws) generally will be subject to state insurance receivership laws. On the other hand, an HMO organized as a corporation under a state's corporation laws and not regulated under the state's insurance laws, or health laws, will probably be subject to liquidation under the federal bankruptcy law.

2. State vs. Federal Bankruptcy Jurisdiction

As a practical matter, it is possible that an insolvent HMO could attempt to seek protection in the federal bankruptcy courts in order to cut off insurance department insolvency actions.

Typically, the issue arises when an HMO petitions for relief under the Bankruptcy Code prior to the initiation of state insurance receivership proceedings, and some party in interest (most likely the regulator) challenges the bankruptcy court's jurisdiction over the HMO. The ultimate question is whether an HMO qualifies as a debtor under Section 109 of the Bankruptcy Code, which explicitly excludes a "domestic insurance company" as a debtor. A regulator should not delay in bringing the

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<sup>9</sup> 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).

jurisdictional question to the bankruptcy court’s attention by alleging that the HMO is ineligible as a debtor under the Bankruptcy Code because it is a domestic insurance company. If the HMO is found not to be a domestic insurance company and is subject to the Bankruptcy Code, all policyholders will be treated as unsecured general creditors. There is no policyholder priority in a federal bankruptcy case, but under state law policyholder-level claims usually have priority over most other creditors. Consequently, creditors other than policyholders, including providers, may prefer the Bankruptcy Code treatment.

Generally, the jurisdictional issue also affects whether: (i) the regulator is appointed as the receiver in a state receivership proceeding; (ii) the HMO’s management is left in place as a debtor in possession under the Bankruptcy Code; or (iii) the bankruptcy court appoints a U.S. Bankruptcy Trustee. One obvious advantage to appointing a state insurance receiver is the extensive insurance expertise and knowledge that insurance receivers possess. It is unlikely that a Bankruptcy Trustee will possess the requisite expertise to successfully reorganize or liquidate an HMO.

### 3. Tests for Eligibility under the Bankruptcy Code

Three legal standards have evolved to assess an HMO’s eligibility as a debtor under the Bankruptcy Code. None provides a bright-line standard. The three tests are known as: (1) the State Classification Test; (2) the Independent Classification Test; and (3) the Alternative Relief Test. The three tests may lead to conflicting outcomes, and different courts have come to different conclusions using the same tests.

#### a. State Classification Test

In the wake of the Seventh Circuit’s ruling in *In re Medcare HMO*, 998 F.2d 436 (7<sup>th</sup> Cir. 1993), the State Classification Test is the dominant test. The court found the multiple tests unworkable. Under the State Classification Test, a debtor’s classification under the Bankruptcy Code is guided by its classification under applicable state law. The Seventh Circuit implemented the State Classification Test by looking at the Illinois HMO Act and the Illinois Receivership Statute, both of which expressly stated that an HMO is a “domestic insurance company” for purposes of the Illinois Insurance Code. Thus, the Medicare court, relying primarily on state legislation and regulation designed to protect enrollees, held that under the State Classification Test an HMO qualified as a domestic insurance company. The court found particularly telling the fact that Illinois classified HMOs as insurance companies for the purposes of liquidation or rehabilitation, conducted under the supervision of the Director of Insurance, and with a priority for enrollee claims. Also significant was the fact that Illinois had established an HMO Guaranty Fund explicitly for the protection of enrollees. In addition, the court pointed out that—although this factor did not determine its decision—an “essential attribute” of an HMO is its insurance component, and both HMOs and insurance companies have a public or quasi-public nature, supporting the conclusion that an HMO is the substantial equivalent of an indemnity insurance company.

#### b. Independent Classification Test

The Independent Classification Test is based on Section 109 of the Bankruptcy Code and established principles of statutory construction. One direction that courts have taken this test is to point out that when a provision specifically excludes certain entities, such exclusion is exhaustive—that is to say, any entity not expressly excluded is implicitly included. Since HMOs existed when the Bankruptcy Code was revised, and HMOs are not listed in Section 109 as an entity that cannot file bankruptcy, the independent classification test make HMOs eligible for relief under the Bankruptcy Code. *In re Cash Currency*, 37 B.R. 617 (N.D. Ill. 1984, aff’d 762 F.2d 542 (7<sup>th</sup> Cir.)), dealt with currency exchanges. It used the independent classification test. *In re*

*Beacon Health*, 105 B.R. 178, employed this test to find that an HMO was a domestic insurance company for Section 109 purposes.

c. **Alternative Relief Test**

The Alternative Relief Test is a results-oriented test. It calls upon the court to consider whether bankruptcy is a satisfactory method compared to state liquidation procedures. Prominently emphasized is the problem with multistate HMOs. The argument goes that subjecting a multi-state HMO to liquidation in many state forums is unnecessarily difficult and inherently unfair (it is also unnecessary, as any liquidator of a multi-state insurer can demonstrate). The Medicare Court resoundingly attacked this view, pointing out that Congress was well aware of the possibility of multistate HMOs and chose not to let it control the situation.

Application to Particular Cases

Most state insurance regulators will prefer to apply the State Classification Test. In light of the U.S. Supreme Court's recognition of insurance liquidation as a critical component in insurance regulation, it is likely that even federal courts presented with demands that they cede jurisdiction to state courts will apply the State Classification Test or something like it. That, however, does not end the analysis because states do not always enforce a clear classification for HMOs. For instance, California regulates HMOs as business corporations, not insurers, and recently created a separate agency for their regulation. Such circumstances offer little scope for a claim of state insurance jurisdiction. Illinois, by contrast, permits an HMO to be organized either as an insurer or as a business corporation, but explicitly subjects both HMOs and insurers to insurance department regulation. New Jersey, for example, provides for state regulation of HMOs through the granting of certificates of authority, but does not explicitly provide for their liquidation. Maryland, on the other hand, provides that HMOs will be liquidated in the same manner as insurers. The HMO Model Act as currently written explicitly provides that HMOs shall be liquidated as insurers. Clearly, the customary state receivership procedures will vary depending on how a state statute provides for the receivership of an HMO.

It should be remembered, however, that a state may still possess regulatory authority over certain aspects of an HMO's operations even if it is not subject to state liquidation.

**E. Causes and Warning Signs of Financial Trouble in an HMO**

An HMO may develop financial trouble for a number of reasons, including:

- Undercapitalization of the HMO.
- Inadequate pricing.
- Overpricing leading to adverse selection and loss of the HMO's members.
- Overestimating enrollment.
- Underestimating medical expense.
- Rapid growth of membership outpacing the HMO's ability to manage its resources.
- Inadequate computer systems and information, causing management to make incorrect business decisions. Most claims adjudication systems provide for "flagging" possible overpayments of claims. These flags may include a test for duplicate claims, including comparison of dates of service on multiple submissions of claims by a provider (often true when timely payments have not occurred). The receiver should determine if any of these "flags" have been bypassed.



Troubled plans have been known to disengage these flags in order to “catch up” on claims processing. This is especially true when claims management personnel are compensated based on timely payment of claims.

- Deficient IBNR associated with claims processing problems and poor utilization controls.
- Uncollectible premium receivables due to non-reconciliation of membership records.
- Poor underwriting procedures, causing inadequate premium rates.
- Unwillingness of providers to follow procedures and policies, or the HMO’s failure to effectively enforce its procedures and policies.
- Provider reimbursement practices which do not allow costs to be properly managed.
- Theft or looting of the HMO’s profits.
- Financially troubled or insolvent provider networks.
- Inadequacy or absence of reinsurance.
- Excessive management fees paid to affiliated or parent companies.

State insurance regulators monitor the financial solvency of HMOs regulated under the state insurance statutes. Generally, such HMOs file annual statements on the NAIC blanks and are subject to examination to the same extent as other licensed insurers. State insurance regulators determine if an HMO is financially troubled. The insolvency of any HMO is a process, not an event. In most cases, the financial performance has been deteriorating over a period of time. Most likely, there have been warning signs, which may include:

- Declining membership.
- An inability to meet filing deadlines with regulators.
- Increased complaints to regulators from providers and members.
- Failure to pay claims in a timely manner.
- Growth of premium deficiency reserves.
- Growth in intercompany receivables.
- Newspaper reports of HMO claim checks being rejected for insufficient funds, resulting in members and providers not being paid for claims.
- Statements by investment bankers and other analysts that warn of HMO concerns to their clients.

In addition, many states have enacted risk-based capital (RBC) requirements for HMOs or are in the process of enacting them. The RBC requirements provide regulators with advance warning of an HMO’s liquidity and capitalization problems. Under the RBC requirements, an HMO must maintain a designated percentage of its assets in a manner and form easily liquidated, if necessary.

The earlier financial trouble is detected, the more alternatives are available to the regulator for rehabilitating the HMO. For this reason, it is important that: (i) receivers communicate with regulators in the financial analysis, examination and provider services areas within the insurance departments; and (ii)

regulators develop a system for recognizing the warning signs and take early action to correct the financial problems of troubled HMOs.

Once the insurance department determines that an HMO is financially impaired or insolvent, the receiver proceeds to place the HMO into some form of state insurance receivership (e.g., conservation, rehabilitation or liquidation). If there is any chance for the HMO to be rehabilitated or sold prior to liquidation, then the HMO may be placed into court-ordered conservation or rehabilitation. A conservation or seizure generally is sequestered or confidential, allowing the receiver to maintain the status quo until the receiver has had an opportunity to more closely examine the HMO's financial condition. Rehabilitation generally operates to vest the receiver with title to all of the HMO's assets, business and affairs.

## **F. Alternatives to Immediate Liquidation of a Financially Troubled HMO**

There are at least three alternatives to immediate liquidation that the receiver may consider, depending on the causes of the insolvency: (i) the HMO's continued operation; (ii) the purchase of the HMO's book of business by another insurer, HMO or MCO; or (iii) the reassignment of a portion of the HMO's membership to other insurers, HMOs or MCOs.

### **1. Continued Operation of the HMO**

If the cause of the insolvency either has been or can be corrected, and if the interests of enrollees are protected, it may be possible to continue to operate the HMO, with or without additional capital, so that future profits eventually reimburse claims arising before the insolvency.

Regulators have a variety of receivership alternatives to accomplish a successful turnaround—administrative supervision, conservation or seizure, or rehabilitation. The best alternative depends on the underlying circumstances of each HMO and should be based on the regulators' and management's best judgment (assuming that the HMO's management is cooperating with the regulators).

The turnaround of the distressed HMO generally consists of three main steps. The first is to review the present financial situation and the underlying causes of the HMO's problems. The second is to stabilize the HMO's business and correct its business operations, policies and procedures. The third step is to recapitalize the business.

#### **a. Review the HMO's Operations**

There are many reasons why an HMO becomes financially troubled and, obviously, some problems are more easily solved than others. For example, an undercapitalized HMO may be able to solve its problem by obtaining investment capital from an outside source, or an HMO that is paying excessive management fees may be able to amend its management agreement and reduce those fees. However, in most cases, the HMO's difficulties will be caused by a variety of complex issues such as inadequate rates, high-priced reimbursement contracts with hospitals and physicians, poor management of utilization, or inadequate information systems and procedures. These complex issues take time to correct because they involve renegotiating contracts with a variety of parties and/or modifying the HMO's processes and procedures. Accordingly, certain steps should be taken to stabilize the HMO's operation in order to allow it time to reorganize. These steps include the following:

- Determining the HMO's current cash position and developing a daily cash management system to control payments during the reorganization, including accelerating the collection of receivables and generating cash from the sale of excess or surplus assets.
- Evaluating the HMO's management team to determine their ability to effect the reorganization.

- Replacing management on either a temporary or permanent basis.
- Communicating with providers to inform them that the HMO is working to resolve its problems and asking for their continued support, including payment concessions or extended terms during the stabilization period (the receiver must be cognizant, however, of prompt-pay laws enacted by many states).
- Cleaning up the accounting, financial reporting and related systems to allow for timely and useful reports and information to be generated, including evaluating the claims processing system to determine if it meets the HMO's needs or if outside assistance is required.

If a receiver is inexperienced or lacks resources, the following steps could be useful:

- Appoint a committee of HMO experts in the state to study the operation of the distressed HMO in such areas as claims, actuarial and management; underwriting and accounting; and review of efficiency and cost effectiveness of the organization in general with an emphasis on data processing.
- Engage a consultant to prepare a business analysis and a rehabilitation plan based upon the above and his or her own review.

b. Develop a Rehabilitation Plan

Once the HMO's operations are stabilized, the receiver will begin developing a corrective action plan or rehabilitation plan detailing the steps to be taken to return the HMO to profitability. The rehabilitation plan is similar to a company's business plan and typically includes: (i) a discussion of the proposed changes to provider contracts, overhead costs and internal procedures; and (ii) detailed financial projections reflecting the expected results of the proposed changes. The rehabilitation plan also should include the following information:

- A narrative description of the proposed plan, including detailed discussions on the proposed changes to each category of revenues and expenses.
- A timeline with target dates for the implementation of each area of change, together with the personnel responsible for implementing the changes.
- Detailed monthly financial projections, including balance sheets, operating statements and cash flow statements for the next three to 12 months.
- A summary of key assumptions used in the financial projections.

The receiver should attempt to implement cost reductions or revenue enhancements during the turnaround of the distressed HMO. Other options and alternatives may come to light, depending on the circumstances of the particular situation. The receiver should also consider:

- Changing provider groups to allow for lower-cost and more efficient services to be provided to enrollees.
- Renegotiating contracts with existing providers.
- Determining appropriate rate increases to return certain books of business to profitability, and negotiating with insurance regulators to obtain those increases.
- Consolidating facilities, where practical.

- Closing facilities, where necessary.
- Selling off excess or surplus assets to reduce overhead and carrying costs and to raise cash.
- Outsourcing back room functions (e.g., accounting, data processing) to reduce costs.
- Eliminating excess employees.
- Reducing management and employee compensation.
- Developing appropriate incentive compensation arrangements.
- Renegotiating leases for offices and sites to obtain more favorable terms.
- Canceling leases, where appropriate, to reduce costs.
- Installing a new management team.
- Discontinuing unprofitable lines of business.
- Adopting new management investment strategies and portfolio management where necessary.
- Introducing new claim reserving techniques where necessary.
- Installing modern business planning techniques where necessary.
- Establishing more well-defined underwriting criteria for brokers and agents and rigid reporting requirements where necessary.
- Determining the loss ratios by broker and agent to follow up on anomalies.
- Entering into new banking relationship where necessary.

A financial recapitalization, in the form of additional equity from current owners or from new outside investors, combined with some form of debt restructuring, may relieve vendor pressure and set the stage for continued operations in for-profit companies. The HMO's operations need to be corrected, however, to allow the HMO to generate adequate profit and to service its debt. These are two steps that need to be taken concurrently. The HMO's recapitalization should be an integral part of the rehabilitation plan. Recapitalization options may include retroactive provider concessions to reduce the amount of outstanding claim liabilities, converting amounts owed to providers into either surplus notes (for not-for-profit HMOs) or equity (for stock HMOs), and forgiveness of amounts owed by a provider.

c. Approval and Implementation of the Rehabilitation Plan

The receiver should carefully evaluate the rehabilitation plan to determine its feasibility. This evaluation process includes, but is not necessarily limited to: (i) an analysis of supporting documentation for the various cost reductions; and (ii) an analysis of market conditions to determine the reasonableness of any rate or enrollment changes. The rehabilitation plan's feasibility is often indicated by the availability (or lack thereof) of detailed support for its underlying assumptions. An abundance of supporting documentation for the cost reductions and revenue enhancements discussed above usually indicates that management has carefully analyzed

the rehabilitation plan. Obviously, a rehabilitation plan that has been carefully prepared and supported is more likely to be successful.

Generally, the receiver will propose a rehabilitation plan to the state court supervising the receivership. Notice of the proposed rehabilitation plan and an opportunity to appear and be heard are given to interested parties. If the receivership court approves the rehabilitation plan, the rehabilitator will implement it in accordance with the state's receivership laws.

Once a rehabilitation plan is adopted, a process should be developed to measure the success of its implementation. At a minimum, the following information should be considered by the receiver on a monthly basis:

- Comparisons of actual numbers vs. rehabilitation plan projections, including balance sheets, operating statements and cash flow statements.
- Enrollment reports.
- Claims status reports (to monitor claims backlog and clearing times).
- Status reports on contract negotiations with providers and copies of executed contracts.

A key issue that a receiver should address in the rehabilitation plan and expect to see demonstrated in its implementation is compliance with statutory requirements for net worth and working capital. If, during the process of the turnaround, the receiver determines that the liabilities of the plan are only increasing and the rehabilitation plan does not appear to be effective, then it may be necessary to place the HMO into liquidation.

Another key issue is preserving the provider network. Because many state guaranty funds do not cover claims incurred prior to receivership, doctors and other providers who may have uncollected balances already are hesitant to continue treating patients while the plan attempts to work out its issues. In some states, the contracted providers must give a mandatory 60-day termination notice. Typically as soon as a public proceeding is filed, the Insurance Department will begin to receive copies of these notices. In addition, subscribers may find it difficult to locate a provider who “has time on the calendar” to treat non-emergency conditions. If too much time elapses while a receiver is attempting to rehabilitate, the provider network will become insufficient to take care of all of the subscribers' needs. One method of handling this is to “rent a network,” but this can be costly and change the financial viability of a turnaround. Time is of the essence in these proceedings, and a receiver embarking on a rehabilitation effort for an HMO needs to have an emergency exit strategy (i.e., consent to liquidation) and a relatively short-term plan in most cases.

## 2. Sale of Blocks of Business

It is also possible that a solvent insurer, HMO or MCO could purchase a block of the troubled HMO's existing enrollees, offering either identical or similar coverage to the enrollees without substantial disruption of their benefits. To the extent the buyer is prepared to purchase the enrollee base or pay a ceding commission, this may represent a sizeable accretion to the assets available to distribute to the HMO's remaining enrollees and creditors. The receiver should give consideration to ensuring that the buyer's existing provider network is sufficient to service the additional enrollee base to minimize possible disruptions in enrollee service.

## 3. Reassignment of Enrollees

If no buyers are available for a block of business, many states possess the regulatory authority to require the surviving market to accept former enrollees of the insolvent HMO on either an open

enrollment basis or by some form of automatic allocation. Receivers should determine whether state laws that permit reassignment also guarantee continuation of coverage for those enrollees. Such reassignment, however, may result in a change of providers, premiums and/or benefits to enrollees. Providers may need to be forcefully reminded that the hold-harmless clauses in their contracts with the insolvent HMO, as well as state consumer fraud laws, prohibit them from seeking to collect unpaid balances from their patients, even though the patient continues in their care under a new HMO or insurer.

## **G. Liquidation of an HMO**

Liquidation of an HMO is different from that of a traditional insurer in at least several material ways. The receiver must address the practical aspects of continuing coverage and the provision of health care services for a period of time during the liquidation. The receiver should also request certain injunctions designed to protect enrollees of a failed HMO. In addition, the claim adjudication process and priority of distribution are slightly different in an HMO insolvency. Receivers should be able to identify those issues that are unique to insolvent HMOs and then determine the appropriate course of action under the circumstances. The following discussion should assist a receiver in handling those issues.

### **1. Continued Coverage**

The receiver's initial concern in liquidating an HMO is ensuring continued coverage to enrollees, if possible. Among the most crucial tasks facing a receiver immediately after appointment will be the need to ensure that the HMO's members have uninterrupted access to covered health care services. Physicians must continue seeing patients, hospitals must continue admitting them, ambulances must continue transporting them, providers of durable medical equipment must continue furnishing wheelchairs, and so on. Providers' insecurity about the prospect of payment for their services may create a significant danger of interruption of such services. Unfortunately, it is very typical in an HMO insolvency that the cash on hand upon takeover is limited and may not even suffice to pay health care providers for such continuation of services during a reasonable transition period. The "insolvency reinsurance" procured by many HMOs (and perhaps required by applicable state and federal statutes) may help to fill this shortfall. Such contracts generally require the reinsurer to reimburse the insolvent HMO for the cost of covered health care services during the period for which premium has been paid.

In addition, provider agreements typically obligate hospitals and physicians to continue to provide services, even without immediate payment, during a short wind-down period. Again, it may be necessary for the receiver to enforce the terms of hold-harmless provisions during this period. Nonetheless, assuring the continuity of care during the period immediately following the receiver's takeover typically is one of the first major challenges presented by the HMO's demise and may prove more difficult than applicable reinsurance coverage and contractual provisions would seem to indicate. In the event that liquidation appears to be inevitable, the receiver should consider replacement coverage so that enrollees do not become uninsured or are not subjected to waiting periods or preexisting condition exclusions. Illinois, one of the few states that provide guaranty fund coverage, requires the guaranty fund to pay for continued coverage for enrollees. In many other states, the insurance commissioner (or other primary regulator) has the authority to require other health plans to hold an immediate open enrollment period, or the commissioner may auto-assign employer groups and individual policyholders to other health plans to ensure continuity of care. In other cases, the membership is sold or transferred to an existing HMO, MCO or insurer. In some cases, the existing block of business may have considerable value, and the receiver may apply any proceeds from the sale of the enrollee base to pay non-enrollee creditors for pre-receivership claims. Often, the insolvent HMO's price and benefit levels are maintained until the individual or group contract ends. Many receivers prefer to negotiate voluntary transfer arrangements with other HMOs, MCOs or insurers that refrain from placing restrictions on the coverage conditions or preexisting limitations. In many states, the assignment of Medicaid enrollees is under the administration of a state

agency. The receiver should collaborate with the appropriate agency to arrange appropriate resolutions. Receivers should be aware of recent court decisions holding HMOs responsible for the practice of medicine.

## 2. Notice to Claimants

Very shortly after assuming control of the HMO's operation, the receiver will need to notify enrollees, providers and other interested parties of the receivership proceeding. A review of the HMO's books and records should provide the names and addresses of the providers, enrollees, subscribers, vendors and other creditors of the estate. As explained in Chapter 5—Claims, the creditors, including the identifiable contract and non-contract providers and enrollees, should be notified of the receivership as soon as possible. Once a claims deadline has been set, another notice setting forth the claims filing requirements should be sent to claimants as well as published in newspapers and national periodicals as necessary. The receiver should consider whether it is appropriate to include in the notice a reminder to providers and enrollees of the effect of hold-harmless clauses on the providers' ability to collect unpaid balances from enrollees. See the section in this chapter on hold-harmless clauses.

Potential Receivers of HMOs with Medicare enrollees should contact CMS as soon as possible to coordinate the liquidation and the potential transition of members to another HMO or traditional Medicare. Typically, CMS guidelines require prior notification of termination of a Medicare contract. For example, CMS must give at least 90 days' prior notice to the HMO if it intends to terminate a Medicare contract. The HMO must then give at least 30 days' prior notice to its Medicare enrollees. In addition, the HMO must publish notice of the termination at least 30 days prior to the effective date of the termination in one or more newspapers in each community or county located in its service area. However, there are circumstances where CMS may terminate a contract immediately, and the notice requirements may be different for a liquidation.

Under normal circumstances, CMS guidelines require prior notification of termination of a Medicare contract for HMOs having Medicare enrollees. For example, CMS must give at least 90 days' prior notice to the HMO if it intends to terminate a Medicare contract. The HMO must then give at least 30 days' prior notice to its Medicare enrollees. In addition, the HMO must publish notice of the termination at least 30 days prior to the effective date of the termination in one or more newspapers in each community or county located in its service area. For companies in receivership, the foregoing example may not be applicable.

Until the above is coordinated with CMS, any premiums received for Medicare enrollees should be accounted for separately and/or maintained in a segregated account.

## 3. Injunctions

Upon commencement of a receivership proceeding, the receiver usually requests that the receivership court issue the customary governing order. Additional injunctive language in the order will help the receiver address the unique circumstances of a failing HMO. Receivers should consider having the following injunctive language added to the governing orders of insolvent HMOs:

### a. Hold-Harmless Injunction

As noted in the section on hold-harmless clauses above, the second type of hold-harmless agreement is that incorporated into the conservation or receivership order. If the insolvent HMO is placed into liquidation, the receiver should request injunctive language protecting enrollees from balance billing and collection agencies, regardless of whether state law requires hold-harmless agreements in provider contracts. Typical injunctive language for an insolvent HMO placed into liquidation is as follows:

All persons, firms, corporations and entities who have provided services, materials and equipment to enrollees of Defendant, whether or not such provider is obligated by statute or agreement to hold enrollees harmless from liability, and which are obligated under state or federal law, agreement or otherwise to hold enrollees harmless from liability for the same, together with their agents, representatives, and employees are hereby restrained and enjoined from bringing or further prosecuting any action at law or in equity, or otherwise seeking to recover any amount owed by Defendant, or by any other person, to such provider as a result of services, materials and equipment provided by such provider, from any enrollee of Defendant, excluding applicable co-payments or deductibles for covered services or fees for services not covered by Defendant, until further Order of this Court. In the event that any such person, firm or corporation violates this injunction, they shall be liable for reasonable costs and attorneys' fees incurred by the receiver (or the enrollee) in enforcing this provision or any court orders related thereto.

If hold-harmless provisions are mandated by state statute, the applicable statute should be referenced in the liquidation order. See the section on hold-harmless clauses in this chapter.

b. Anti-Reinsurance Cut-Through Injunction

Receivers may also want to request additional injunctive relief to assist them in recovering all reinsurance due and owing to the HMO estate. Typical injunctive language is as follows:

All persons including policyholders and enrollees of the Defendant, and all persons asserting claims against such policyholders/enrollees, are hereby restrained and enjoined from instituting or pursuing any action or proceeding in any Court or before any administrative agency or tribunal, including boards and commissions administering workers' compensation, occupational disease or similar laws of this State or of any state or of the United States, which seek in any way, directly or indirectly, to contest or interfere with the Receiver's exclusive right, title and interest to funds recoverable under treaties and agreements of reinsurance heretofore entered into by or on behalf of the Defendant as the ceding insurer.

c. Claims Moratorium with Hardship Provision

In an administrative supervision, conservation or rehabilitation where the HMO's rights and liabilities may not have been fixed by court order, the receiver should request a claims moratorium with a hardship provision, as follows:

Defendant and its directors, officers, agents, servants, representatives and employees, and all other persons or entities, are restrained from making payment on claims and other obligations incurred by Defendant, as a result of its having issued contracts, policies or certificates of insurance, as may arise or become due during these proceedings until the further order of this Court and subject to the condition that certain "hardship claims" upon the written direction of the (Conservator or Receiver) shall be excepted from such moratorium.

"Hardship claims" are claims which are determined, solely at the receiver's discretion, and without further order of the Court, to be a covered claim for a significant economic loss that requires immediate relief and no other economic resource is reasonably available to the claimant to meet that loss.

The claims moratorium and hardship provision are intended to preserve the HMO's assets during the initial investigation period while allowing for the payment of a limited number of hardship claims to prevent any undue burden on claimants. In some instances, the receiver may determine



that the HMO's assets are so minimal that a hardship provision is not warranted. In such cases, the receiver may request a claim moratorium without any provision for the payment of hardship claims.

#### 4. Asset Marshaling

One of the most time-consuming responsibilities of the receiver is marshaling all of the insolvent HMO's assets for eventual liquidation and distribution to enrollees and creditors. The receiver should obtain or prepare as quickly as possible the appropriate lists of the HMO's assets and immediately seize possession and control of them to prevent the assets from disappearing during the wind-down phase. Typical security measures include changing locks on offices and facilities, restricting access to alarm codes, and hiring security guards to protect the assets. Often the most significant assets of an insolvent HMO are the causes of action it may have against shareholders, officers and directors, the HMO's insurance carriers, the HMO's law firms, and outside accounting firms. All correspondence between the HMO and these parties should immediately be secured. The receiver should secure the company's email server and attempt to recover "deleted" e-mails, which can contain critical information. HMOs often use Pharmacy Benefit Managers (PBMs) to administer their prescription drug program. The receiver should consider auditing the PBM's performance under these contracts for adherence to the average wholesale pricing requirements, rebates, dispensing fees and excluded drug formulary.

Please see Chapter 1—Takeover and Administration for a more detailed discussion of marshaling assets.

#### 5. Deposits

Most states' statutes require that HMOs establish and/or maintain a deposit of assets, typically either cash or securities, with the insurance commissioner or other state official as a condition of being authorized to do business. Although the amount of the required deposit varies somewhat from state to state (Section 18A of the NAIC Health Maintenance Organization Model Act calls for a deposit which at all times shall have a market value of not less than \$1,000,000), generally such deposits, and the income therefrom, are included in the admitted assets of the HMO for the purpose of determining its net worth. The purpose of these deposits is to protect the interests of the enrollees and to assure the continuation of health care services to enrollees in the event the HMO is placed in rehabilitation or liquidation. The commissioner may use the deposit to defray the administrative expenses of a receivership proceeding, and the deposit is an asset subject to the distribution provisions of the state's liquidation statute.

Several states also require an additional deposit to secure the payment of uncovered expenditures (see Section 20 of the NAIC Health Maintenance Organization Model Act). Uncovered expenditures include out-of-network services and other services rendered by providers that are not subject to hold-harmless agreements where the enrollee may be liable for payment. Such deposits are also included in the admitted assets of the HMO for the purpose of determining net worth. However, there may be statutory restrictions upon the use of the deposit assets for purposes other than the payment of claims for uncovered expenditures. The receiver should review the statutes of the state(s) in which an uncovered expenditures deposit was established and/or consult with legal counsel before using such assets to pay other claims in the event of the liquidation of the HMO.

#### 6. Liquidating Assets

Generally, the HMO's assets are liquidated in the following order, subject to the circumstances of any specific insolvency:

- (1) Enrollee base

- (2) Surplus real property holdings
- (3) Core leaseholds / office facilities
- (4) Provider base
- (5) Provider facilities
- (6) Provider practices
- (7) Equipment
- (8) Furniture and fixtures

a. Enrollee Base

Frequently the most significant asset belonging to an insolvent HMO is its “enrollee base,” which means all of the individuals that were enrolled in and insured by the HMO as of the liquidation date. Some of the enrollees are persons who entered into individual contracts with the HMO, while others became enrolled as the beneficiaries of an agreement entered into for their benefit under a group contract between their employer and the HMO. In either case, the HMO would have agreed to either provide or arrange for health care services for those enrollees by specified contracted health care providers for a prepaid monthly fee.

The sale of the enrollee base can generate significant cash for the estate. The receiver should begin to consider such a sale as soon as liquidation is deemed to be inevitable, which may be prior to any formal liquidation steps having been taken. The receiver should consider contacting prospective buyers on an ex parte, confidential basis, subject to confidentiality agreements, to begin to put in place the mechanism to move the largest enrollee base possible and thereby maximize the value to the estate.

The speed with which the enrollee base is to be transferred should, however, also be balanced with the amount that may be realized from a transfer. This balance is delicate and results will vary on a case-by-case basis, depending on factors such as geography, the size of the enrollee base and the number of prospective buyers.

Depending on the location of the HMO’s service area, there may be many, few or no other HMOs willing to pick up the enrollee base of the insolvent HMO. The receiver should develop lists of prospective buyers from the following sources:

- HMOs in the same state.
- HMOs in the contiguous regions served by the insolvent HMO.
- Insurance companies operating in the same state.
- Insurance companies in the contiguous regions served by the insolvent HMO.
- Medical service provider groups in the insolvent HMO’s service area.
- Medical service provider groups in contiguous regions.
- Contacts within the state department of insurance.
- Other sources as they become available that may be market or geographically specific.

With respect to timing, the sale of the enrollee base should be accomplished within 30 days from the date of the initiation of insolvency proceedings. This would be a target subject to the specific circumstances of any HMO insolvency. This would allow for the completion of due diligence by prospective buyers while keeping the entire sale process on a short timeline. The enrollee base should be considered the equivalent of a perishable asset, to be moved as quickly as possible.

The receiver should have packages of information prepared for review by prospective buyers. These should include all relevant data pertaining to the enrollee base or the various portions of the enrollee base being offered for sale, including both demographic and geographic data, subject to appropriate confidentiality measures. The sale of the enrollee base can be achieved in a variety of manners, including:

- Auctions. Prospective buyers, after payment of an appropriate security deposit, would bid against each other through one or more rounds of bidding with the receiver or his advisers acting as the auctioneer. Prior to the auction, the receiver and his advisors should also review the financial wherewithal and the operational expertise of prospective bidders and determine the suitability of their inclusion in the auction.
- Single sealed bid sale. Similar to auctions, a sealed bid sale allows bidders to submit one offer for the asset(s) being sold. The receiver then selects the highest qualifying bid and completes the sale.
- Multiple sealed bid sale. The bidders are told up front that the top bidders will have an opportunity to re-bid in a second round.

Other sale processes may be available to the receiver as the circumstances of the specific receivership dictate. The receiver should explore all avenues for the sale of assets, as constraints allow.

#### b. Provider Base

Associated with the HMO are the medical service providers, generally groups of doctors that have contracted with the HMO to provide health care services to the enrollees. These are generally referred to as the provider base. The prospective buyer of the enrollee base of a liquidated HMO may not be interested in assuming or acquiring the HMO's provider base. Frequently, the provider contracts are the prime reasons for the financial difficulties encountered by the HMO. Therefore, an acquirer would want to negotiate its own arrangements with the former provider network or seek a different provider network.

A primary public interest affected by the insolvency of an HMO is the continuity of health care services for enrollees. Because it is the nature of an HMO to arrange for or provide health care services to the plan's enrollees, the HMO's insolvency cannot be dealt with simply by the mere payment of money by a different payer, as is the case when a traditional indemnity insurer is liquidated. Another difference lies in the fact that the insolvency of a traditional indemnity insurer tends to reduce only the small part of the medical-service providers' income derived from those patients insured by the insolvent insurer, but when an HMO becomes insolvent, the contracted providers may be unwilling or unable to provide services without the prospect of payment. In some states, however, a provider may be required to continue to provide coverage for a specified time or under certain circumstances.

### 7. Claims Adjudication

Claims administration in an HMO receivership involves many of the same issues that need to be addressed in any insurance receivership proceeding, including establishing a claims procedure, providing notice to all potential creditors, and the processing and payment of claims. However,

because there is generally no guaranty fund coverage, the receiver must expend considerably more resources in the claims adjudication process than would be required for covered lines of insurance. For this reason a careful evaluation of the maintenance of the HMO's existing claims staff is necessary. Please see Chapter 5—Claims for a discussion of these issues.

Claims against an HMO estate may be asserted directly by the HMO's enrollees for unpaid medical services, and in some instances continuing treatment obligations. In reviewing these claims, the receiver, or guaranty funds where applicable, should obtain and review the HMO's records in order to establish the following: (i) enrollee eligibility status at the time of service; (ii) payment history; (iii) determination of coverage; and (iv) co-payment, "other insurance" and deductible requirements.

Claims will also be presented by providers of medical care, treatment and services to the HMO's enrollees. Claims may include those of physicians, physician groups, hospitals, laboratories, pharmacies and pharmacy benefit managers. The receiver's primary obligation in reviewing these claims is to identify whether the HMO had a contract with the provider or a third party that, in turn, contracted with the provider. If so, such claims should be evaluated in accordance with the terms of the applicable contracts, including payment schedules. For claims presented by providers that did not have contracts with the HMO, the HMO's obligations should be reviewed on a fee-for-service basis. Where a provider's claim against the HMO derives from the HMO's obligation to its enrollee, issues—such as enrollee eligibility status at the time of service; payment history; determination of coverage; and co-payment, other insurance and deductible requirements—should be carefully reviewed in order to properly evaluate the provider's claim.

Before commencing a claim evaluation project, it is often helpful to randomly analyze the HMO's claim review history prior to receivership in order to develop an understanding of how the HMO previously administered the claims. Care must be taken to assure that the enrollee and the provider do not submit duplicate claims for the same service. If duplicate claims are submitted, the receiver needs to determine who is the appropriate party to receive payment.

When administering claims against an insolvent HMO, the receiver should bear in mind that there are different rules applicable to Medicare and Medicaid HMOs. See the section in this chapter on federal regulations for a further discussion of the issues involved with federally regulated HMOs.

## 8. Guaranty Funds and Other Protection Mechanisms

Most states do not have HMO guaranty funds or other protection mechanisms that are intended to pay insolvent HMOs' pre-liquidation contractual obligations and/or related expenses. Because of its potentially critical importance in the rehabilitation or liquidation of an HMO, receivers must know whether HMO guaranty funds or other protection mechanisms exist, and if so, how they operate and which states are implicated.

### a. HMO Protection Mechanisms Generally

Typically, HMO guaranty funds and other protection mechanisms ("guaranty funds") are funded by, and comprised of representatives of, the HMOs admitted to do the relevant kinds of business in a particular state. The scope of coverage provided by the guaranty funds varies from state to state. Generally, guaranty funds are triggered either by the commissioner's determination that the HMO is impaired or the entry of a final order of liquidation.

Increasingly, HMOs placed into receivership have been authorized to do business in more than one state, or have enrollees residing across state lines who are afforded coverage by virtue of contracts sold to their employers in the domiciliary state. If coverage exists under more than one guaranty fund, efforts should begin early in the receivership to coordinate the roles of the affected funds. Even when only one guaranty fund is involved, it is important to determine the extent to which it provides insurance coverage for claims, and whether it covers out-of-state enrollees.

As a rule, one of the most crucial tasks initially facing a receiver is to ensure that the HMO's enrollees have uninterrupted access to covered health care services. At least one state's HMO guaranty fund continues coverage for enrollees for a period of thirty to ninety days (i.e., until the policies may be canceled in accordance with their terms), and therefore, enrollees must continue to pay premiums to the HMO guaranty fund. And like any other HMO, the guaranty fund is permitted to cancel coverage for non-payment of premium.

b. HMO Insolvency Reinsurance

Providers' insecurity about the prospect of payment for their services may create a material danger of interruption of such services. Unfortunately, it is very typical of HMO insolvencies that cash on-hand upon takeover is limited and may not even suffice to pay health care providers for such continuation of services during a reasonable transition period. The "insolvency reinsurance" procured by many HMOs (and perhaps required by applicable state and federal statutes) may fill this shortfall. Such policies generally require the reinsurer to reimburse the insolvent HMO for the cost of covered health care services during the period for which premium has been paid. In addition, Federal law, state statutes or provider agreements typically obligate the hospital or physician to continue to provide services, even without immediate payment, during a short wind-down period. Insolvency reinsurance may have been helpful in some cases, but in at least one state the statutory requirement for HMOs to carry this reinsurance was eliminated by the legislature after the receiver was forced to litigate for five years to obtain payment. See *In re International Medical Ctrs.*, 604 So. 2d 505 (Fla. 1st DCA 1992).

c. A Survey of Statutory HMO Protection Mechanisms

Receivers should review the specific statutes in the applicable states to determine if protection exists and if so, what benefits are covered or provided. Those states having such mechanisms differ in the type and scope of protection afforded HMO enrollees. For example, the protection could provide for the payment of unpaid claims, the continuation of coverage, the payment of administrative expenses, forced enrollment in solvent HMOs, or coverage under an existing guaranty fund.

A few states have enacted HMO guaranty funds or similar protection mechanisms, but the protection has not actually been activated.<sup>10</sup> By contrast, the Illinois HMO Guaranty Fund has been triggered many times over the past 10 years or so. The Illinois HMO Guaranty Fund's coverage is limited to claims of Illinois enrollees who are financially responsible for unpaid claims and non-contracted provider claims, up to a statutory limit of \$300,000, and excludes claims by other insurers, contracted providers and other third parties.

Alternatively, the Florida consumer protection mechanism provides for continuation of coverage for enrollees of insolvent HMOs for a limited period of time, but does not provide for the payment of existing liabilities.<sup>11</sup> The Florida HMO Consumer Assistance Plan continues coverage to enrollees, through the solvent HMOs operating in the state, for a period of up to six months during liquidation. The Florida coverage is limited to \$300,000 in benefits for any one enrollee. Similarly, in Utah, the insurance rehabilitation and liquidation statute provides for continuation of coverage upon an HMO's insolvency, and a *pro rata* assessment of all solvent HMOs for the cost of providing these benefits. Under Texas law, while there is no provision for the continuation of coverage, solvent HMOs may be assessed for the administrative expenses incurred in liquidating or rehabilitating an insolvent HMO.

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<sup>10</sup> See ALA. CODE § 27-44-1

<sup>11</sup> See FLA. STAT. §§ 631.811-828

The West Virginia Health Maintenance Organization Guaranty Act requires the guaranty fund to appoint one or more other HMOs to enroll the members of an insolvent HMO on a proportionate basis, and therefore does not provide for the payment of HMO claims. Idaho recently amended its Life and Health Insurance Guaranty Association Act to include coverage for enrollees (only) of managed care plans. In Wisconsin, HMOs are included within the scope of the Insurance Security Fund (Wisconsin's equivalent of the Model Guaranty Fund Act). Unlike the other states discussed above, in Wisconsin, HMO claims are covered by the same guaranty fund protection as other accident and health claims.

#### **IV. 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, 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.

## V. 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;
- (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.<sup>12</sup>

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 [http://www.naic.org/IID\\_docs/trust.doc](http://www.naic.org/IID_docs/trust.doc).

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

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<sup>12</sup> Ibid, pg. 6.



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 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).<sup>13</sup> 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

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<sup>13</sup> ERISA Section 3(40)(A); 29 USCA Section 1002 (40)(A).

MEWAs or are vague about the department's authority to assume control over a MEWA in liquidation. 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.*<sup>14</sup> 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

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<sup>14</sup> See, for example, Sections 624.436-624.446, Florida Statutes.

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.<sup>15</sup>

(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 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.

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<sup>15</sup> 29 USCA 1002 (40)(A)

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 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."<sup>16</sup> 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 Department of Labor (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.

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

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<sup>16</sup> ERISA Section 3(40)(A)(i)

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.

## VI. 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.

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,



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.

## VII. 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<sup>17</sup> 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).

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<sup>17</sup> E.g., S.C. Code § 38-90-410, *et seq.*

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.<sup>18</sup> 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.<sup>19</sup> 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](http://www.naic.org).

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<sup>18</sup> *Accord* NAIC Protected Cell Company Model Act § 6.

<sup>19</sup> *Accord* NAIC Protected Cell Company Model Act § 7.

## 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.

## **VIII. 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.<sup>20</sup> 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 Model Act). The Model Act 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 Model Act. 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**

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 transfers; c) provide for the

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<sup>20</sup> 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.

treatment of ancillary proceedings by the domiciliary state; and d) provide for the treatment of claimants residing in other-than-domiciliary states.<sup>21</sup>

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 entry of an order giving the receiver possession of the company. Upon taking possession of the assets,

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<sup>21</sup> 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).

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 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 Model Act.

## **B. The Insurers Rehabilitation and Liquidation Model Act**

The Model Act 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 Model Act 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 Model Act

Ten sections (54-63) of the Model Act adopt much of the UILA, as well as its policy objective: centralization of delinquency proceedings in the domiciliary jurisdiction. Unlike the UILA, however, the Model Act no longer refers to the insolvency proceedings as a “delinquency proceeding.” Rather, the Model Act distinguishes between conservation and “formal proceedings,” i.e., rehabilitation and liquidation. States are considered reciprocal under the Model Act 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 Model Act parallel those in the UILA, i.e., the same grounds for rehabilitation or liquidation set forth in Section 15 of the Model Act. 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 Model Act, 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 Model Act 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 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 Model Act 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 Model Act 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 Model Act requires that the receiver provide periodic accountings to the supervising court.

With respect to assets, the Model Act 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 Model Act and the UILA treat the filing of claims differently. Under the Model Act, 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 Model Act 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 Model Act, 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 Model Act also now differs from the UILA in its treatment of controverted claims. Under the Model Act, 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 Model Act 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.

#### 6. Priority of Distribution

Under the Model Act, general assets are distributed in accordance with the domiciliary state's priority of distribution scheme. The Model Act was drafted so that the determination of priority by an ancillary liquidator and court is not binding upon the domiciliary liquidator. The Model Act 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.<sup>22</sup> The UILA contains no similar penalty provisions.

### C. Insurers Receivership Model Act

IRMA was adopted by the NAIC in December 2005 to replace the earlier Model Act. There are several areas of change between IRMA and the Model Act, 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 Model Act. 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

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<sup>22</sup> Model Act § 58

(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 (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."

## **IX. 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 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 (for example, 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.

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.

**CHAPTER 9 – LEGAL CONSIDERATIONS**

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## I. INTRODUCTION

### 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 significantly differ from those of any other state. While these materials include information that is generally true throughout the U.S., it is essential that receivers and other practitioners examine the laws of each state involved. Federal law should also be consulted concerning certain issues.
- These materials are not an adequate substitute for advice of legal counsel. They are designed to assist the reader in effectively communicating with legal counsel and in understanding the relevant legal issues. They do not and cannot make the utilization of legal counsel unnecessary. Competent legal counsel must be retained to act on behalf of the receiver and participate in the administration of the insurer's affairs.
- The law relating to insolvent insurers is evolving. While these materials are intended to be current as of date of publication and will be periodically updated, it is suggested that counsel be consulted on all legal issues.

### B. Diversity of Law

Historically, insurers and reinsurers have been excluded from the provisions of federal bankruptcy law.<sup>1</sup> 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.<sup>2</sup>

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.

Most states have enacted insurer delinquency proceeding statutes modeled after either the Uniform Insurers Liquidation Act (Uniform Act), the *Insurers Rehabilitation and Liquidation Model Act* (Liquidation Model Act) or the *Insurer Receivership Model Act* (#555), also known as IRMA,—collectively, the Model Acts.<sup>3</sup> Because of the widespread influence of the Uniform Act and the

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<sup>1</sup> 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 (7<sup>th</sup> 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).

<sup>2</sup> 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).

<sup>3</sup> 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].

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.

This chapter is designed to serve as a supplement to each of the other chapters in the handbook. With the exception of Chapter 8—Special Receiverships, this chapter includes a topic heading that corresponds to each of the other chapter titles in the handbook. Thus, the first topic heading in the legal chapter entitled “Takeover and Administration” provides a discussion of the legal issues which may arise as a result of those activities discussed in Chapter 1—Takeover and Administration. Although most of the legal issues discussed in this chapter apply to Chapter 8—Special Receiverships, there are certain legal issues unique to such receiverships that are discussed solely in Chapter 8.

## **II. TAKEOVER AND ADMINISTRATION**

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

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

### **A. Pre-Takeover/Informal Actions**

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

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<sup>4</sup> See Liquidation Model Act, *supra*, at Section 5, IRMA at Sections 201, 206, and 215 ILCS 5/186.1-186.2.

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

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

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

### 1. Grounds for Order

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

### 2. Contents of Order

Generally, the order appoints the regulator to take possession and control of all or part of the property, books, accounts, documents and other records of the insurer. Further, the order generally gives control of the insurer’s physical premises to the regulator. The order will usually be accompanied by an injunction enjoining the insurer, its officers, directors, managers, agents and employees from disposing of property or transacting the business of the insurer except upon the permission of the receiver or further court order. (See Chapter 8—Special Receiverships, section on Liquidation of an HMO, Injunctions.)

### 3. Duration of Order

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

- a. the receivership court shall specify the duration of the seizure order, which shall be the time the court deems necessary for the regulator to ascertain the condition of the insurer;
- b. the regulator may request an extension or modification of the order if necessary to protect policyholders, creditors, the insurer or the public; and

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<sup>5</sup> Section 104 J of IRMA defines a “formal delinquency proceeding” as a conservation, rehabilitation or liquidation proceeding.

- 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.

#### 4. Review of Order

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

#### 5. Powers and Duties of the Regulator Under Order

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

### **C. Conservation**

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

#### 1. Conservation under Article III of IRMA

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

##### a. Conservation Orders

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

##### b. Powers and Duties of Conservator

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

c. Termination of Conservation

The conservator must conduct an analysis of the insurer to determine if it is possible to correct the problems that precipitated the need for conservation. The conservator must then file a motion requesting that the insurer be either released from conservation, or placed in rehabilitation or liquidation. The motion must be filed within 180 days of the conservation order, unless the court grants a 180-day extension. See IRMA § 302. The conservator is required to coordinate with guaranty associations to ensure an orderly transition in the event of liquidation. See IRMA § 303.

2. Conservation of Property of Foreign or Alien Insurers

Most states' 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 is generally not confidential.

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

**D. Rehabilitation**

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

1. Grounds

The grounds upon which a regulator may petition the court for an order of rehabilitation vary from state to state. A regulator must allege and prove a specific statutory ground for rehabilitation. Per § 207 of IRMA, the grounds upon which a regulator may petition the court are the same whether the requested order is for conservation, rehabilitation or liquidation.

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

2. Burden of Proof

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

3. Contents of a Rehabilitation Order

An order of rehabilitation generally appoints the regulator as rehabilitator; vests the rehabilitator with possession or title to all of the insurer's assets, books, records, accounts, property and premises<sup>6</sup>; 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. 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

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<sup>6</sup> See Liquidation Model Act, at Section 12; Uniform Act, Section 2(2); IRMA, §401.

property is located, so that creditors and the public are put on notice of the rehabilitation. Additionally, the order should be served on all financial institutions where the insurer maintains accounts or has other assets.

The Model Acts typically provide 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.

#### 4. Rehabilitation Plan

The receivership act may allow, or require, the rehabilitator to file a plan of rehabilitation ("plan"). Under IRMA the filing of a plan is mandatory; § 403 A. requires that a plan be filed within one year after entry of the rehabilitation order or such further time as the court may allow. In contrast, some receivership acts require that a plan be filed only if the rehabilitator proposes to reorganize, convert, reinsure or merge the insurer. The plan should not treat creditors less favorably than they would be treated in liquidation.<sup>7</sup> It should be noted that the Model Acts do not require that the plan provide for the emergence of the insurer from rehabilitation as a going concern. Thus, a plan for a run-off may be permissible. After formulating the plan, the rehabilitator must submit it to the supervising court for approval. The court will either approve, disapprove or modify the plan. State law typically requires that the court give notice and hold hearings upon any proposed plan. The court's review of the rehabilitator's proposed plan is generally a limited one, subjecting the rehabilitator's proposal to an abuse of discretion standard.<sup>8</sup> (See Chapter 8—Special Receiverships, section on Alternatives to Immediate Liquidation of a Financially Troubled HMO, for further discussion.)

#### 5. Insufficient Assets

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

#### 6. Agency Force

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

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<sup>7</sup> 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).

<sup>8</sup> *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).



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.

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 and to recommend that the policyholders keep their policies in force.

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.<sup>9</sup>

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.<sup>10</sup>

#### 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. § 404 A of IRMA 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, § 404 B.

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. 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 § 902 of IRMA, 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

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<sup>9</sup> The proceedings involving Executive Life of California and Mutual Benefit Life are recent examples.

<sup>10</sup> 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. 1<sup>st</sup> 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).

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

### 1. Grounds

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

### 2. Order of Liquidation

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

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

### 3. Effect on Policies

#### a. Life & Health Policies

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

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<sup>11</sup> See *In re Conservation of Alpine Ins. Co.*, 741 N.E.2d 663 (Ill. App. 1<sup>st</sup> 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).

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

b. Property & Casualty Policies

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

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

The liquidator is authorized to:

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

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

5. Litigation

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

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

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<sup>13</sup> 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).

## 6. Notice

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 funds, all agents of the insurer and all policyholders, claimants against policyholders, cedents and reinsurers, creditors, and former employees at their last known address. The liquidator should also give notice by publication in a newspaper of general circulation in the county in which the insurer has its principal place of business. Potential claimants are required to file their claims on or before the date specified in the notice, IRMA § 208 and § 505.

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

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

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

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

If a policyholder must file a "request for continuation of coverage" for a life or annuity policy to make a claim with the policyholder's state guaranty association, the liquidator's notice must clearly state that such action must be taken or forfeiture of the insurance may occur. (See Chapter 8—Special Receiverships, section on Liquidation of an HMO.)

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

In either case, the applicant is required to present a petition for intervention, along with the initial pleading or motion he or she proposes to file. IRMA has three alternatives for dealing with right to intervene in § 105 I. Under all three alternatives, intervention is not allowed 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 for a limited purpose upon application to and approval by the receivership court. Alternative 2 permits guaranty association intervention as a matter of right upon application to and approval by the receivership court. Alternative 3 is silent as to guaranty associations.

#### 8. Deadline for Filing Claims

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

#### 9. Jurisdiction and Ancillary Receiverships

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.

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.

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.

Ancillary receiverships are permitted under IRMA, but if there is a pending domestic receivership, an ancillary can only be established with the domicile's consent, § 1001.

#### 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.<sup>14</sup> 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."<sup>15</sup>

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

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<sup>14</sup> 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).

<sup>15</sup> *Foster v. Mutual Fire, Marine & Inland Ins. Co.*, 614 A.2d 1086, 1092 (Pa.1992).

so advanced to be repaid out of the first available assets of the insurer. § 804 of IRMA allows some unclaimed funds of receivership estates to be used to create a general receivership expense account which can provide the funds needed to administer low- or no-asset estates.

## F. Substantive Consolidation

### 1. Substantive Consolidation in Receivership Proceedings of “Non-Insurer” with “Insurer”

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

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 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

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<sup>16</sup> See e.g., *Green v. Champion Ins. Co.*, 577 So.2d 249 (La. App. 1<sup>st</sup> 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).

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.<sup>17</sup> 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.<sup>18</sup> 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.<sup>19</sup> 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.<sup>20</sup> 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.<sup>21</sup>

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 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.<sup>22</sup>

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.<sup>23</sup> 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

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

<sup>18</sup> 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).

<sup>19</sup> 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.

<sup>20</sup> 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).

<sup>21</sup> See e.g., *In re Augie/Restivo Baking Co., Ltd.*, 860 F.2d 515, 518 (2d Cir. 1988).

<sup>22</sup> 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).

<sup>23</sup> 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).



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.<sup>24</sup> 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.

## 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.<sup>25</sup> The liquidation court is the state court of the state where the insurer is domiciled that initially ordered the insolvent insurer into liquidation. (See Chapter 8—Special Receiverships for a discussion of jurisdictional issues specific to HMO receiverships.) 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 court may decide matters involving the legal rights of the insolvent toward debtors of the estate, and the liquidation court must honor the judgment of another court on these rights.<sup>26</sup>

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 owes the reinsurer money, the reinsurer may file the judgment along with a proof of claim in the estate of the insolvent, and the state liquidation court must accept the judgment as conclusive regarding legal liability. The

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<sup>24</sup> 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).

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

<sup>26</sup> *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. 1<sup>st</sup> 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).

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.<sup>27</sup> 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.<sup>28</sup> 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.<sup>29</sup>

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 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. 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.

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<sup>27</sup> *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*).

<sup>28</sup> *Id.*

<sup>29</sup> See *Prentiss v. Allstate Ins. Co.*, 87 F.Supp. 2d 514 (W.D.N.C. 1999).

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.<sup>30</sup> The court should not permit the action to proceed outside an ancillary receivership proceeding.<sup>31</sup>

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,<sup>32</sup> 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.<sup>33</sup> Other courts, particularly in New York, have said that state insurance liquidation statutes control because of the federal McCarran-Ferguson Act<sup>34</sup> and that a claimant cannot compel arbitration over the liquidator's objection.<sup>35</sup> In

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<sup>30</sup> 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).

<sup>31</sup> 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).

<sup>32</sup> 9 U.S.C. §§ 1-16, 201-208 (West 2001).

<sup>33</sup> *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. 10<sup>th</sup> Dist. 1990); *Benjamin v. Pipoly*, 155 Ohio App 3d 171 (2003); *Selcke v. New England Ins. Co.*, 995 F.2d 688 (7<sup>th</sup> Cir.), mot. to vacate denied, 2 F.3d 790 (7<sup>th</sup> 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 (7<sup>th</sup> Cir. 1984); *Bennett v. Liberty National Fire Insurance Co.*, 968 F.2d 969 (9<sup>th</sup> 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*.

<sup>34</sup> See *McCarran-Ferguson Act*, 15 U.S.C.A. §§ 1011-1012 (West 2000).

<sup>35</sup> *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. 1<sup>st</sup> 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. 1<sup>st</sup> 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. 1<sup>st</sup> 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*.

some instances, the dispute may be held to be outside the scope of the arbitration clause and, therefore, within the liquidation court's jurisdiction.<sup>36</sup> 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.<sup>37</sup> Other receivership courts, however, have allowed policyholders committees to be appointed so as to provide an additional means of protecting the interests of policyholders.<sup>38</sup>

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

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

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<sup>36</sup> See e.g., *Washburn v. Societe Commerciale de Reassurance*, 831 F.2d 149 (7<sup>th</sup> Cir. 1987).

<sup>37</sup> 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).

<sup>38</sup> Policyholder committees have been given standing by courts supervising the insolvencies of Mutual Fire, Marine & Inland Insurance Company (Pa. Court) and Constellation Reinsurance Company (N.Y. 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).

be possible. The guidelines applicable to a receivership with a small amount of assets may not function appropriately for an estate with a sizable asset portfolio.

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

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

## 2. Statute of Limitations

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

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

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

### a. Tolling in General

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

10 years after the date on which the cause of action has accrued. Again, counsel should be consulted to ascertain the potential impact of tolling provisions.

b. Circumstances Unique to Receivers

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

In addition, some courts have held that certain causes of action (such as those against former directors and officers, voidable preferences and RICO actions) are unique to the receiver and, as a result, the statute of limitations does not begin to run until the receivership is commenced.<sup>39</sup> 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 of adverse domination has also been applied to persons other than corporate officers and directors.<sup>40</sup> Adverse domination is a reliable mechanism for fraud claims. However, some courts have refused to apply the doctrine to negligence claims.<sup>41</sup>

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

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<sup>39</sup> 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 (4<sup>th</sup> 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 (4<sup>th</sup> 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).

<sup>40</sup> 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 (9<sup>th</sup> 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).

<sup>41</sup> 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 (5<sup>th</sup> 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 (5<sup>th</sup> Cir. 1995) (Texas law); *FDIC v. Cocks*, 7 F.3d 396 (4<sup>th</sup> 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. Blasdel*, 930 F.Supp. 417 (D. Ariz. 1994) (Arizona law); but see *FDIC v. Jackson*, 133 F.3d 694 (9<sup>th</sup> 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 (6<sup>th</sup> Cir. 1997); *Clark v. Milam*, 872 F.Supp. 307 (S.D.W.Va. 1994), affirmed, 139 F.3d 888 (4<sup>th</sup> 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).

receiver, or the equivalent of a receiver.<sup>42</sup> 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.<sup>43</sup>

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 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.<sup>44</sup> The commissioner's administrative subpoena powers also may be available.<sup>45</sup>

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.<sup>46</sup>

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,

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<sup>42</sup> See 11 U.S.C. § 108; 12 U.S.C. §§ 1821(d)14(A), (B), (C).

<sup>43</sup> 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).

<sup>44</sup> See e.g., Liquidation Model Act, *supra*, note 3, at Section 24.A.(6) and IRMA §504 A. (1).

<sup>45</sup> See e.g., *Angoff v. M&M Management Corp.*, 897 S.W. 2d 649 (Mo.Ct. App. 1995).

<sup>46</sup> Fed. R. Civ. P. 26(b)(1).

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 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<sup>47</sup> 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.

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.<sup>48</sup>

- 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

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<sup>47</sup> See Fed. R. Civ. P. 26(b) (3).

<sup>48</sup> See *United States of America v. American Telephone and Telegraph Co.*, 86 F.R.D. 603 (D.D.C. 1979).

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

#### b. Mutuality

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

i. Mutuality of Capacity

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

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

- Agents and Brokers and Premium Obligations. Traditionally, setoffs between agents or brokers and the company have been denied on mutuality of capacity grounds. The reason is that the agent’s role usually is viewed not as that of a party to a contract, but rather as a fiduciary. Thus, the statutes of most states (with few, limited exceptions) provide, and most courts have held, that an agent may not set off its obligation to remit earned or unearned premiums to a company against claims for future commissions or other damages. This prohibition against agent setoffs of premiums generally does not apply to insureds, because there is no mutuality of capacity problem. See Liquidation Model Act Section 33A(1) and IRMA § 613.
- Affiliates. As a general rule, setoffs are permitted only between the parties to a particular contract. Thus, a debtor cannot set off an amount it owes the company against an amount the company owed the debtor’s affiliate or subsidiary company. Similarly, an insolvent insurer may not assert a setoff owing to one of its affiliates or subsidiaries. See Liquidation Model Act Section 30B(3),(4) and IRMA § 609B(3),(4). Whether setoffs may be allowed in the case of debtors who have merged depends upon the circumstances of the merger. The general rule is that debts may not be purchased by, or transferred to, another debtor for setoff purposes. See Liquidation Model Act Section 30B(2) and IRMA § 609B(2).
- Assessment and Capital Obligations. In most instances, mutual company policyholders who are liable for assessment for company losses may not set off their losses and unearned premiums against their assessment obligations. Likewise, stockholders may not set off their capital contributions. See Liquidation Model Act Section 30B(5) and IRMA § 609B(5).
- Receivers have unsuccessfully disputed reinsurance setoff where the debts and credits between the insolvent insurer and reinsurer arose from different contracts between the parties. The dispute centers on the mutuality of the debts and credits in issue, and is sometimes referred to as a dispute over multiple contract setoff.<sup>49</sup> 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

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<sup>49</sup> 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.*

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.<sup>50</sup>

- **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.<sup>51</sup>
- **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 the differences between contingent, unliquidated and immature claims, see Chapter 5—Claims, section on Establishing a Claims Procedure, The Fixing Date.
- **After-Acquired Setoffs.** Closely related to the rule against setoffs among affiliates is the general rule against after-acquired setoffs. The rule is that a party may not acquire after receivership a debt or claim by assignment or otherwise for use as a setoff in the receivership. See Liquidation Model Act Section 30.B.(2) and IRMA § 609B(2). Many states’ statutes prohibit such setoffs.

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<sup>50</sup> *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).

<sup>51</sup> *Stamp v. Ins. Co. of N. America*, *supra*.

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.<sup>52</sup> 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.<sup>53</sup> 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 pursuing 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, there is an open issue of the extent to which setoffs may be taken regarding claims against the company by the federal government.

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<sup>52</sup> 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).

<sup>53</sup> 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).

## I. Recoupment

The equitable doctrine of recoupment has been recognized in insurance and other types of insolvency cases.<sup>54</sup> 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.

## J. 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.<sup>55</sup> 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.<sup>56</sup> 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;<sup>57</sup> 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.<sup>58</sup>

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.

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<sup>54</sup> 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).

<sup>55</sup> 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).

<sup>56</sup> 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).

<sup>57</sup> 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).

<sup>58</sup> 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).

## **K. Closing of a Receivership Estate**

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

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

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

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

## **L. Destruction of Records**

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

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

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

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

## **M. 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.

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

§ 804 of IRMA has two alternative approaches for dealing with unclaimed funds. Alternative 2 is to follow the general escheat process in state law. Alternative 1 sets up a procedure requiring the funds to be

held for two years after termination of the receivership after which the court can order the funds be deposited in a general receivership expense account, be escheated to the state, or be used to reopen the receivership and distributed to known claimant.

### **III. CLAIMS**

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

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

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

The issues discussed below represent pitfalls in the claims administration process where receivers have or may encounter legal controversy. There are few reported decisions on receivership claims administration questions. The guidelines in the claims chapter of this handbook are guidelines on how to conduct the claims administration process (see Section 8.B.7.g 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<sup>59</sup> to insurance liquidation proceedings are discussed in detail below.

#### **B. Notice Issues**

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

#### **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.

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<sup>59</sup> 31 U.S.C. § 3713.



## **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.

### 2. Punitive/Extra-Contractual Damages

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

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

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

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

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

### 3. Surety/Fidelity Bonds

The claim element questions in the surety/fidelity bond field usually revolve around the allowability of attorneys' fees, interest and liquidated damages. The case law seems to hold that, unlike punitive damages, if the underlying bond provided for such elements, they may be allowed by the receiver. With respect to coverage, at a minimum, there must have been a default by the bond principal before the cancellation date or, so far as fidelity bonds are concerned, the act or occurrence that caused damage covered by the bond must have taken place before the cancellation date. In addition, issues may arise concerning the return of unearned premiums (since surety premium is normally deemed to be fully earned at inception), whether bonds are cancelable, and what priority class a bond claimant is entitled to assert. IRMA § 801 C places in Class 3 (policyholder class) claims of "...obligees (and, subject to the discretion of the receiver, completion bonds) under surety bonds and surety

undertakings (not to include bail bonds, mortgage or financial guaranty or other forms of insurance offering protection against investment risk, or warranties), claims by principals under surety bonds and surety undertakings for wrongful dissipation of collateral by the insurer or its agents ...”

#### 4. Contingent Claims

##### a. Proofs of Claim—Unstated in Amount

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

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

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

- i. the traditional run-off method in which the receivership is continued until all or substantially all the claims become absolute, i.e., mature to the point where liability and value are clearly proven;
- ii. the cut-off approach in which an estate’s liability for any claims that remain contingent or unliquidated are terminated by a specific date or event, e.g., bar date;
- iii. an estimation method in which the receiver estimates and, if appropriate, allows (approves for distribution) contingent and unliquidated claims at a net present value.

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

For example, § 39 of the Liquidation Model Act and § 701 A of IRMA require claims to be filed “on or before the last day for filing specified,” i.e., by a bar date which, depending on the jurisdiction, can be as liberal as a date chosen by the receiver at his discretion or a specific date in the statute. IRMA § 701 further specifies that the last day for filing shall not be later than 18 months after entry of the order of liquidation unless extended for good cause. An early bar date could prevent late-maturing or long-tail claims from meeting a receivership’s proof requirements and exclude them from any distribution of assets. In any estate where long-tail exposure is significant, this not only causes inequity by eliminating long-tail policyholders’ reasonable expectations of recovery but, by precluding the development of such long-tail claims, it also significantly reduces the amount of reinsurance that can be collected by the receiver and used to benefit creditors.

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

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

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

A second problem facing estimation plans is the likelihood that they will be challenged by reinsurers.<sup>60</sup>

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.

#### b. Policyholder Protection Claims

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

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

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<sup>60</sup> See *Quackenbush v. Mission Insurance Co.*, 46 Cal. App. 4<sup>th</sup> 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).

## 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 those 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.)

## 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.

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

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

- K. (1) "General assets" includes all property of the estate that is not:
  - (a) Subject to a properly perfected secured claim;
  - (b) Subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons; or

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

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

Discussed below are a few of the legal issues surrounding claims against assets that are restricted in one way or another, such as a “special deposit claim.”<sup>63</sup> 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.<sup>61</sup>

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

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

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<sup>61</sup> *Underwriters National Assurance Company (UNAC)*, 102 S. Ct. at 1357, 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.

## 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.<sup>62</sup> (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

#### Securities Act of 1933 (1933 Act)

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.

#### 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."

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<sup>62</sup> See, e.g., *Rohm & Haas Co. v. Continental Assurance Company*, 58 Ill. App. 3d 378, 374 N.E.2d 727 (1978)

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<sup>63</sup>, and is subject to the registration and other requirements of the 1940 Act, unless an exception applies.

#### Securities Exchange Act of 1934 ("1934 Act")

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

#### Code of Federal Regulations

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

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

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

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.

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<sup>63</sup> 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).

b. State Statutes and Rules

NAIC Variable Contract Model Law (#260)

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

- Income, gains and losses from assets allocated to a separate account are credited to or charged against the account, without regard to other income, gains or losses of the insurer.
- Amounts allocated to a separate account are owned by the insurer, and the insurer is not a trustee with respect to such amounts. If and to the extent provided under the applicable contracts, the portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business of the company (generally referred to as “asset insulation”).
- Transfers of assets between a separate account and other accounts are subject to restrictions. The Commissioner may approve other transfers if they are not found to be inequitable.
- Except as otherwise provided, pertinent insurance law applies to such separate accounts.

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

- Applies to group life insurance contracts and group annuity contracts, as described in the rule, which use a separate account.
- Prescribes rules for establishing and maintaining separate accounts that fund guaranteed minimum benefits under group contracts, and the reserve requirements for accounts.

NAIC Variable Annuity Model Regulation (#250)

- Defines a variable annuity as a policy that provides benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer.
- Sets forth reserve and nonforfeiture requirements for variable annuity contracts and provides that the insurer must maintain separate account assets with a value at least equal to the reserves and other contract liabilities with respect to the account, except as may otherwise be approved by the commissioner.
- To the extent provided under the contracts, that portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

NAIC Variable Life Insurance Model Regulation (#270)

- 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), § 3 (K):

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

- (1) Specifically subject to a perfected security interest as defined in the Uniform Commercial Code or its equivalent in this state.
- (2) Specifically mortgaged or otherwise subject to a lien and recorded in accordance with applicable real property law.
- (3) Specifically subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons.
- (4) Required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons.

As to an encumbered property, "general assets" includes all property or its proceeds in excess of the amount necessary to discharge, in accordance with the Act, the sum or sums secured thereby.

Assets held on deposit pursuant to a state statute for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

Separate Account Exclusion in Distribution Scheme

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

c. Case Law

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

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

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

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

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

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

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

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

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 preempted by the McCarran-Ferguson Act.

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

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

- i. A separate account not governed by the 1940 Act may nevertheless be treated as legally insulated under a state's receivership act:
  - If the state variable contract law (and the policy/contract, if necessary) so provide.

- If a state insurance law requires that a separate account be held for the benefit of specified persons, it is not a general asset under an act based on IRMA or IRLMA.
  - If the separate account is established as a "valid and existing" express trust for the security or benefit of specified persons as described in the receivership act, it is excluded from the general assets of the receivership under an act based on IRMA or IRLMA.
  - If the receivership act's distribution scheme contains a provision that governs the treatment of a separate account, and the account is established as specified by such provision, then claims under the separate account agreement are payable from the account as provided by the provision.
- ii. If accounts are established in accordance with any of the requirements described in (a), they should be reflected as restricted assets on the receivership's financial statement. (It should be noted that state statutes or rules may vary from the NAIC models. Not all states have a specific exemption for separate accounts in the distribution scheme, and differences also exist in variable contract laws. At least one state has prohibited the use of insulated separate accounts for non-variable products that do not reflect investment results of the separate account, but have guaranteed rates or returns. See Minnesota Department of Commerce Bulletin 97-6, October 22, 1997.)
- iii. If an account is not exempted from the definition of a general asset or excluded from the distribution scheme, the receivership act will typically provide that it is subject to distribution to creditors.
- iv. An annuity contract or life policy that imposes certain significant investment risks on the owners, such as a "market value adjustment," or an "index-linked variable annuity," might be required to be registered under the 1933 Act regardless of whether it is funded by a separate account registered under the 1940 Act ("Other SEC Registered Products"):
- Other SEC Registered Products such as registered modified guaranteed annuities and index-linked variable annuities may be funded by a separate account established in accordance with one of the requirements described in B.2.(a), above.
  - Whether or not funded by a separate account, the receiver could face compliance issues under the 1933 Act with respect to such Other SEC Registered Products.
  - Section 989J of the Dodd-Frank Act contains a provision that limits the ability of the SEC to classify indexed annuities and other insurance products as securities. This provision known as the Harkin Amendment.
- v. Transfers between a separate account and other accounts may create issues in a receivership. Under the NAIC Model Variable Contract Law, such transfers are subject to restrictions, and the Commissioner may approve transfers that are not "inequitable." Because the Model Law states that pertinent provisions of insurance law apply to separate accounts, except as otherwise provided, the provisions of a receivership act regarding voidable transfers and preferences may be applicable to such transfers.

### 3. Guidelines

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 the National Organization of Life and Health Insurance Guaranty Associations [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<sup>64</sup> into which premiums are deposited and allocated to "subaccounts," each of which invests in a specified underlying mutual fund, which itself must be registered under the 1940 Act. The underlying mutual fund may or may not be managed by an affiliate of TIC.
    - Managed Separate Account. A Separate Account that invests directly in a portfolios of securities or other investments and, therefore, actively manages the investments at the Separate Account level, and has a board of directors responsible for managing the Separate Account. See Section C (5)(D), below.
  - Variable Products Backed by Separate Accounts NOT Registered Under the 1940 Act (Exempt SAs).
    - Separate Accounts supporting Variable Products issued in connection with certain qualified retirement plans as specified in Section 3(a)(2) of the 1933 Act and Section 3(c)(11) of the 1940 Act. Such Separate Accounts are not registered under the 1940 Act and the Variable Products are not registered under the 1933 Act.
    - Separate Accounts supporting private placement (i.e., not registered) Variable Products under Section 4 of the 1933 Act and either Section 3(c)(1) or Section 3(c)(7) of the 1940 Act. Very limited in number and qualification of policyholders. Such Separate Accounts are not registered under the 1940 Act.
    - Even though these insurance products are exempted from SEC registration, they are still deemed to be securities, and are subject to the anti-fraud provisions of the federal securities laws. The offering documents (e.g., private placement memorandums, including financial statements) and marketing materials for these products must not contain any material omissions or misstatements. Once a TIC goes into receivership, the offering documents and marketing materials for such products should be amended to reflect such a material event and to explain the consequences for the contract owner.
  - Other SEC Registered Products Backed by Separate Accounts NOT Registered under the 1940 Act. In certain situations, products other than Variable Products may be registered 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.)

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<sup>64</sup> Under Section 4 (2) (b) of the 1940 Act, a UIT may not have a board of directors.

- 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)<sup>65</sup>, except in limited circumstances<sup>66</sup>. For products registered under the 1933 Act that are not backed by 1940 Act registered separate accounts, there could be filings that must be made with the SEC under Section 15(d) of the 1934 Act (Forms 10-Ks, 10-Qs and 8-Ks). The regulator/receiver should obtain a complete set of all SEC filings, including:
  - All recent SEC registration statements containing audited financial statements.
  - All periodic reports.
  - TIC's "plan of operations" or similar documentation for the operation of the Separate Account(s) (filed with certain state insurance departments).
  - All agreements with reinsurers, distributors, third party credit support providers, guarantors, investment advisors to the underlying mutual funds, custodians and other service providers involved in TIC's maintenance of the Separate Account(s).
- Rule 38a-1 Written Compliance Policies and Procedures and Annual Reports of the Chief Compliance Officer

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

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

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

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<sup>65</sup> 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.

<sup>66</sup> 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.

- 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.<sup>67</sup>
- 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.
- 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.

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<sup>67</sup> But see footnote 65.

- 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 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 the NOLHGA, which will coordinate with its member guaranty associations to evaluate coverage and the possible methods by which the guaranty associations may discharge their statutory obligations. Early communications with the guaranty associations through the NOLHGA to help evaluate the possible guaranty association coverage and approaches for delivering that coverage, including with respect to compliance, operational, and other issues arising from the possible continuation of coverage of such products, would be an important piece of the approach.
- Are TIC's Separate Accounts UITs or Managed Separate Accounts or Exempt SAs? If the TIC structured its separate accounts as Managed Separate Accounts (i.e., actively managed and investing directly in securities), then it will be governed by a separate board of directors (sometimes called a board of managers) subject to specified duties and obligations under the 1940 Act.
  - What, if any, authority does the TIC have over the Separate Account Directors or their election or appointment?
  - What limitations exist on the actions of those in control of the Separate Account?

d. Coordination with Other Interested Federal Regulators

Other regulators may be involved with issues concerning the insulation of separate accounts assets, such as federal banking regulators concerning variable contract bank owned life insurance (BOLI) 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](http://www.sec.gov).

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

ii. SEC's Role

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

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

iii. Insurer Receivership

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

The receiver's team should include legal counsel qualified to provide advice on the federal securities laws the rules under those laws and compliance issues, and on how state receivership laws and federal securities laws might interact in a receivership. The receiver needs to ensure that communication channels are open with the SEC staff and needs to ensure that the 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<sup>68</sup>. There are also periodic reporting obligations under the 1934 Act that have to be complied with as well. The federal securities laws and the rules under those laws regulate registered Variable Products by requiring insurance companies to conduct operations in a certain way. The 1933 and 1934 Acts impose disclosure obligations with regard to registered Variable Products and the 1940 Act imposes disclosure and operating requirements on the registered separate accounts that issue those products. The Variable Products that must be registered with the SEC under both the 1933 Act and the 1940 Act are variable annuity (VA) contracts and variable life insurance (VLI) policies (unless there is an applicable exemption). These products must be registered because they are securities and the policy owner receives a pass through of the investment performance of the assets that are held in the separate accounts. The 1933 Act is a disclosure regime that requires a prospectus to be included as a part of the registration statement. The 1940 Act classifies separate accounts that insurance companies create to fund variable products as investment companies and generally requires that they be registered. A separate account is essentially a pool of assets under the control of the insurance company but where policy owners have a beneficial interest in the assets in that pool and in the financial performance of those assets. For that reason, the 1940 Act and the rules under that Act place stringent regulatory requirements on separate accounts. These requirements are similar to the requirements for mutual funds.

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

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

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<sup>68</sup> See also footnote 64.

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.<sup>69</sup>

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

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<sup>69</sup> Unregistered fixed account options are frequently included as an option in registered Variable Products.

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,<sup>70</sup> 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<sup>71</sup>; and/or 3) a transition to liquidation.

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

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

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<sup>70</sup> But see footnote 65.

<sup>71</sup> 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.

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.

#### 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

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 covering 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<sup>72</sup> that are issued by a properly licensed life insurer and owned by residents of their state. Guaranty association statutes generally exclude coverage for that portion of a product not guaranteed by the insurer or where the risk is borne by the contract owner.

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

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<sup>72</sup> Coverage for unallocated annuities varies in accordance with the type of arrangement involved. Unallocated annuities are beyond the scope of this Chapter.

(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. The receiver and the guaranty associations (with respect to the covered policies) will most likely look 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/or the guaranty associations. No-action letter relief would likely be sought from the SEC staff in connection with a transfer of the Variable Products backed by separate accounts registered under the 1940 Act, and also in connection with change in control issues arising from the liquidation.

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

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

vii. Securities Laws Considerations Post-Receivership

(a) Separate Accounts and General Account Guarantees

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

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

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

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

General guidance: In summary, the receiver needs to identify the types of insurance products to be administered during receivership, and review and evaluate the impact of and compliance with the applicable state receivership laws and federal securities laws applicable to the insurer and its registered products and any separate accounts. The



receiver must administer the separate account in the same manner as the insurer pre-receivership, and must preserve the separate account insulation.

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

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

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

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

#### (c) Registration Statements and Prospectus Disclosure – Supplementation Requirements

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

##### (1) Suspension of Sales

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

it cannot comply with any federal securities law requirements because any Variable Products and/or Other SEC Registered Products remain registered securities under the 1933 Act and the separate account, if registered, remains registered as an “investment company” under the 1940 Act, the receiver should consult with experienced legal counsel and then SEC staff. Note that suspending acceptance of premiums under Variable and other SEC Registered Products raises disclosure issues under the federal securities laws, that is whether the insurer had adequately disclosed previously to those considering purchasing the contract that it had reserved the right to take that action in the future.

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

(2) Transferring the Registered Variable Product Business

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

(3) Continuing to “Evergreen” Prospectuses and File Required Reports

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

(d) Redeemability

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

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

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

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

(e) Possible Resolution of Blocks of Business

It may not be possible to arrange a “pre-packaged receivership” that results in the immediate sale/transfer of the registered product business at the time of the insurer’s liquidation order, due to the nature of products in the marketplace at the time (including guarantees provided with Variable Products). There may be a need to restructure the registered product contracts and cease accepting premiums. Note that ceasing to accept premiums on variable annuities with living benefit guarantees and on variable life insurance policies present challenging issues that are of concern to the SEC (e.g., new premiums may be necessary to achieve the policy owner’s expected benefits under living benefit guarantees or to keep variable life policies in force).

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

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

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

## **I. Large Deductibles**

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

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

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

If the insurer becomes insolvent and is placed into liquidation, the property and casualty and workers compensation guaranty associations will be triggered to begin paying claims. Just like the insurer, the guaranty association will be responsible for first dollar coverage of the claims. After the guaranty association pays the claim, the liquidator can then collect the amount of the claim within the deductible from the insured or the collateral. Historically, receivers and the guaranty associations disagreed on the disposition of these proceeds. Some receivers believe that the proceeds are claims based assets, similar to

reinsurance recoverables, which should go into the general assets of the estates and be distributed *pro rata* to all claimants. The guaranty associations believe that, to the extent that the claim payment is within the deductible, they are not paying a claim on behalf of the insolvent insurer but rather on behalf of the insured and therefore, they should receive the reimbursement directly.

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

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

- § 712 of IRMA requires the receiver to collect the deductible reimbursements as a general asset of the estate, but the amount collected is to be distributed to the guaranty associations that have paid claims within the deductible amount as early access subject to claw-back if the amount distributed ultimately exceeds the amount to which the receiving guaranty association would be entitled from the final estate distribution.
- Under Guideline #1980 subsection B, “Unless otherwise agreed by the responsible guaranty association, all large deductible claims that are also “covered claims” as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling.” Refer to the Guideline subsection B for further discussion of deductible claims paid.

## **J. Federal Government Claims**

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

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

- A. person indebted to the government is insolvent; and
  - i. the debtor without enough property to pay all debts makes a voluntary assignment of property;
  - ii. the property of the debtor, if absent, is attached; or
  - iii. an act of bankruptcy is committed, or
- B. the estate of a deceased debtor, in the custody of the executor or administrator, is not enough to pay all debts of the debtor.

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

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

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

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 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.<sup>73</sup> 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.<sup>74</sup> 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.<sup>75</sup> The Court found that the preference given by the Ohio statute to administrative expenses and policyholder claims was reasonably necessary to further the goal of protecting policyholders. The preferences given by

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<sup>73</sup> *U.S. Dept. of Treasury v. Fabe*, 113 S.Ct. 2202 (1993).

<sup>74</sup> *Id.*

<sup>75</sup> But see, *Ruthardt v. United States of America*, 303 F.3d 375 (1<sup>st</sup> Cir. 2002) where the court interpreted *Fabe* in deciding whether the federal claim priority statute preempted a state liquidation priority statute giving guaranty fund claims priority over federal claims. The First Circuit Court of Appeals stated, "*Fabe's* premise was not that priority (over the United States) for policyholders is all right and priority for anyone else is not; *Fabe* itself upheld a priority for administrative expenses of liquidation (and apparently for administrative expenses of guaranty funds, too...) because these reimbursements facilitated payment to policyholders. ...the question is one of degree not of kind." *Id.* at 382. See also Section IV of this chapter on Priority of Claims.

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.<sup>76</sup> 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.<sup>77</sup>

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.<sup>78</sup> 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.<sup>79</sup>

### **K. Cut-Through Endorsements**

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

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

### **L. Equitable Subordination**

The theory of equitable subordination may be available to the receiver. Equitable subordination is a theory whereby the claims of one creditor are subordinated to the claims of other creditors to the extent necessary to redress harm caused by such creditor's inequitable conduct.<sup>80</sup> (A related remedy is to reclassify debt owed to a shareholder as equity. Reclassification is based on the grounds that the

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<sup>76</sup> 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.

<sup>77</sup> 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).

<sup>78</sup> *North Carolina, ex. rel. Long as Liquidator of Northwestern Security Life Insurance Co. v. United States*, 139 F.3d 892 (4<sup>th</sup> Cir. 1998).

<sup>79</sup> *Ruthardt v. United States of America*, 303 F.3d 375, 384 (1<sup>st</sup> Cir. 2002); *Garcia v. Island Program Designer, Inc.*, 4 F.3d 57 (1<sup>st</sup> Cir. 1993).

<sup>80</sup> See generally *4 Collier on Bankruptcy* 510.05 (15 ed. rev. 1997).

shareholder inequitably substituted debt for equity capital.)<sup>81</sup> 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.<sup>82</sup> 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.”<sup>83</sup> On the other hand, to subordinate the claim of a non-fiduciary, the plaintiff must prove egregious misconduct.<sup>84</sup>

Equitable subordination may be useful as an alternative remedy for fraud, fraudulent transfer, breach of fiduciary duty or the like.<sup>85</sup> In fact, it may be the only remedy available as a practical matter when the target is another insolvent insurance company (or a debtor in a bankruptcy case). In that situation, an action against the target would be subject to the anti-litigation injunction in the target’s proceedings. However, unlike other actions, equitable subordination should not be held to violate that injunction because equitable subordination addresses the treatment of a claim filed by the target in the insolvent insurance company’s proceedings. The filing of such a claim subjects the target to the jurisdiction of the receivership court and should be held to waive any stay as to the filed claim.

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

### **M. Inter-Affiliate Pooling Agreements<sup>86</sup>**

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

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<sup>81</sup> See e.g., *In re Hyperion Enterprises, Inc.*, 158 B.R. 555 (D.R.I. 1993); *In re Disonics, Inc.*, 121 B.R. 626 (Bankr. N.D. Fla. 1990). See also *In re Herby’s Foods, Inc.*, 2 F.3d 128 (5<sup>th</sup> Cir. 1993) (equitable subordination on similar theory).

<sup>82</sup> See e.g., *Pepper v. Litton*, 308 U.S. 295 (1939); *Taylor v. Standard Gas & Elec. Co.*, 306 U.S. 307 (1938).

<sup>83</sup> *In re Mobile Steel Co.*, 563 F.2d 692, 701 (5<sup>th</sup> 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).

<sup>84</sup> *In re Giorgio*, 862 F.2d 933 (1<sup>st</sup> Cir. 1988).

<sup>85</sup> 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).

<sup>86</sup> 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).

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 (Holding Company Act), a pooling transaction cannot be implemented unless the relevant insurance commissioners have determined that the proposed agreement is fair and reasonable.<sup>87</sup> 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.<sup>88</sup> 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.<sup>89</sup>

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

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<sup>87</sup> See NAIC Insurance Holding Company System Regulatory Act §§5A(1), 5A(4).

<sup>88</sup> See e.g., *Rubin v. Manufacturers Hanover Trust Co.*, 661 F.2d 979 (2d Cir. 1981).

<sup>89</sup> See e.g., Uniform Fraudulent Transfer Act §6(5).



subsidiary is solvent. However, if the subsidiary is insolvent, generally there is a contrary result.<sup>90</sup> 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.<sup>91</sup> 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.<sup>92</sup> 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.<sup>93</sup> 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.<sup>94</sup>

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.<sup>95</sup>

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

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<sup>90</sup> 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).

<sup>91</sup> 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).

<sup>92</sup> 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).

<sup>93</sup> 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 (4<sup>th</sup> Cir. 1982). cert. denied, 461 U.S. 928 (1983).

<sup>94</sup> 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).

<sup>95</sup> See *Banco de Desarrollo Agropecuario, S.A. v. Gibbs*, 709 F. Supp. 1302 (S.D.N.Y. 1989).

discussed below, that is the obligation that fiduciaries have to their charges. Accordingly, it may be argued that the Holding Company Act imposes liability in the event that the transaction was unfair.

The theory of equitable subordination may be used to subordinate pooling agreement claims of affiliates of the relevant insurers to the claims of general creditors of the insurer such as reinsurers. Equitable subordination may be useful as an alternative remedy to actions for affirmative recovery such as fraud, fraudulent transfer or breach of fiduciary duty. In fact, it may be the only remedy available to the receiver if the target affiliate is also in insolvency proceedings. That is so because, unlike suits seeking affirmative recovery, equitable subordination should not be held subject to the anti-litigation injunction in the target company's insolvency proceedings.

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

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

#### **IV. PROPERTY/CASUALTY GUARANTY ASSOCIATIONS**

##### **A. Introduction**

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

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

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

##### **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.<sup>96</sup>

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.<sup>97</sup> Guaranty associations are comprised of all the insurers authorized to write policies in a particular state, and their citizenship is deemed to be the same as that of their members.

## B. Legal Disputes Over Triggering of Guaranty Associations

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

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

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

Simply, to be insolvent for guaranty fund purposes, the insurer must have been declared insolvent by a court of competent jurisdiction.

### 1. Court of Competent Jurisdiction

The phrase court of competent jurisdiction does not mean that only a court in the insurer's domiciliary state may issue the order of insolvency. Generally, any court in any state may issue the order so long as certain requirements are met.<sup>98</sup> Usually, these requirements are: 1) the state has

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<sup>96</sup> *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).

<sup>97</sup> See *Rhulen Agency Inc. v. Alabama Ins. Guar. Ass'n*, 896 F.2d 674 (2d Cir. 1990).

<sup>98</sup> 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).

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.<sup>99</sup>

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.<sup>100</sup> 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.<sup>101</sup> However, if an order of liquidation is not appealed, it is final on the date issued.<sup>102</sup>

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:

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<sup>99</sup> See *New Jersey Property*, 137 N.J. Super. at 345, 349 A.2d at 92.

<sup>100</sup> 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).

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

- 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—§ 5H

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

- (1) an unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and:
  - (a) The claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the state in which its principal place of business is located at the time of the insured event; or
  - (b) The claim is a first party claim for damage to property with a permanent location in this state.
- (2) Except as provided elsewhere in this section “covered claim” shall not include;
  - (a) Any amount awarded as punitive or exemplary damages;
  - (b) Any amount sought as a return of premium under any retrospective rating plan;
  - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
  - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;
  - (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
  - (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

- (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
- (h) Any claims for interest; or
- (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.<sup>103</sup> This requirement is primarily to prevent excessive or duplicative claim payments.<sup>104</sup> 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.<sup>105</sup>

#### 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.<sup>106</sup> 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.<sup>107</sup>

#### 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.<sup>108</sup> 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.<sup>109</sup> Whether the insured later

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<sup>103</sup> 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).

<sup>104</sup> 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).

<sup>105</sup> *Betancourt v. Ariz. Prop. & Cas. Fund*, 823 P.2d 1304 (Ariz. Ct. App. 1991).

<sup>106</sup> See *Florida Ins. Guar. Ass'n*, 355 So. 2d at 141.

<sup>107</sup> *P.I.E. Mutual Ins. Co. v. Ohio Guar. Ass'n*, 66 Ohio St. 3d 209, 611 N.E.2d 313 (Ohio 1993).

<sup>108</sup> *Qualls v. Missouri Ins. Guar. Ass'n*, 714 S.W.2d 732 (Mo. Ct. App. 1986).

<sup>109</sup> *Id.*

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.”<sup>110</sup> This provision requires that a claim meet a policy's coverage requirements before it will be paid.<sup>111</sup>

i. Claims Where Liability is to a Third Party

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

ii. Settlements

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

The association shall:

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

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<sup>110</sup> Model #540, *supra* note 96, at section 5F.

<sup>111</sup> 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).

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.<sup>112</sup> 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.<sup>113</sup>

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.<sup>114</sup>

### 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.<sup>115</sup> 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.<sup>116</sup>

Generally, "[a] corporation is an entity separate and distinct from its stockholders and from other corporations with which it may be connected."<sup>117</sup> 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

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<sup>112</sup> See *King Louie Bowling v. Missouri Ins. Guar. Ass'n*, 735 S.W.2d 35 (Mo. Ct. App. 1987).

<sup>113</sup> *Id.* at 38.

<sup>114</sup> *Id.*

<sup>115</sup> 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).

<sup>116</sup> *Id.* at 910.

<sup>117</sup> *Id.*



and within the coverage. Thus, the corporation could not recover from the guaranty association.<sup>118</sup>

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."<sup>119</sup> 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).

- 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.<sup>120</sup> 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.<sup>121</sup> 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.<sup>122</sup>

d. Unearned Premiums

Most guaranty association acts and the Model #540 specifically allow claims for unearned premiums.<sup>123</sup> Generally, there is a cap and deductible that will apply, and unearned premium recovery is limited to the extent that the insurer would have had to reimburse the insured.

- Assignments Allowed

In a New Jersey action, a claimant bank had financed insurance premiums.<sup>124</sup> 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.<sup>125</sup> While the applicable act distinguished reinsurers' claims from others, it did not distinguish between individual and corporate claimants. Had the legislature intended to

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<sup>118</sup> *Id.*

<sup>119</sup> Model #540, at Section 5H.

<sup>120</sup> See *Vaughn v. Vaughn*, 23 Wash. App. 527 (Wash. Ct. App. 1979), 597 P.2d 932, review denied, 92 Wash. 2d 1023 (1979).

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 528.

<sup>123</sup> Model #540, at § 5H.

<sup>124</sup> See *Broadway Bank & Trust Co. v. New Jersey Ins. Ass'n*, 146 N.J. Super. 80, 368 A.2d 983 (1976).

<sup>125</sup> *Id.*

differentiate between individuals and commercial assignees, it would have expressly done so.<sup>126</sup>

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.<sup>127</sup> A first-party claim for property damage is also covered if the property from which the claim arises is permanently located in the guaranty association's state.

i. Residence of Claimant

An individual, or other entity, must be a resident of the guaranty association's state at the time of the insured event to support a covered claim.<sup>128</sup> 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.<sup>129</sup> The court held that a corporate claimant need not be a domestic corporation to seek recovery from a guaranty association. Whether a corporation has established residence in a foreign jurisdiction for guaranty association purposes depends upon the aim and context of the statute containing the residency requirement.

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

ii. Location of Property

Guaranty association acts generally require that the property from which the claim arises must be permanently located in the state.<sup>130</sup> 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.<sup>131</sup> Subsequently, the insurer became insolvent and the insured submitted a claim to the New Jersey Guaranty Association. The guaranty association argued

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<sup>126</sup> *Id.* at 986.

<sup>127</sup> See also *Kroblin Refrig. Express v. Iowa Ins. Guar. Ass'n.*, 461 N.W.2d 175 (Iowa 1990).

<sup>128</sup> See Model #540, at § 5H(1)(a).

<sup>129</sup> 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).

<sup>130</sup> *Id.* at Section 5G(1)(b)

<sup>131</sup> See *Eastern Seaboard*, 175 N.J. Super. at 589.

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.<sup>132</sup>

#### b. Outside the Scope of Guaranty Association

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

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

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

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<sup>132</sup> See Model #540, at § 5H(2)(c).

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.<sup>133</sup>

Michigan also has a net worth exclusion. The U.S. Court of Appeals has addressed the constitutionality of Michigan's net worth exclusion.<sup>134</sup> 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."<sup>135</sup> 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,"<sup>136</sup> the court upheld the net worth exclusion.

- Assigned Rights Treated as Separate Claims

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<sup>133</sup> 1990 Ga. Laws Section 33-36-3(2)(g).

<sup>134</sup> 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).

<sup>135</sup> 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.

<sup>136</sup> *Borman's*, 925 F.2d at 163.

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.<sup>137</sup>

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.<sup>138</sup> The company was, therefore, entitled to all unearned premiums on the canceled policies to which the policyholders would have been entitled but for the assignments.

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

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

#### **D. Primary Responsibility for Handling a Claim**

##### Coverage Under More Than One Guaranty Association

In certain circumstances, more than one guaranty association may be obligated to cover a claim. Since coordination between state guaranty associations and the receiver is essential, receivers should understand the issues which arise in determining when dual liability attaches. The order of recovery is set forth in § 14B of Model #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.<sup>139</sup>

#### **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

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<sup>137</sup> See *United Budget Co. v. Georgia Insurer's Insolvency Pool*, 253 Ga. 435, 321 S.E.2d 333 (Ga. 1984).

<sup>138</sup> *Id.* at 337.

<sup>139</sup> Model #540, at Section 14B.

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.

In a California case,<sup>140</sup> the claimants were an anesthesiologist and a nurse-anesthesiologist insured for malpractice from 1971 to 1973. In 1978, their insurer became insolvent and the California State Insurance Commissioner was appointed receiver of the insurer. The receiver sent notice that claims must be filed within six months to all insureds under professional liability policies since 1974. The claimants were therefore not notified.

In 1980, two years after the claim deadline, claimants were sued for malpractice and submitted claims to the California Insurance Guarantee Association (CIGA). CIGA rejected the claims and the superior court denied the claimants' petition to allow the claims.

On appeal, the court held that claimants were entitled to relief because a California statute required the receiver to give written notice to persons known or reasonably expected to have or be interested in claims against the insurer.<sup>141</sup> Thus, CIGA was estopped from asserting the time limits and denying the claim.

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.<sup>142</sup>

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.<sup>143</sup> 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.<sup>144</sup> 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.

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<sup>140</sup> See *Middleton v. Imperial Ins. Co.*, 34 Cal.3d 134, 193 Cal. Rptr. 144, 666 P.2d 1 (1983).

<sup>141</sup> Cal. Ins. Code, Section 1063.7 (West 2000).

<sup>142</sup> Post-Assessment Model Act, *supra* note 91, at Section 8A(1)(b).

<sup>143</sup> 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).

<sup>144</sup> 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).

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.<sup>145</sup>

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

In an Illinois case,<sup>146</sup> 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.<sup>147</sup>

### 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.<sup>148</sup> In a Massachusetts action,<sup>149</sup> a state-created reinsurance fund was set up to cover high risk policies. Under this scheme, insurers ceded high risk

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<sup>145</sup> *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).

<sup>146</sup> See *Union Gesellschaft Fur Metal Industrie Co. dba Union Fronenberg 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).

<sup>147</sup> 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).

<sup>148</sup> See *Massachusetts Motor Vehicle Reinsurance Facility v. Commissioner of Insurance*, 379 Mass. 527 (Mass. 1980).

<sup>149</sup> *Id.*

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.<sup>150</sup>

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.<sup>151</sup>

### 4. NAIC Proposed Reporting Guidelines

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

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

## **G. Priority of Claims**

### Order of Distribution

The Liquidation Model Act sets forth the priority of distribution of claims from the insolvent insurer's estate. However, statutory priorities differ substantially 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:

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<sup>150</sup> See *Excess and Casualty Reinsurance*, 656 F.2d at 495; *American Reinsurance*, 527 F. Supp. at 457.

<sup>151</sup> *Id.*



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- 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;<sup>152</sup>
- Class 7. Claims of a state or local government for a penalty or forfeiture;
- Class 8. Surplus notes or similar obligations;
- Class 9. Claims of shareholders or other owners in their capacity as shareholders;

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

- Class 1. Costs of administration;
- Class 2. Expenses of guaranty associations;
- Class 3. Policyholder, third-party claims and guaranty association claims under policies;
- Class 4. Claims under financial guaranty and mortgage guaranty insurance policies;
- Class 5. Claims of the federal government other than under policies;
- Class 6. Limited compensation for employee services;
- Class 7. General creditor claims;
- Class 8. Claims of a state or local governments, and claims for services and expenses in opposing the delinquency proceeding;
- Class 9. Claims for penalties, forfeitures and punitive damages;
- Class 10. Late filed claims;
- Class 11. Surplus notes or similar obligations;
- Class 12. Interest on allowed claims if approved by receivership court;
- Class 13. Claims of shareholders or other owners in their capacity as shareholders.

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

Realistically, administrative expenses and guaranty association expenses may exhaust the estate's assets. Therefore, policyholders must rely upon state insurance guaranty funds for the payment of

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<sup>152</sup> 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).

claims and the return of unearned premiums. Once a guaranty fund pays a claim, it is subrogated to the rights of the 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. § 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.<sup>153</sup>

North Carolina has addressed the question of which associations will be subject to the early access statute.<sup>154</sup> 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,<sup>155</sup> the court held that a guaranty fund was entitled to a credit balance held by a reinsurance facility. The court rejected the argument that the credit balance was an asset that the receiver could recover. The guaranty fund was perceived as standing in the shoes of the insolvent insurer since it paid all claims against the insurer. The court reasoned that by giving the money to the guaranty fund, it placed more money in the hands of the member insurers, thus lowering the fund's costs and policyholders' premiums.

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

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

### **1. Subrogation**

When a guaranty association pays a claim on behalf of an insolvent insurer, the guaranty association is generally considered to step into the shoes of that insurer. Then, through subrogation, a guaranty association may seek indemnity from a third party as if it were the insolvent insurer.<sup>156</sup> Model #540 Section 8A(2) provides:

- The association shall...

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<sup>153</sup> Liquidation Model Act, at Section 38; IRMA §803 B.

<sup>154</sup> See *State of North Carolina v. Reserve Ins. Co.*, 303 N.C. 623 (1981).

<sup>155</sup> *North Carolina Reinsurance Facility v. North Carolina Ins. Guar. Ass'n*, 67 N.C. App. 359, 313 S.E.2d 253 (1984).

<sup>156</sup> 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).

- 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.<sup>157</sup>

## 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:

- The Association shall have the right to recover from the following persons the amount of any “covered claim” paid on behalf of such person pursuant to the Act:
  - Any insured whose net worth on Dec. 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds \$50 million and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act; and
  - Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act.

Thus, a guaranty association may effectively seek reimbursement for claims paid on behalf of parties whose assets exceed a statutorily given threshold.<sup>158</sup> 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 for significant impact on the relationship between life and health guaranty associations and receivers. Because guaranty association statutes 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.<sup>159</sup> 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 the National Organization of Life and Health Insurance Guaranty Associations (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

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<sup>157</sup> See generally *Dan Reid Ford, Inc. v. Feldman*, 421 So. 2d 184 (Fla. App. 5th Dist. 1982).

<sup>158</sup> But see *North Carolina Ins. Guar. Ass’n. v. Guilford Tech*, 648 S.E.2d 859 (2007) (Sovereign immunity prevents Association from recovering payments made on behalf of high net worth insured)

<sup>159</sup> See NAIC Life and Health Insurance Guaranty Association Model Act [hereinafter Model #520].

addition, guaranty associations may exercise the right to determine these legal issues locally through declaratory judgment actions.<sup>160</sup>

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.<sup>161</sup>

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.<sup>162</sup>

## **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.<sup>163</sup> 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.<sup>164</sup> 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.<sup>165</sup> 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.<sup>166</sup>

## **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.<sup>167</sup>

## **D. Triggering of Guaranty Associations**

Guaranty associations primarily act after the entry of an order of liquidation upon the finding of insolvency. However, some statutes give guaranty associations discretion to act in cases of an impaired insurer to guarantee, assume or reinsure any or all policies or otherwise provide money to the insurer. Some statutes empower guaranty associations to act only after the liquidation order becomes final.<sup>168</sup> In

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<sup>160</sup> See *New Mexico Life Insurance Guaranty Assoc. v. Moore*, 93 N.M. 47, 596 P.2d 260 (1979).

<sup>161</sup> *Pennsylvania Life & Health Ins. Guaranty Ass'n v. Superior Court*, 22 Cal. App. 4th 477, 27 Cal. Rptr. 2d 507 (Ct. App. 1994).

<sup>162</sup> *In the Matter of Estate of Medicare 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).

<sup>163</sup> See *Maryland Life and Health Insurance Guaranty Association v. Perrott*, 301 Md. 78, 482 A.2d 9 (1984).

<sup>164</sup> See Model #520, at Section 8J.

<sup>165</sup> *In the Matter of the Liquidation of American Mutual Liability Insurance Co.*, 417 Mass. 724, 632 N.E.2d 1209 (Mass. 1994).

<sup>166</sup> *Texas Life, Accident, Health & Hospital Service Insurance Guaranty Association v. Gaylord Entertainment Co.*, 105 F.3d 210 (5th Cir. 1997).

<sup>167</sup> 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 (3<sup>rd</sup> Cir. 1996). See also *Quackenbush v. Allstate*, 517 U.S. 706 (1996).

<sup>168</sup> See Model #520, *supra* note 147, at Section 8A.

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 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. In like manner, an insured may be unable to obtain new health insurance or, at least, he may lose protection for prior illness."<sup>169</sup> Some guaranty associations may offer substitute coverage either by reissuing terminated coverage or issuing alternative policies.

Often, an attempt will be made to rehabilitate the company. This is particularly appropriate if the reason for the company's troubles is investments, such as real estate, that have not increased in value as expected. By restructuring the policyholders' contracts and prohibiting policyholders from withdrawing money for a period of time, it may be possible to allow the investments to realize their full potential.

If rehabilitation is not possible, attempts will likely be made to find a company that will guarantee, assume or reinsure the life policies and annuity contracts of the insolvent insurer. The receiver and the guaranty associations will generally cooperate closely in this effort. Life insurance insolvencies often involve many states because most life companies offer their products in multiple states. Therefore, the receiver may have to work with many guaranty associations. This effort can be facilitated and coordinated by NOLHGA (See Chapter 6(III)(A).)

### **F. Assumption Reinsurance**

Whenever possible, NOLHGA will assist the receiver in transferring future policy obligations to a solvent insurer.<sup>170</sup> This may require executing numerous assumption reinsurance documents and extensive cooperation between the guaranty associations and the receiver. The assuming carrier may be required to obtain approval of assumption certificates in the states where the insurer did business. The NOLHGA may also assist the receiver in resolving a number of particular legal issues including policyholder notice, policyholder consent, contingent liability accounting and preservation of tax losses or other tax benefits. Whether the receiver or the guaranty associations are entitled to the ceding commission is subject to debate.<sup>171</sup>

### **G. Residency**

Following Model #520, all guaranty association laws limit their protection generally to policyholders who reside in the state.<sup>172</sup> 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 are usually covered by

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<sup>169</sup> See Model #520, *supra* note 147, at, Section 8L.

<sup>170</sup> See Model #520, at Section 8M.

<sup>171</sup> For one of the few disputes which has led to completed litigation, see *Continental Security Life v. Missouri Life and Health Ins. Guar. Assn.*, Cole County Cr. Ct., Case No. CV189-546CC 12-16-94, holding that ceding commissions are assets of the estate; however, insolvency plans in other cases have been structured and approved by courts on a different basis.

<sup>172</sup> See Model #520, at Section 3A.

the guaranty association of the domiciliary state of the insolvent insurer.<sup>173</sup> A related issue is whether the guaranty association laws of the other state provides substantially similar coverage for residents of the domiciliary state. This issue has been addressed by two states.<sup>174</sup> Another related issue that Idaho has addressed is how the obligations of relevant guaranty associations are affected by the residency of a certificate holder under a group policy.<sup>175</sup> Finally, an emerging legal issue is the coverage eligibility of residents who are not citizens of the U.S.<sup>176</sup> Under Model #520, the situs of coverage for unallocated annuities is the state of the principal place of business of the plan sponsor.<sup>177</sup> The situs of coverage for structured settlement annuities is the residency of the payee.<sup>178</sup>

## H. Eligibility of Insurer

A guaranty association is obligated to provide benefits to those persons who are covered under contracts issued by a “member insurer.”<sup>179</sup> The definition of “member insurer” varies from state to state. For example, one case discussed whether certain group health insurance for a self-funded trust constituted “direct disability insurance” under the state’s guaranty association act.<sup>180</sup> Similar disputes have generated litigation over whether health maintenance organizations are to be included under a non-model act.<sup>181</sup> The courts have not yet addressed a number of legal issues regarding the eligibility of an insolvent insurer in instances involving mergers or assumptions occurring between various combinations of licensed and unlicensed companies.<sup>182</sup> Under the Model #520, a health maintenance organization is excluded from the definition of “member insurer.”<sup>183</sup>

## I. Exclusions from Coverage

There are specific exclusions from guaranty association coverage,<sup>184</sup> including reinsurance unless assumption certificates have been issued<sup>185</sup> and any portion of a contract under which the risk is borne by the contract holder.<sup>186</sup> Local variances in statutory language may lead to legal disputes. In one case decided under New Mexico’s guaranty association act, the court found that the insurer’s single premium deferred annuity contracts were not included among the covered contracts.<sup>187</sup> Other states have specific exclusions for municipal guaranteed interest contracts, unallocated funding obligations or structured settlements.<sup>188/189</sup> Also, Minnesota held that certain unallocated funding obligations must be included in

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<sup>173</sup> See Model #520, at Section 3A(2)(b).

<sup>174</sup> See Idaho Attorney General Opinion No. 78-35, 1978 Op. Atty. Gen’l. 140 (8-24-78).

<sup>175</sup> See Idaho Attorney General Opinion No. 78-35, 1978 Op. Atty. Gen’l. 140 (8-24-78).

<sup>176</sup> 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.

<sup>177</sup> See Model #520, Section 3A(3)(a).

<sup>178</sup> See Model #520, at Section 3A(4)(a).

<sup>179</sup> See Model #520, at Section 5L.

<sup>180</sup> See *SouthTrust Bank of Alabama v. Alabama Life and Disability Ins. Guaranty Assn.*, 578 So. 2d 1302 (Ala. 1991). See also *Intervenor Policyholders of American Indemnity Trust v. Oklahoma Life and Health Ins. Guar. Assn.*, 825 P.2d 1341 (Okla. 1992).

<sup>181</sup> See *New Mexico Life Ins. Guaranty Assn. v. Moore*, 93 N.M. 47, 596 P.2d 260 (1979).

<sup>182</sup> Model #520, at Section 3B(2)(f).

<sup>183</sup> See Model #520, at Section 5L(2).

<sup>184</sup> See Model #520, at Section 3B(2).

<sup>185</sup> See Model #520, at Section 3B(2)(b).

<sup>186</sup> See Model #520 at Section 3B(2)(a).

<sup>187</sup> See *New Mexico Life Ins. Guar. Assn. v. Quinn & Co.*, 111 N.M. 750, 809 P.2d 1278 (1991).

<sup>188</sup> See Model #520, *supra* note 147, at Section 3B(2)(g) and (h). California is one of over a dozen jurisdictions whose guaranty fund statutes have for certain periods specifically excluded unallocated funding obligations from coverage. New York is one of the jurisdictions that specifically covers such obligations.

the “annuity” assessment base. This issue directly affected the capacity of the guaranty fund to pay the outstanding claims.<sup>190</sup> Guaranty association statutory coverage for guaranteed investment contracts varies across the country with approximately 26 guaranty associations covering them to some extent, 25 excluding coverage and one silent on the subject. Arizona, Maryland and Pennsylvania held that certain guaranteed investment contracts were covered contracts.<sup>191</sup> Courts in California, Michigan, New Mexico, Oklahoma, South Carolina, Texas and Virginia have reached opposite conclusions.<sup>192</sup>

## J. Benefit Limitations

An Illinois court held that a guaranty association’s liability to annuitants was limited only as to the annuitants’ rights to withdraw part or all of the immediate value of the contract before maturity.<sup>193</sup> The guaranty association argued that the law limited their obligation to \$100,000 because annuity payouts were based on cash value. The Illinois Director of Insurance argued that the \$100,000 limit referred only to the right to withdraw part of the cash value prior to maturity and that the general \$300,000 limitation should apply. The court held that the guaranty association law should be construed liberally to effect its purpose in protecting policyholders and ruled in favor of the higher limitation.<sup>194</sup>

There is some variation from state to state in the dollar limits of specific benefits by guaranty associations. In addition, life and annuity contracts may be subject to interest limitations as set forth in the Model #520.<sup>195</sup> And finally, at least one state’s guaranty association applies a deductible to certain life and health claims.<sup>196</sup>

## K. Priority of Claims

The priority of distribution from an insolvent insurer’s estate may become the subject of differing legal interpretations, such as in the context of the appropriate priority for life and health administrative claims of various sorts submitted by guaranty funds. 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.<sup>197</sup> This preservation of statutory priority to guaranty association claims over those of the federal government was confirmed recently in *Ruthardt v. United States of America*.<sup>198</sup>

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<sup>189</sup> The Iowa Life and Health Guaranty Association for certain periods has not covered structured settlement annuities.

<sup>190</sup> See *Minnesota Life and Health Ins. Guaranty Assn. v. Dept. of Commerce*, 400 N.W.2d 769 (Minn. Ct. App. 1987).

<sup>191</sup> *Arizona Life & Disability Ins. Guar. Fund v. Honeywell, Inc.*, 190 Ariz. 84, 945 P.2d 805 (Ariz. 1997); *Board of Trustees of the Maryland Teachers & State Employees Supplemental Retirement Plans v. Life and Health Ins. Guar. Corp.*, 335 Md. 176, 642 A.2d 856 (1994); *UNISYS Corp. v. Pennsylvania Life and Health Ins. Guar. Ass’n.*, 667 A.2d 1199 (Pa. Cmwlth. 1995), *aff’d*, 684 A.2d 546 (1996).

<sup>192</sup> *UNISYS Corp. v. California Life and Health Ins. Guar. Ass’n.*, 63 Cal. App. 4th 634, 74 Cal. Rptr. 2d 106 (Ct. App., 1998); *Henry L. Meyers v. Michigan Life & Health Ins. Guar. Ass’n.*, 222 Mich. App. 675, 566 N.W. 2d 632 (1997); *Krahling v. First Trust National Assoc.*, 944 P.2d 914 (N.M. Ct. App. 1997); *Oklahoma Life & Health Ins. Guar. Ass’n. v. Hilti Retirement Sav. Plan*, 939 P.2d 1110 (Okla. 1997); *South Carolina Life and Accident and Health Ins. Guar. Ass’n. v. Liberty Life Ins. Co.*, 500 S.E.2d 193 (S.C. Ct. App. 1998), *aff’d*, 2001 S.C. Lexis 63 (S.C. April 2, 2001); *Unisys Corp. v. Texas Life, Accident, Health & Hospital Serv. Ins. Guar. Ass’n.*, 943 S.W.2d 133 (Tex. Ct. App. 1997); and *Bennet v. Virginia Life, Accident and Sickness Ins. Guar. Ass’n.*, 251 Va. 382, 468 S.E.2d 910 (1996).

<sup>193</sup> See *Matter of Georgetown Life Ins. Co.*, 148 Ill. App. 3d 360, 102 Ill. Dec. 204, 499 N.E. 2d 984 (1st Dist. 1986), appeal denied, 106 Ill. Dec. 46, 506 N.E. 2d 352 (1987).

<sup>194</sup> *Id.*

<sup>195</sup> See Model #520, *supra* note 147, at Section 3B(2)(c).

<sup>196</sup> See e.g., Wis. Stat. Ann. Section 646.31(3) (West 2000).

<sup>197</sup> 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.

<sup>198</sup> *Ruthardt v. United States of America*, 303 F.3d 375 (1<sup>st</sup> Cir. 2002).

In *Ruthardt*, the United States Court of Appeals for the 1<sup>st</sup> 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' reimbursement claims.<sup>199</sup>

Litigation has arisen concerning the status of various claims under pertinent state liquidation statutes. In a major liquidation proceeding, the California Insurance Commissioner, acting as conservator, determined that owners of Municipal Bond Guaranteed Investment Contracts (Muni-GICs) would not be given claims priority status as "policyholders" but would be given lower priority status (all other claims). In reversing this determination, a California appellate court examined California's liquidation statute and the historical treatment of annuities-certain, and ruled that Muni-GICs are entitled to liquidation priority as "policyholder claims."<sup>200</sup>

## **L. Early Access**

### **1. General**

For a discussion of the general legal issues surrounding early access distributions to guaranty associations, see above (refer to specific section for P&C). The availability of early access is important in life and health insurer insolvencies, which often involve the transferring policy obligations through assumption reinsurance. Guaranty associations typically incur significant up-front costs in those transactions. Early access distributions are an effective way of defraying those costs, thereby lessening the need for assessments on member insurers.

### **2. Security Deposits**

Early Access agreements between receivers and guaranty associations often provide that any security deposit obtained by the guaranty association will be treated as an early access distribution. However, in a U.S. Supreme Court decision, it was decided that the guaranty association could not claim the sole right to a local deposit when the Indiana domiciliary rehabilitation court previously had approved a plan that included the deposit.<sup>201</sup>

## **M. Enhancement Plans**

In recent life insurer insolvencies, receivers working in cooperation with NOLHGA, affected guaranty associations, and in some cases the insurance industry, developed innovative plans to remedy the insolvency and benefit 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 contributions from the insurance industry to protect the account values of uncovered policyholders and the creation of a new insurance company by NOLHGA and the affected guaranty associations to assume the business of the failed insurer.<sup>202</sup>

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.<sup>203</sup>

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<sup>199</sup> "[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.* at 382.

<sup>200</sup> *Texas Commerce Bank v. Garamendi*, 11 Cal. App. 4th 460 (Ct. App. 1992).

<sup>201</sup> See *North Carolina Life and Accident and Health Insurance Guaranty Association v. Underwriters National Assurance Co.*, 48 N.C. App. 508, 269 S.E.2d 688 (1980), *rev'd*, 455 U.S. 691 (1982).

<sup>202</sup> See e.g., the Rehabilitation Plans for Executive Life Insurance Company, Mutual Benefit Life Insurance Company, and Guaranty Security Life Insurance Company.

<sup>203</sup> *Lawrence v. Illinois Life & Health Guar. Assn.*, 688 N.E.2d 675 (Ill. App. Ct. 1997).



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.<sup>204</sup>

## N. Constitutional Issues

The constitutionality of the general guaranty association mechanism and assessment process was established by the Supreme Court of the State of Washington in a 1974 decision.<sup>205</sup>

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.<sup>206</sup>

## 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).<sup>207</sup> 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 may be important to orderly receivership proceedings. Data can also constitute important evidence in legal proceedings. Electronically stored data is no exception.

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.

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<sup>204</sup> 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.

<sup>205</sup> *Aetna Life Ins. Co. v. Washington Life & Dis. I.G. Ass'n.*, 83 Wash. 2d 523, 520 P.2d 162 (1974).

<sup>206</sup> 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.

<sup>207</sup> 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.

- **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.

#### **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.”<sup>208</sup> In § 104V(3) of IRMA, the definition of “property of the insurer” or “property of the estate,” includes:

All records and data that are otherwise the property of the insurer, in whatever form maintained ... within the possession, custody or control of a managing general agent, third-party administrator, management company, data processing company, accountant, attorney, affiliate or other person.

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<sup>208</sup> Fed. R. Civ. P. 34(a).

See also § 118 A. of IRMA, which requires TPAs, MGAs, agents, attorneys and other representatives of the insurer to release records to the receiver.

Once the order is obtained, the seizure must be executed in such a way as to minimize the likelihood that any valuable information will be inadvertently or deliberately lost. Typically, immediately preceding the seizure, the state's examiners will be focusing on the insurer. During this time, the examiners will obtain an understanding as to how the insurer maintains its data, where such data is located and who has access to modify the data. When fraud by officers or others with access to data is suspected, special efforts should be made to execute the seizure in such a way as to preserve that data, especially private notes and communications that may be found on personal computers.

The decision as to whether a computer contains useful data should be made only by a data processing expert. Often, data that would appear to a novice to have been deleted from a computer can in fact be retrieved by a person who is knowledgeable about the computer system. This is especially true of personal computers. When a file is deleted from a personal computer, the file actually remains on the disk, but the computer designates the space occupied by those files as available to be overwritten with new information. A knowledgeable data processing person can recover the original file, which may contain valuable information.

## **B. Legal Action Against Others to Obtain Data**

While a court order will permit a receiver to assert control over records of the insurer that are in the hands of third parties, it may be necessary to enforce the order against those parties. If the receiver believes that a third party will not voluntarily comply with the order, or does not trust the third party to properly comply with the order, it may be necessary to enlist the assistance of courts and law enforcement to obtain compliance.

The initial question is whether data in possession of a third party really is a record of the insurer. This question is typically answered by applying state law to the relationship between the third party and the insurer. Agreements between the insurer and agents, especially MGAs, may provide that the records of the agent, including not only policy and claims information, but also customer lists, are the property of the insurer. These agreements may also give the insurer the right to audit the third party and obtain copies of data in possession of that third party. Even without an agreement specifically designating the third party's records as the property of the insurer, applicable state law may impose trust or fiduciary obligations upon the third party deeming the third party's data as records of the insurer.

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 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.

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 estate in connection with an insurer's insolvency. The legal matters reviewed herein are by no means conclusively established; consultation with counsel is essential.

Jurisdictional issues discussed in detail in this chapter in section II(H)—Important Legal Procedural Issues, should be considered in connection with matters discussed in this section.

#### 1. Receiver's Authority to Sue

The authority of the receiver to assert a cause of action is established by relevant state statute and the receivership court's order, see also § 402 and § 504 of IRMA.

#### 2. Receiver's Standing

It is now well established throughout the U.S. that the breadth of a receiver's standing is defined by the language of its statutory authorization. Statutes that vest the receiver with "title to all property, contracts and rights of action of the company" are typically construed to authorize the receiver to bring any suit the company could have brought, but no others.<sup>209</sup> 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.<sup>210</sup>

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.<sup>211</sup>

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

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<sup>209</sup> E.g., *Schacht v. Brown*, 711 F.2d 1343, 1346 n.3, (7th Cir.), cert. denied, 464 U.S. 1002 (1983).

<sup>210</sup> 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."

<sup>211</sup> 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).

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.<sup>212</sup>

While it is well established that the receiver has standing to bring suit, states are divided on the question of whether that standing is exclusive. That is whether the fact that the receiver had standing to assert a claim on behalf of a creditor or policyholder of the insolvent insurer precludes that creditor or policyholder from asserting that same claim on his or her own. Some states have said that the receiver's right must be paramount and exclusive so as to avoid disorder and confusion in the administration of the insolvent insurer's affairs. § 504 A(10) of IRMA provides in relevant part:

The liquidator shall have the power: .... To prosecute or assert with exclusive standing any action that may exist on behalf of creditors, members, policyholders or shareholders of the insurer or the public against any person, except to the extent that the claim is personal to a specific creditor, member, policyholder or shareholder and recovery on the claim would not inure to the benefit of the estate...

Courts in other states have ruled, however, that while the receiver clearly has standing to represent injured policyholders and creditors of an insolvent insurer, standing is non-exclusive. The receiver should consult counsel to determine whether the receiver's standing is exclusive or non-exclusive in the applicable jurisdiction.

## **B. Audit/Investigation of Financial Statements**

The question of the accurate preparation of financial statements is at the core of the management's duty to the insurer, and thus, at the heart of the receiver's analysis of the insolvent estate. The following is a discussion of potential claims against third parties for their willful and/or negligent damage to the insurer through their acts leading to the misrepresentation of the insurer's financial condition. It must be stressed, however, that any potential claim and/or suit must be evaluated by the receiver's attorneys to determine the utility and the cost-effectiveness of bringing the claim and/or suit.

### **1. Claims Against Accountants and Actuaries**

#### **a. Misrepresentation of Solvency**

The outside accountants of an insurer owe a duty to the insurer to perform their audits in adherence with professional standards required by the American Institute of Certified Public Accountants (AICPA), applicable state statutes and common law. The outside accountants may be liable for failure to adhere to these standards. Increasingly, insurers employ actuaries to certify loss reserves. Those actuaries are also held to a standard of professionalism when they render a loss reserve certification. A serious deviation from good accounting and/or actuarial practices may render the actuaries and accountants liable for damages. If the accountants and/or actuaries fail to fulfill their duties with respect to an insurer which subsequently is discovered to be insolvent, such failure may give rise to liability to the estate, as well as to policyholders, cedents, reinsurers and other interested third parties.

Accountants render opinions when they audit financial statements. An unconditional opinion is generally considered to be a sign of good financial health by industry, investors and the public. The refusal to render an audit opinion or an audit opinion with conditions is an indication that the

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<sup>212</sup> 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).

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.

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.<sup>213</sup>

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

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<sup>213</sup> 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).



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 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 attorneys, its internal audit reports, its bankers' loan files, its consultants, 'managing general agents' and reinsurance intermediaries' files, as well as the file of Insurance Department officials who regulated or examined the company prior to insolvency.

### **C. Voidable Preferences**

#### **1. Terms of Specific Statute Govern**

A receiver is authorized to reclaim property transferred by the insolvent insurer to another party if the transaction constituted a "voidable preference" as defined by statute. In general, these statutes permit the receiver to recover certain assets which were transferred by the insurer in order to satisfy prior debts and which result in some creditors receiving a greater share of the insurer's assets than other creditors similarly situated. A preferential transfer under IRMA § 604 may be to or for the benefit of a creditor. The statutes in place in various states differ significantly in substance, scope and form. Some states, in fact, do not have a voidable preference statute. A receiver should consult the applicable statutes in the receiver's state to ascertain if there is a voidable preference rule and, if so, to learn the particular requirements of that statute.

#### **2. General Elements of Voidable Preferences**

Generally, voidable preference statutes authorize receivers to avoid transactions meeting all of the following requirements:

##### **a. Transfer of Property of the Insurer**

The transaction must involve a transfer of the insolvent insurer's property before the receiver may have a right to reclaim the transferred assets. Transfers by third parties, such as bank payments on a letter of credit which was issued at the request of the insolvent insurer, are not voidable by a receiver as a preference. The issuance of collateralized letters of credit, however, may constitute indirect transfers, which may be voidable.

Similarly, receivers cannot recover property held in trust by the insolvent insurer that is transferred to its beneficial owner because the insurer does not hold this property for its own use, but only for the use of the beneficial owner. However, if the insurer's property is transferred into the trust during the preference period, the transaction may be voidable.

##### **b. Transfer During Specified Time Period**

Voidable preference statutes only permit receivers to recover transfers which occur within a particular time period immediately preceding the receivership proceedings. This period of time is frequently referred to as the "preference period." Property transferred before the preference

period generally is not recoverable under voidable preference statutes (although the property may be recoverable under other theories). While this is generally true, some statutes contain an exception to this rule. (See below.)

The preference period may vary from four months to two years depending upon the particular state's law. In addition, many statutes provide longer preference periods for transfers involving directors, officers, substantial shareholders or other persons with significant influence over the affairs of the insolvent insurer than they do for transfers to parties totally unrelated to the insurer. Depending upon the state, the preference period may be measured from the date of the liquidation order, the rehabilitation order, the order declaring the insurer insolvent, or the filing of the liquidation, rehabilitation or conservation proceeding. Again, the receiver must consult state law on this issue.

Receivers should be aware that controversies may arise over the exact timing of a particular transfer if the transfer involves anything more complex than a cash payment. Courts are divided evenly on relatively common transactions, such as check payments. Some courts have ruled that the transfer occurred upon delivery of the check, while others have ruled that the transfer occurred when the bank honored the check.

As an alternative to proving that the transfer occurred during the preference period, some statutes provide that the receiver may void a transaction if the receiver establishes that the insurer was insolvent at the time of the transfer, even though the transfer occurred before the preference period.

c. Transfer Must be Made in Order to Satisfy an Antecedent Debt

Most voidable preference statutes authorize receivers to avoid transactions only when the transactions involve transfers to creditors in satisfaction of an “antecedent debt,” that is, transactions which do not constitute substantially contemporaneous exchange. Payments in exchange for contemporaneous transfers of goods or services are generally not voidable by the receiver under these statutes.

Sophisticated and complex transactions may involve controversial determinations of exactly when the insurer incurred the debt (that is, whether the debt is an antecedent debt). Transactions involving contingent liabilities may also be controversial because they involve uncertain liabilities which will be incurred by the insolvent insurer in certain circumstances. It is not clear in what circumstances these contingent liabilities may constitute an antecedent debt. These determinations are highly fact-dependent, and the conclusions may vary from jurisdiction to jurisdiction.<sup>214</sup>

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

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<sup>214</sup> See *Wilcox v. CSX Corp.*, 70 P.3d 85, 473 Utah Adv. Rep. 25, 2003 UT 21(2003).

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.

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. § 605 of IRMA addresses fraudulent transfers.

### 2. Elements of Fraudulent Transfer

The fraudulent transfer laws perform a function similar to the purpose of voidable preference statutes. Both laws authorize the receiver to rescind certain transactions and bring previously transferred assets back into the insolvent insurer's estate. The voidable preference statutes, however, address transfers made to satisfy antecedent debts which result in some creditors receiving a greater percentage of their debt than other creditors in the same class (see previous discussion). The fraudulent transfer laws deal with transfers for inadequate consideration and with transfers aimed at obstructing or defrauding other creditors.

Fraudulent transfer laws vary from state to state, but most laws permit the receiver to avoid transactions which meet the following requirements:

#### a. Transfer for Unfair Consideration or with Fraudulent Intent

Many fraudulent transfer laws require the receiver either to demonstrate that the insolvent insurer did not receive "fair consideration" for the transfer or to establish that the transaction was made with the intent to hinder, delay or defraud other creditors in order for the receiver to rescind the transaction as a fraudulent transfer and thereby recover the transferred assets.

#### b. Transfer During Specified Time Period

Fraudulent transfer statutes typically apply only to transfers made within one year prior to a particular stage of the receivership proceedings, such as the filing of a successful petition for receivership. The particular time period, however, varies in different states, and the receiver should consult counsel to determine the rule in the particular jurisdiction. Issues addressed in the voidable preferences section concerning potential disputes as to the timing of a particular transaction are equally relevant in the context of fraudulent transfers. The receiver should consult the previous discussion of voidable preferences for further information on this issue. Simply stated, the exact timing of a particular transfer (and especially a transfer involving a complex commercial transaction) is not always clear and can cause disputes as to the applicability of a fraudulent transfer law to the particular transaction.

#### c. Status of Insurer

Some states may require the receiver to show that the insurer was insolvent or otherwise financially impaired at the time of the transaction (or became insolvent because of the transaction) in order to attempt to recover a fraudulent transfer.

#### d. Distinct Rules for Reinsurance Transactions

Many states impose different standards on reinsurance commutations occurring within the fraudulent transfer period. The receiver may be able to rescind a commutation with a reinsurer if the receiver can prove that the insolvent insurer did not receive the present fair equivalent value

of its release of the reinsurer from liability. The receiver should consult Chapter 7—Reinsurance for further information on this subject.

### 3. From Whom Can the Receiver Recover the Amount of the Transfer?

Receivers may recover the value of the fraudulent transfer from the person who received the transfer from the insurer. Receivers also may be able to recover the value of the transfer from other persons who are subsequent holders of the transferred property, although many statutes do not permit recovery from such persons if they provided present fair equivalent value for the property when they procured it. In addition, the receiver may be able to assert a claim against persons who participated in the transfer, such as directors, officers, employees or other “insiders” of the insolvent insurer. The potential liability of such persons is discussed in greater detail under a separate heading in this chapter.

### 4. Mechanics of Recovery of Fraudulent Transfers

To recover assets conveyed in transactions which constitute fraudulent transfers, the receiver needs to commence suit within the period of the applicable statute of limitations. Counsel should be consulted as to procedural requirements.

### 5. Typical “Red Flag” Transactions

To the degree practicable, the receiver should examine all transactions which occur during the fraudulent transfer period to see if the transfers may be rescinded. Receivers should pay special attention to extraordinary dividend payments to stockholders, commutation agreements with reinsurers, related party transactions, portfolio transfers, surplus relief reinsurance treaties and any unusual disbursements. While all of these transactions may be entirely innocent, they can also be tainted by fraudulent intent or by unfair consideration which may enable the receiver to rescind the transactions.

## **E. Related-Party Transactions**

A common “target” of receivers involves improper or questionable transactions between the insurer and those “related” to it, including parent corporations and shareholders, prior to insolvency.

### 1. Holding Company Act

The Insurance Holding Company System Regulatory Act (the Holding Company Act) constitutes an extensive statutory scheme regulating among other things, the registration, reporting, examination, acquisition and control by holding companies of an authorized insurer. By statute, “control” is presumed if the holding company owns 10% or more of the voting shares of an insurer. Furthermore, the Holding Company Act requires that all material transactions must first obtain regulatory approval, and that in any event, all transactions between the holding company and the “held” insurer must be “fair and equitable.” As such, any transactions between the now insolvent insurer and the controlling party which do not meet the standard (preferences, non-arms-length transactions) may be attacked by the receiver under those statutes.

### 2. Piercing the Corporate Veil

The ability of a receiver to assert a successful “piercing the corporate veil” claim against the former parent or shareholder of an insolvent insurer will necessarily depend upon the elements of such a claim under the relevant state’s laws. Defendants, however, have often attacked such a claim as a matter of law in arguments that closely relate to standing arguments. In essence, defendants have argued that receivers only have standing to sue on behalf of the fallen insurer and, therefore, argue

that a corporation may never pierce its own veil.<sup>215</sup> Nevertheless, it can be argued that the receiver also represents creditors and policyholders who can clearly assert alter ego claims or piercing the corporate veil claims. In addition, there is a fundamental difference between an “alter-ego” action brought by a receiver and that brought by a viable corporation. When a viable corporate entity sues on its own behalf, it is in essence suing for the benefit of its shareholders. Thus, a suit by a viable corporate entity seeking to pierce its own veil is the equivalent of a suit by a corporation (for the benefit of its shareholders) against its shareholders. As such, many courts have found that such an action must fail. Where, however, the corporate entity is in receivership, the receiver’s suit is for the benefit of the insurer’s creditors. In such a setting, the interests of the party plaintiff (i.e., the receiver on behalf of the estate, representing among others, the creditors) differs from the defendants (the shareholders).

In addition, the Holding Company Act expressly contemplates actions against holding company systems which own and control an insurer. In fact, one of the provisions typically found in these statutes mandates that officers and directors of a controlled insurer manage the insurer so as to assure its separate operating identity. Violation of that statute, coupled with the express right of action under a separate provision, clearly contemplates an alter ego or piercing the corporate veil claim under insurance laws.

#### **F. Other Suspect Transactions**

Besides the above enumerated transactions which are not exhaustive, it is possible that aspects of or the intent of any transaction may be fraudulent. Therefore, all material transactions should be investigated to see if they indicate fraud, self-dealing, violation of law, conflict of interest, etc. Insolvency may be accompanied by acts which render the management, board of directors or vendors of services liable for damages. Recovery of these damages will increase the assets of the estate and, thus, the amount available for distribution.

#### **G. Potential Actions Against Unrelated Third Parties**

In the examination of the insolvent insurer, the receiver may come across possible causes of action to bring against third parties and present all such findings to counsel. The rights to bring a suit and/or make a claim must be evaluated in terms of the relevant statutes and case law.

##### **1. MGA/Agent/Broker**

Although producers share certain characteristics, only agents (including MGAs) represent the insurer and ordinarily owe a duty to the insurer. Nevertheless, in certain states, brokers may owe a duty to the insurer. There are states in which all producers are deemed agents. Consult an attorney to determine the duty owed by the producer. Under the insurance laws, almost all states require producers to maintain trust funds which are held to pay premiums to insurers and for other purposes. MGAs who underwrite business must comply with the legal requirements of the rating law and may not underprice the business so as to make it unprofitable. MGAs may have violated underwriting guidelines or made claim payments in violation of guidelines set up by the insurer. This may make them liable under a breach of contract theory if their agency agreement required adherence to insurer guidelines. In particular, a MGA may have had binding reinsurance authority. Breaches of authority, lack of good faith or other acts may make the MGA liable under a contract or tort theory depending on the acts committed.<sup>216</sup>

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<sup>215</sup> *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).

<sup>216</sup> E.g., *Omaha Indemnity Company v. Royal American Managers*, 777 F. Supp. 1488 (W.D. Mo. 1991).

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 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.

Close attention should be paid to the security provided to the company by its reinsurers, including letters of credit and trust accounts. These should be reviewed early to determine whether there is compliance with the obligations under the reinsurance treaties. To assure the reinsurer does nothing to diminish the security as a result of the receivership, it is essential for the receiver to provide notice of the insurer's receivership to all institutions that have issued letters of credit or are acting as the escrow agents. The same parties should also be advised that the receiver must be notified of any transaction that may affect the security. Once it is determined that the security is in place, it is still necessary to continue to monitor the security during the receivership to ensure that it remains in place, including seeing that letters of credit are renewed and that security is increased pursuant to the reinsurance agreement, if appropriate.

#### b. Fraudulent Transactions

The beneficiary of a fraudulent transaction may, under many state fraud statutes, owe the proceeds back to the insurer. (See the section on Investigation and Asset Recovery in this chapter.)

## H. Dividends and Intercompany Transactions

State insurance codes have strict limitations on how much money can be paid as dividends by insurance companies to their shareholders. All dividends paid by the company should be reviewed to determine compliance with these limitations. The receiver should also examine whether the financial statements were manipulated to make otherwise impermissible dividends appear valid.

As part of this process, intercompany transactions should be reviewed to look for disguised dividends. The company may have entered into cost sharing agreements, tax sharing agreements, marketing agreements and other such transactions with affiliates. These transactions should be reviewed closely. When a company is foreclosed from issuing dividends, it may try to disguise dividends as transactions pursuant to these agreements.

Illegal dividends may be recovered in actions for fraud or breach of fiduciary duty. Additionally, some insurance codes allow the receiver to recover all dividends, whether lawful or unlawful, that were made during a stated time period prior to the receivership. Furthermore, the failure of the company's auditors and external accountants to detect unlawful dividends may form the basis of a negligence action.

## **I. Directors, Officers and Shareholders**

### **1. Mismanagement/Negligence**

Numerous actions have been filed by receivers throughout the country against former directors and officers of now insolvent insurers for gross negligence and mismanagement that caused the insurers' insolvency. Prior to instituting action, corporate bylaws should be reviewed to determine whether corporate officers will be indemnified for defense costs for actions against them arising from the performance of their corporate duties.

Examples of mismanagement and negligence claims asserted in these actions are failure to exercise due care, breach of fiduciary duties owed by the defendant officers and directors to the corporation and its shareholders, self-dealing and the filing of false and misleading financial reports.

In addition, many of these actions have also alleged fraud and breach of fiduciary duties against an insurer's former directors and officers and the corporation's parent. Possible bases for legal action against an insurer's management or ownership are:

- Operating the insurer as a "loss leader" to enhance other elements of the controlling parties' business at the expense of the insurer;
- Failing to operate the insurer as an independent profit-making corporation;
- Permitting the insurer to violate the insurance laws;
- Managing and operating the insurer without regard to its profitability or solvency and in a manner inconsistent with prudent business practices;
- Operating the insurer to serve the interests of the controlling parties in contravention to the insurer's own interests;
- Forcing the insurer to pay monies to one or more members of the insurer's holding company system when such members performed no services for the insurer;
- Binding the insurer to extremely unprofitable policies;
- Binding the insurer to, or forcing the insurer into, highly disadvantageous arrangements with other members of the holding company system, their clients or others;
- Causing the insurer to make preferential transfers to members of the holding company system and others;
- Causing the insurer to enter into transactions with affiliates that were unfair to the insurer and in violation of the Holding Company Act;
- Failing to investigate, review, scrutinize, monitor, supervise and manage the financial affairs of the insurer to prevent its insolvency;
- Allowing the insurer to maintain inadequate books and records;

- Failing to establish and apply reasonable and prudent underwriting guidelines; or
- 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.<sup>217</sup> RICO claims against the insurer’s attorneys, solicitors, reinsurers, agents, brokers and shareholders have also been sustained.<sup>218</sup>

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.<sup>219</sup> 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.<sup>220</sup>

## 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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<sup>217</sup> 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).

<sup>218</sup> 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).

<sup>219</sup> *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.

<sup>220</sup> See *Reeves v. Ernst & Young*, 507 U.S. 170 (1993).

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.

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.<sup>221</sup> IRMA § 112 addresses the issue of defenses, which may be asserted against the receiver.

### 1. Ratification

Defendants have asserted the defense that no viable action can be brought against them since the Board of Directors ratified the complained of conduct. This defense is generally unsuccessful and considered contrary to public policy.<sup>222</sup>

Only disinterested directors and shareholders can ratify transactions. However, acts which are fraudulent, prohibited by statute or violate public policy cannot be ratified. Such acts are void rather than merely voidable.

Moreover, creditors are not prejudiced by the corporation's acts of ratification. Any ratification, even if effective, would therefore not preclude a receiver's action on behalf of the creditors.

### 2. Misconduct "Aided" Insurer

Defendants have also asserted the defense that if any misconduct occurred, it only served to place more money in the insurer's coffers by encouraging outsiders to continue doing business with the insurer and/or prolonging the insurer's existence. Courts currently respond to this defense by attempting to distinguish between conduct that injures the corporation and conduct that benefits it.<sup>223</sup>

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.<sup>224</sup> 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.<sup>225</sup>

### 3. Fiduciary Shield Doctrine

The fiduciary shield doctrine holds that the acts of an agent performed in-state for an out-of-state corporation will not form the basis for exercising jurisdiction against the agent as an individual, but may be used to subject the corporation to jurisdiction.

Courts in some states have limited the doctrine, theorizing that it would be inequitable to allow a corporate agent to assert the doctrine where the agent has committed a tort in the state.

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<sup>221</sup> 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).

<sup>222</sup> *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).

<sup>223</sup> 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.

<sup>224</sup> E.g., *FDIC v. Ernst & Young*, 967 F.2d 166 (5th Cir. 1992).

<sup>225</sup> 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).

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.<sup>226</sup>

#### 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.<sup>227</sup>

Preliminarily, it should be noted that an affirmative claim against the receiver may be barred by the liquidation order.<sup>228</sup> There is also a recognized distinction between the regulator and the receiver.<sup>229</sup> 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.<sup>230</sup>

#### 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.<sup>231</sup>

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<sup>226</sup> E.g., *Rollins v. Ellwood*, 141 Ill.2d 244, 565 N.E.2d 1302 (1990).

<sup>227</sup> 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.

<sup>228</sup> *Id.*

<sup>229</sup> *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.)

<sup>230</sup> *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).

<sup>231</sup> 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.

## 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. 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.<sup>232</sup>

## 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.

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Texas 1990); *FDIC v. Farris*, 738 F. Supp. 444 (W.D. Okla. 1989); *FDIC v. Carlson*, 698 F. Supp. 178 (D. Minn. 1988); *FDIC v. Butcher*, 660 F. Supp. 1274 (E.D. Tenn. 1987); *FDIC v. Buttram*, 590 F. Supp. 251 (N.D. Ala. 1984); *FSLIC v. Williams*, 599 F. Supp. 1184 (D. Md. 1984); *FDIC v. Bird*, 516 F. Supp. 647 (D.P.R. 1981). But see *Mutual Sec. Life Ins. Co. v. Fidelity & Deposit Co.*, 659 N.E.2d 1096 (Ind. Ct. App. 1995) (In action for coverage under fidelity bond issued to insolvent insurer limiting coverage to losses discovered by insurer during bond period, liquidator could not use "adverse domination" to toll discovery period, despite allegation that discovery delay was caused by insurer's officer).

<sup>232</sup> 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).

## 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.<sup>233</sup> IRMA § 112A provides that an allegation of improper or fraudulent conduct by management is not a defense to the receiver's action to enforce a contract unless the other party can prove that the fraud was "materially and substantially related" to the creation of the contract.

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.

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<sup>233</sup> 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).



A receiver faced with such a demand for rescission may wish to argue that granting rescission fails to take into account the governing principles of law and public policy. Further, rescission contravenes the fundamental purpose of the insurance laws throughout the country, because it would result in a significant preference to reinsurers, as compared to other creditors against the estate, many of whom are innocent policyholders.<sup>234</sup> 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.<sup>235</sup>

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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<sup>234</sup> 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*.

<sup>235</sup> 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.").

In summary, allegations of fraud could trigger efforts by reinsurers to rescind their reinsurance agreements with the insolvent insurer. While the receiver has available arguments against rescission, the receiver should be aware that the consequences to the estate are potentially severe. Counsel must be consulted and all potential ramifications explored before allegations of fraud are asserted.

## 2. Receiver's Claim of Proceeds of Directors and Officers Policy

The receiver is the successor in interest to the insurer. Therefore, the receiver has a right to claim against the directors' and officers' liability policy previously provided by the insurer. However, be advised that a claim based on fraud or intentional misrepresentation might provoke a reaction by vendors such as MGAs and reinsurers. They may argue the fraud allegedly prohibited them from rendering proper services to the insurer and, therefore, they are immune from suits and claims as described above. The directors and officers liability insurance policy, if any, may also exclude coverage of claims based upon fraud. The tension and conflict in these two positions should be noted and discussed with the estate's attorney.

## IX. REINSURANCE

### A. Introduction and Goal

The concept of reinsurance is discussed in detail in Chapter 7—Reinsurance. In this section, we will discuss the various legal issues and concepts that may arise in the course of the receivership, both where the insurer was the ceding insurer and where the insurer was the reinsurer.

This is an important area of law as reinsurance recoveries will often be the largest asset of the estate.

### B. Reinsurance Ceded and Assumed

Chapter 7—Reinsurance sets forth a detailed discussion of ceded and assumed reinsurance.

### C. Reinsurance Accounting and Collection Procedures

#### 1. Loss Notifications

Agreements between primary insurers and reinsurers generally contain a provision requiring the insurer to give prompt and adequate notice to the reinsurer in the event of a loss which may trigger the indemnity required under the agreement. Chapter 7—Reinsurance includes a discussion of notice requirements.

- Timeliness

A legal issue often encountered is whether failure to give timely notice of a claim to a reinsurer relieves the reinsurer of the obligation to make a payment based upon the claim.

Case law in this area is far from settled. Some federal and state courts have determined that before a reinsurer can avoid liability due to late notice of loss, the reinsurer must be able to show that it has been prejudiced or suffered damage as a result of the lack of notice.<sup>236</sup> 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 resulting from the breach.<sup>237</sup> This is frequently a difficult burden for a reinsurer to meet, but the prudent

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<sup>236</sup> See *Christiana General Insurance Co. v. Great American Insurance Co.*, 745 F.Supp. 150, 161 (S.D.N.Y. 1990).

<sup>237</sup> *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).

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.<sup>238</sup> The receiver should consult counsel to ascertain the applicable rule in the local jurisdiction.

## 2. Defenses to Collection Based on Contract

### a. Contract Limitations

In addition to the “late notice” defense, several other defenses to payment under reinsurance agreements may emerge. Depending upon the particular facts, reinsurers may assert that a claim arose after the expiration of either the primary coverage or the reinsurance coverage or is otherwise beyond the scope of coverage provided by the underlying insurance or the reinsurance agreement.

### b. Exclusions

Both the underlying insurance policies and the reinsurance agreement will typically include descriptions of excluded risks. Before billing reinsurers, the receiver should verify that the loss is within the covered terms of the reinsurance agreement.

## D. Secured Reinsurance

At the present time, the NAIC is considering the design of a revised United States reinsurance regulatory framework. This revised framework would establish a Reinsurance Evaluation Office. Among other things, this office would determine which other foreign countries have equivalent regulatory systems as the U.S. Reinsurers from those countries would be certified to access the United States market through a port of entry similar to foreign direct insurers. Additionally, collateral requirements would be set based on the nature of the reinsurance exposure, rather than on reserves. For a summary of the NAIC’s work on this, see *NAIC Reinsurance Collateral Update*, Brian Fuller NAIC Senior Reinsurance Manager, Sept. 27, 2007.

### 1. Credit for Reinsurance in General

U.S. licensed reinsurers are regulated in essentially the same manner as primary insurers, except for rate and form regulation. Because U.S. insurance regulators have no, or limited jurisdiction over non-U.S. reinsurers, the reinsurance transaction (as opposed to the reinsurer) is regulated through the cedent by prescribing the terms under which the cedent can take financial statement credit for reinsurance recoverables.

While an insurer can opt to obtain reinsurance that does not qualify for financial statement credit, in most circumstances, it will be very important to a ceding insurer that it be allowed to take credit on its financial statements for reinsurance which it procures. However, there is no regulatory requirement that reinsurance meet this standard.

All U.S. jurisdictions have developed standards prescribing the circumstances in which a ceding insurer is allowed to take credit for reinsurance. The credit for reinsurance laws are important to a receiver for several reasons. If a reinsurer is licensed or authorized in a state, no security is typically required. However, if a reinsurer is not licensed or authorized, it is important for a receiver to know that there may be security posted in favor of the insolvent insurer securing obligations owed to that insurer by reinsurers. Alternatively, if the insolvent insurer was a reinsurer, assets of the insolvent insurer may be encumbered elsewhere to provide security necessary for credit for reinsurance

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<sup>238</sup> *Liberty Mutual Ins. Co. v. Gibbs*, 773 F. 2d 15 (1<sup>st</sup> Cir. Mass. 1985).

purposes. This security usually takes one of three forms: letters of credit, trust funds and funds withheld.

## 2. Letters of Credit (LOC)

Situations where letters of credit are used for credit for reinsurance purposes involve three separate and distinct contractual arrangements. First, the reinsurance agreement itself usually will expressly require the reinsurer to provide security necessary for credit for reinsurance purposes. Second, there will be a contract between the reinsurer and the issuer of the letter of credit (LOC) (almost always a bank) pursuant to which the issuer agrees to issue the LOC in return for compensation. This agreement is sometimes referred to as an "account agreement." The account agreement usually requires the reinsurer to post collateral with the issuer to protect the issuer in the event that the issuer is compelled to make payment under the LOC. The third contract is the LOC itself, which is a separate and distinct contract entered into between the issuer of the LOC and the ceding insurer as the beneficiary of the LOC.

### a. Maintenance

The mechanics involved in maintaining letters of credit are discussed in Chapter 7. The receiver should bear in mind two legal issues in connection with maintenance of LOCs. First, in most cases, the reinsurance agreement will expressly impose a contractual obligation upon the reinsurer to maintain the LOC for as long as the reinsurer has outstanding obligations under the agreement. If the receiver of an insolvent ceding insurer receives notice that a LOC will not be renewed while a reinsurer's obligations are still outstanding, the receiver should consult counsel immediately. The reinsurer's actions may give the receiver a contractual right to draw on the LOC. Such failure may also provide the receiver with a basis to charge the reinsurer with breach of the reinsurance contract.

Second, all LOCs posted for credit for reinsurance purposes are required to include an "evergreen clause" under which the issuer of the LOC agrees to give the beneficiary advance written notice prior to termination of the LOC. If appropriate notice is not provided, the LOC automatically renews. If the issuer allows termination without providing the receiver with requisite advance notice, there may be a cause of action available against the issuer for breach of the terms of the LOC and possibly for failure to fulfill the issuer's fiduciary responsibility to the ceding insurer as beneficiary.

### b. Draw Down on LOC

The key legal issue for the receiver to remember in connection with a draw down on a LOC is the fact that the LOC and the reinsurance contract are separate and distinct contracts. A commercial dispute as to whether a particular obligation is due under the reinsurance agreement should not form a basis for a court to prevent a draw under the LOC. Letters of credit established for credit for reinsurance purposes are generally "clean" and "unconditional," meaning that all that is necessary for a draw to take place is for the ceding insurer to make a proper demand upon the issuer. It is generally well established that courts will not interfere with such a draw except in two cases: first, where the attempted draw is fraudulent; and, second, where the underlying transaction is so tainted with fraud that the draw should not be allowed (called "fraud in the transaction"). Of course, a draw that is appropriate under the terms of the LOC may ultimately be found to have constituted a breach of the underlying reinsurance agreement if the obligation is not actually due.

### c. Right to Collateral

Once an issuer pays on a letter of credit, it will most certainly apply the collateral posted as security for the LOC by the reinsurer under the account agreement against the outstanding balance due from the reinsurer. Thus, wrongful or premature draws on LOCs may damage the

estate of an insolvent 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.<sup>239</sup> 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

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<sup>239</sup> 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.

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.

### **E. Setoff**

While the concept of setoff can involve fairly complex computations, it contemplates that funds owed by an entity to an insolvent insurer's estate will be set-off against funds owed by the insolvent insurer to that entity, so that only the net will be collected or paid. The mechanics and potential financial ramifications of setoffs for an estate are discussed in detail in the reinsurance and accounting chapters of this handbook.

### **F. Cancellation of Reinsurance Agreements**

A receiver should have staff review all agreements to determine what, if any, provisions are included regarding cancellation in the event of insolvency. Generally, absent such a provision (and frequently even if present) a receiver is empowered by the relevant state statute to cancel any contracts including reinsurance agreements, see § 114 and § 504A(8) of IRMA. Whether representing an insolvent reinsurer, primary insurer, or an insurer with both ceded and assumed reinsurance, notice to the opposite contracting party is essential. This is so that ceding insurers can replace their coverage and reinsurers can be aware of the date when their liabilities are cut off.

In the context of a life and health insurer insolvency, guaranty associations should be consulted before the company's ceded reinsurance agreements are canceled or otherwise terminated. Indemnity reinsurance may provide guaranty associations with valuable financial support in transferring policy obligations to an assuming insurer. Model #520 and IRMA §612 recognize this by providing guaranty associations with the right to assume the insolvent company's indemnity reinsurance agreements for the purpose of meeting coverage obligations.<sup>240</sup>

### **G. Rescission**

#### 1. Rescission Defined

Black's Law Dictionary (8th ed. 2004) defines rescission of contract as follows:

A party's unilateral unmaking of a contract for a legally sufficient reason, such as the other party's material breach, or a judgment rescinding the contract; VOIDANCE. • Rescission is generally available as a remedy or defense for a nondefaulting party and is accompanied by restitution of any partial performance, thus restoring the parties to their precontractual positions.

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<sup>240</sup> Model #520, at Section 8.N.

## 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.<sup>241</sup> 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.”<sup>242</sup> Whether a breach qualifies as material or substantial enough to serve as grounds for rescission is a question of fact which depends on the circumstances of each case.

A party’s right to rescind a reinsurance treaty is not absolute. If a party knows of facts giving rise to the right of rescission and fails to declare a rescission and disclaim the benefits of the contract within a reasonable time, the right to rescind may be barred. Also related to an insurer’s right to rescind a reinsurance treaty are the questions of whether voluntary rescission may constitute a preference under existing statutes, the Liquidation Model Act and/or IRMA and, if a preference is created, whether it is a voidable preference. For example, if a ceding insurer, immediately before being declared insolvent, agrees to rescind from inception a ceded treaty where reinsurance recoverables exceed ceded premiums, the receiver may attempt to void the transaction. Each transaction should be analyzed in terms of the elements of a voidable preference discussed earlier in this chapter.

### H. Use of Reinsurance to Wind Up the Affairs of an Insolvent Insurer

There are several reinsurance transactions available which may serve as tools for winding up the affairs of the insolvent insurer. These are briefly described below.

#### 1. Commutations

A commutation agreement is one pursuant to which a reinsurer and a ceding insurer agree to terminate all obligations under a reinsurance agreement, accompanied by a final cash settlement. Commutations are discussed in detail in Chapter 7—Reinsurance.

There may be a commutation clause in the relevant reinsurance agreement. Alternatively, the parties may simply agree to the commutation based upon negotiations. The end product of the negotiations will be the reinsurer making a one-time cash payment into the estate in return for a full release from all future liability.

Given the material nature of the transaction, approval of the transaction should be obtained from the receivership court.

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<sup>241</sup> 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).

<sup>242</sup> *Id.*

§ 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. If guaranty fund assets will be needed to fund reserves when transferring a book of business, the receiver should work with the NOLHGA or the affected guaranty association during rehabilitation to locate a solvent carrier and to coordinate the transfer with the entry of a liquidation order.

- Mechanics

Notification to policyholders is essential if the agreement is to have the desired effect of precluding future claims by the policyholders against the ceding insurer's estate. In some states, notice alone may not be sufficient to achieve a novation; e.g., the policyholders' written agreement may be required. In some instances, both the transferring insurer and the assuming insurer have been found to have a continuing obligation to the insured where notice was not given and consent was not obtained. Applicable state law should be consulted to determine what law is followed in each jurisdiction. Mechanically, the assuming reinsurer issues what are called "assumption certificates" to the policyholders notifying them of the change in insurer. Given the material nature of the transaction, approval of the receivership Court should be obtained.

## I. Portfolio Transfers and Financial Reinsurance

The various types and effects of financial reinsurance are discussed in detail in Chapter 7—Reinsurance.

### 1. Regulation of Financial Reinsurance

#### General Transfer of Risk Provisions

To receive accounting treatment as a reinsurance transaction, a transfer of risk is required. NAIC Statement of *Statutory Accounting Principles 62—Property and Casualty Reinsurance* (SSAP No. 62) requires the transfer of insurance risk for the ceding company to be granted accounting credit for the transaction. SSAP No. 62 states that the reinsurer must indemnify the reinsured entity, not only in form but in fact, against loss or liability by reason of the original reinsurance. Receivers should consult SSAP No. 62 if there are questions surrounding the accounting treatment of a particular reinsurance transaction. See Chapter 7—Reinsurance for a more detailed statement.

### 2. Financial Reinsurance in the Insolvency Context

Receivers of insolvent insurers which have engaged in financial reinsurance transactions should examine carefully the insurer's reinsurance agreements, giving careful consideration to the nature and purpose of the agreements. Among the factors that a receiver must weigh in evaluating whether a financial reinsurance agreement occurred between the insolvent ceding insurer and a reinsurer(s) are:

- Whether the transaction was accomplished solely to prolong the life of the ceding insurer;
- Whether a financial reinsurance transaction occurred between affiliates;



- Whether the transaction was close to the date of the declaration of insolvency;
- Whether the transaction was negotiated by officers or directors of an insurer who might have had a personal interest in the transaction;
- Whether accountants who prepared the ceding insurer’s annual statement appear to have correctly reflected the transaction; and
- Whether there were any possible affiliations between the reinsurance intermediary and the parties to the financial reinsurance transaction.

If the receiver has reason to believe upon examining all facts that a financial reinsurance transaction did not meet the risk transfer requirements of SSAP No. 62, the receiver should consult with counsel to ascertain whether there are any viable causes of action arising out of the activities of the parties to the financial reinsurance transaction.

## J. Dispute Resolution

There is no question that an insolvent insurer will have many disputes to resolve. There will be looming questions, however, of how the resolutions will occur, how long they will take and how much they will cost. These are questions a receiver will face on a regular basis and they are virtually always about collecting or paying money. More often than not, they involve reinsurance proceeds.

The insolvent insurer has various options in settling disputes: negotiation; mediation; arbitration; and litigation. As a general rule, negotiation is the fastest and least expensive option and litigation is the most costly and time consuming.

Arbitration has many advantages in the dispute resolution process. A majority of reinsurance agreements provide for it as the sole means of resolving conflict.<sup>243</sup> 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.<sup>244</sup> 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

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<sup>243</sup> See e.g., *Selcke v. New England Ins. Co.* 995 F.2d 688, 689, 690 (7th Cir. 1993).

<sup>244</sup> 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.).

the reinsurers when it ceased to be a potential source of future business. Reinsurers will typically resist litigation. Each receiver must determine in each case when arbitration would be advantageous to the estate.

### **K. Pre-Answer Security**

Courts may require certain insurers to post security when sued in U.S. jurisdictions in which they are not licensed. Thirty-eight states have adopted the Uniform Unauthorized Insurers Act. For example, New York Insurance Law Section 1213(c) requires a foreign or alien (nonadmitted) insurer to post “pre-answer security” before it files any pleadings in the court. The security must be sufficient to guarantee the payment of a final judgment that may be issued against the insurer. In New York, a failure to post the required security may result in a default judgment.

The law was originally enacted to protect policyholders who experienced difficulty executing judgments against unauthorized foreign and aliens insurers with insufficient assets in the state in question to satisfy the judgment. Although reinsurers have argued that the statute was not intended to apply to them, courts consistently have applied the statute to reinsurers being sued by ceding insurers or their receivers.<sup>245</sup>

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.<sup>246</sup>

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.<sup>247</sup> 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.<sup>248</sup>

Additionally, some courts have held that arbitrators have broad authority to require pre-hearing security.<sup>249</sup> Arbitration panels also are increasingly requiring the posting of security. Reinsurers may be subject to posting security in actions seeking to compel arbitration or to confirm arbitration awards.

### **L. Discovery of Reinsurers**

Reinsurance information has been generally undiscoverable to policyholders. In those instances where policyholders have tried to obtain information regarding their insurer's reinsurance, the release of the information has been denied on the basis of relevancy since the policyholder had no contractual right to the reinsurance proceeds.<sup>250</sup> Insurers and reinsurers have also contested production on the basis that the information was proprietary and confidential.<sup>251</sup>

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<sup>245</sup> See e.g., *Morgan v. American Risk Management, Inc.*, 1990 WL 106837 (SDNY July 20, 1990).

<sup>246</sup> *Morgan v. American Risk Management, Inc.*, 1990 WL 106837 (SDNY July 20, 1990);

<sup>247</sup> *John Hancock Property & Casualty Insurance Co. v. Universale Reinsurance Co.*, 1993 U.S. Dist. LEXIS 9411 (SDNY July 12, 1993).

<sup>248</sup> See e.g., *Stephens v. National Distillers and Chemical Corp.*, 69 F.3d 1226 (2d Cir. 1995).

<sup>249</sup> *Pacific Reinsurance Management Corp., v. Ohio Reinsurance Corp.*, 935 F.2d. 1019 (11th Cir. 1991).

<sup>250</sup> See e.g., *Leski, Inc. v. Federal Ins. Co.*, 129 F.R.D. 99, 106 (D.N.J. 1989).

<sup>251</sup> See e.g., *National Union Fire Ins. Co. v. Stauffer Chemical Co.*, 558 A.2d 1091, 1097 (Del. Super. Ct. 1989).

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.<sup>252</sup>

If discovery of reinsurance information is being sought by the receiver or discovery demands are being made on the receiver, counsel should consult local law to determine the extent to which such information is discoverable.

#### **M. Priority of Claims for Payment of Reinsurance**

Both the Liquidation Model Act and IRMA exclude from the policyholder level distribution class “obligations of the insolvent insurer arising out of reinsurance contracts,” see § 801 C(1) of IRMA and § 47C(1) of Liquidation Model Act. Those claims are subordinated to the unsecured claim distribution class. States without this exclusion that have considered the issue have reached the same conclusion, See *Covington v. Ohio General Insurance Co.*, 99 Ohio St.3d 117, 789 N.E.2d 213 (2003); *Neff v. Cherokee Insurance Co.*, 704 S.W.2d 1 (Tenn. 1986); *In re Liquidation of Reserve Insurance Co.*, 122 Ill.2d 555, 524 N.E.2d 538 (1988); *Foremost Life Insurance Co. v. Indiana Dept. of Ins.*, 274 Ind. 181, 409 N.E.2d 1092 (1980).

### **X. EXHIBITS**

*Exhibit 9-1: NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers*

*Exhibit 9-2: Considerations for Separate Accounts – Receivers’ Checklist*

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<sup>252</sup> *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).

**Exhibit 9-1: NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers**

NAIC PROPOSED GUIDELINES  
RELATING TO THE REPORTING OF LOSS INFORMATION TO REINSURERS

- The parties to reinsurance agreements involving a U.S. ceding insurance company are presumed to know the role of guaranty associations in a domestic liquidation.
- Liquidators have the obligation for loss reporting to reinsurers in accordance with the terms of the insolvent insurance company's reinsurance agreements.
- Liquidators should promptly advise the guaranty associations of the loss reporting requirements of applicable reinsurance agreements and what additional information is needed from the guaranty associations.
- Guaranty associations should acknowledge the responsibility to furnish timely and adequate information to liquidators so that the liquidators may meet their loss reporting obligations to reinsurers.
- Reinsurers should request from liquidators only that information to which the reinsurers are entitled under the reinsurance agreement.
- Reinsurers should not contact guaranty associations directly. Upon consultation with each guaranty association, liquidators should permit and initiate arrangements for reinsurers to review the claims handling practices of guaranty associations and to examine claim files in which reinsurers have an interest. Guaranty associations should acknowledge their obligation to permit such reasonable review by representatives of liquidators or reinsurers; liquidators should acknowledge their obligation to timely advise guaranty associations of such requests of reinsurers to examine claim files and to verify the scope of such review. Reinsurers are encouraged to provide a summary of their findings to liquidators, who will then provide a copy to the appropriate guaranty association.
- Unless otherwise determined by the liquidator, guaranty associations should promptly report the following loss information to liquidators; liquidators should promptly provide this information to reinsurers to, among other things, provide reinsurers an opportunity to elect to participate in the defense and to establish the reinsurers' own reserves:
  - \* Initial reports on each claim arising after liquidation.
  - \* Narrative description of each claim arising after liquidation.
  - \* Regular reporting of payments and notification of closing, updated at least on a quarterly basis.
  - \* Regular reporting of reserve information, including reports of changes in reserves, updated at least on a quarterly basis; also included with such reports should be projected loss exposures regardless of the guaranty association's maximum statutory liability (cap), or in the alternative immediate notification of any claim that is reserved at or near the cap.

- \* Interim reporting of information to liquidators with respect to bodily injury, personal injury and/or property damage claims of a catastrophic nature as well as environmental, toxic pollution, hazardous waste, des, asbestos-related, agent orange and other product liability claims and major losses; major losses should be defined in each insolvency by agreement between the liquidator and the guaranty associations.
- \* Interim reporting of known trial dates and settlement conferences on specified types of claims as agreed between liquidators and guaranty associations.
- \* Interim reporting of significant changes in the status of claims, reserve changes and loss or expense payments; the liquidators should promptly advise the guaranty associations of the reporting requirements with respect to each book of business.

Provision by guaranty associations of the above-listed information in a sufficiently detailed, uniform format utilizing electronic data processing capabilities is desired.

- In claims arising out of policies with aggregate coverage limits, it is the responsibility of liquidators to monitor the cumulative payments and/or allowances (pre- and post-liquidation) and to promptly advise guaranty associations of policies having aggregate limits and the amount remaining available under each such limit. Guaranty associations should consult with the liquidator on all claims involving an aggregate limit prior to entering into any settlement or issuing any payment. Liquidators should furnish such aggregate status information to reinsurers upon request.
- Liquidators and reinsurers should accept determinations of “covered claims,” as defined under the applicable guaranty association statutes, and the amount of “covered claim” payments made by guaranty associations unless an extraordinary fact situation exists, or an applicable law justifies a challenge.
- Under reinsurance agreements, salvage and subrogation recoveries may belong to the reinsurers rather than liquidators; thus, the guaranty associations and liquidators should consult and cooperate with each other concerning the handling and disposition of salvage and subrogation recoveries.
- In the absence of prejudice, the payment of loss due under a reinsurance agreement by a reinsurer should not be withheld solely on the basis of time limits of the liquidator’s reporting of that loss where the liquidator can show reasonable compliance with the applicable loss reporting requirements under the agreement.
- Guaranty associations should recognize liquidators’ requirements to receive original closed claims files. Liquidators should recognize guaranty associations’ requirements to retain closed claim files through an audit cycle. Liquidators should consult with the reinsurers and guaranty associations concerning the establishment of appropriate document retention/destruction procedures, subject to the liquidation court’s approval.
- Guaranty associations should recognize liquidators’ requirements, from time to time, to have reproduced some or all open and closed claim files; liquidators will be reasonable in such requests and shall consult with guaranty associations regarding the manner and timing of payment of reproduction costs.

- Liquidators and reinsurers should transmit information through reinsurance intermediaries when provided for in the applicable reinsurance agreements, unless there has been agreement by all concerned that the information should be transmitted directly between the reinsurers and the liquidator.
  
- Numerous reinsurers may have an interest in an individual claim. It is incumbent upon the liquidators and reinsurance intermediaries to develop procedures to efficiently match and respond to reinsurers' inquiries in a reasonable and practicable manner and to avoid requesting duplicate data from guaranty associations.

**Exhibit 9-2: Considerations for Separate Accounts Receivers' Checklist**

**Considerations for Separate Accounts – Receivers' Checklist**

This receiver's checklist accompanies Chapter 9: Legal Considerations – III. H. General Guidance for Receivers in a Future Receivership of a Troubled Insurer that Issued SEC Registered Products. The checklist is intended to assist with issue spotting and identifying areas where receivers should be in communications with the U.S. Securities and Exchange Commission (SEC). Receivers should be aware that insurers' registered products are constantly evolving, and that the issues that might be encountered in a receivership of an insurer that issued registered products are likely to be different than those in prior receiverships due to the different product mixes. Receivers encountering SEC registered products in a receivership should early in the proceedings retain experienced legal counsel qualified to provide advice on the federal securities laws the rules under those laws and compliance issues, and on how state receivership laws and federal securities laws might interact in a receivership.

1. Immediately identify the types of insurance products to be administered during receivership.
2. Immediately determine whether or not products are registered with the SEC. Registered products include:
  - Variable Products (variable annuities or variable life insurance policies).
    - If there are registered variable products, then any separate account supporting those Variable Products will also be subject to registration under the Investment Company Act of 1940 (1940 Act) and be subject to additional compliance requirements under the 1940 Act.
  - Other SEC Registered Products (e.g., certain fixed annuities with market value adjustments or index-based adjustments to value).
3. Receivers should identify other interested federal regulators and establish lines of communication with them.
4. Receivers of an insurer with Managed Separate Accounts should communicate with the board of directors of that Managed Separate Account since any action taken may require board approval.

If the insurer has registered products, immediately contact SEC staff to establish lines of communication and identify contact points for coordination.

  - The SEC's website contains contact numbers for SEC offices in Washington and for SEC's regional offices: [www.sec.gov](http://www.sec.gov).
  - Information regarding the SEC Division of Investment Management and how to contact these SEC staff may be located at: [www.sec.gov/investment](http://www.sec.gov/investment).
5. Immediately focus on SEC registered products. The federal securities laws applicable because of the insurer's registered products vary depending on the type of product.
  - Review and evaluate the impact of and compliance with the applicable state receivership laws and the federal securities laws applicable to the insurer and its registered products, in particular if the registered products are variable products with separate accounts.

For variable products,

- Determine types of separate accounts supporting the variable products and whether any existing separate account was, or was required to be, registered under the 1940 Act as either:
  - Unit Investment Trust (UIT).
  - Managed Separate Account.
- Determine if variable product is backed by insulated separate account not registered under the 1940 Act (Exempt SAs).

- Obtain and review available 1933 Act and 1940 Act registration statements and other filings.
  - Obtain complete set of all SEC filings, looking for:
    - Insurer's "Plan of Operations" or similar documentation for operation of separate account (may not be filed with the SEC).
    - Obtain all agreements with reinsurers, distributors, third-party credit support providers, guarantors, administrative service providers, custodians and investment advisors/managers involved with insurer's maintenance of separate accounts
- Obtain and review Rule 38a-1 written compliance policies and procedures and annual compliance reports.
- Obtain copies of any significant SEC orders or other relief applicable to the separate account that modifies the regulatory regime governing the account.
- Determine the types of variable products and amount of the insurer's net financial exposure.
  - Locate and review all prospectuses filed with SEC and all variable product forms insurer issued.
- Determine all guarantees provided with registered products, such as:
  - Expense charge guarantees.
  - Mortality guarantees.
  - Optional guaranteed benefits, such as guaranteed death benefits (GMDBs), and guaranteed living benefits such as guaranteed minimum withdrawal benefits (GMWBs), guaranteed minimum accumulation benefits (GMABs) and guaranteed minimum income benefits (GMIBs).
- Determine the standards governing the guarantees.
  - Based upon or determined from guaranteed return of premium, guaranteed annual interest rate return, or highest anniversary value.
- Determine insurer's financial risk not supported by separate accounts.
  - Review all actuarial memoranda and analysis.
- Determine insurer's financial hedging transactions to support obligations under variable products.
  - Evaluate whether hedging programs are adequate.

For other SEC Registered products,

- Determine if SEC registered product is backed by an insulated separate account that is not registered under the 1940 Act (such as registered MVA, and registered index-linked variable annuities).
- Obtain and review available 1933 Act registration statements and other filings and all 1934 Act reports (Form 10-K, 10-Q and 8-K), if applicable.
  - Obtain complete set of all SEC filings, looking for:
    - Insurer's "plan of operations" or similar documentation for operation of separate account (may not be filed with the SEC).
    - Obtain all agreements with reinsurers, distributors, third-party credit support providers, guarantors, administrative service providers, custodians, and investment advisors/managers involved with insurer's maintenance of separate accounts
  - Determine the types of other SEC registered products and amount of the insurer's net financial exposure.
    - Locate and review all prospectuses filed with SEC and all product forms insurer issued.



- Determine all guarantees provided with other SEC registered products, such as:
  - Expense charge guarantees.
  - Mortality guarantees.
  - Optional guaranteed benefits, such as guaranteed death benefits (GMDBs), and guaranteed living benefits such as guaranteed minimum withdrawal benefits (GMWBs), guaranteed minimum accumulation benefits (GMABs) and guaranteed minimum income benefits (GMIBs).
- Determine the standards governing the guarantees.
  - Based upon or determined from guaranteed return of premium, guaranteed annual interest rate return, or highest anniversary value.
- Determine insurer’s financial risk not supported by separate accounts.
  - Review all actuarial memoranda and analysis.
- Determine insurer’s financial hedging transactions to support obligations under variable products.
  - Evaluate whether hedging programs are adequate.
- 6. Determine whether from an operations standpoint the receiver should maintain the insurer’s infrastructure, compliance procedures, administrative procedures, technology, fund managers, etc.
  - Obtain and review all documentation, contracts, licenses, etc., pertaining to these matters.
- 7. Life Guaranty System
  - Collaborate with guaranty associations (through the NOLHGA in multi-state insolvency) as soon as practical regarding registered products that may be eligible for guaranty association coverage, including the assessment of (i) what securities laws might apply to covered registered products and any related separate accounts and (ii) compliance and operational issues with respect to the possible continuation of covered registered products, including whether the receiver should maintain the insurer’s infrastructure, technology, product administration, fund managers and other relevant operational mechanisms
- 8. Explore sale of insurer’s book of business (assumption reinsurance transaction)
  - Communicate with SEC staff and legal counsel regarding plans to transfer registered products book of business.
- 9. Securities Laws Compliance Considerations
  - Separate accounts supporting variable products
    - Properly established, insulated separate accounts supporting registered products must be preserved.
    - Assets in the separate account are insulated and ear-marked and are thus protected from the claims of general creditors in the insurer’s receivership.
  - General Account Guarantees regarding SEC Registered and variable products.
    - Insurer’s general account guarantees are subject to claims paying ability of the insurer.
    - Claims associated with the insurer’s guarantee of the variable product are claims against the general assets of the insurer.
  - SEC Registered Products with Guarantees.
    - Guarantees are subject to claims paying ability of the insurer.

- Disclosure Requirements.
  - Initiation of receivership proceedings and other actions taken during receivership will likely necessitate filings with the SEC and disclosure to owners of the registered products. The receiver should seek advice from legal counsel regarding what events need to be disclosed under the federal securities laws and the manner and timing of such disclosures.
- Registration Statements and Prospectus Disclosure Requirements – Supplementation Requirements.
  - Receivers may seek guidance from SEC staff and legal counsel on the need to keep product registration statements and prospectuses current at different stages of receivership.
  - Suspension of Sales & New Premium.
    - Consult with SEC staff and legal counsel as soon as possible in the receivership process if receiver decides it cannot comply with any federal securities law requirements, since commencement of a receivership does not terminate the registration of any contracts registered as securities under the 1933 Act or of any separate account registered as an “investment company” under the 1940 Act.
    - Consult with legal counsel regarding the need to obtain a no action letter from SEC staff regarding not issuing updated prospectuses.
    - Suspending new premiums on in-force SEC Registered Products could be problematic and should be discussed with SEC staff before implementation.
  - Transferring Registered Variable Product Business.
    - Communicate with SEC staff and legal counsel regarding plans to transfer a book of business to an assuming solvent insurer.
    - No Action relief should be sought in connection with such a transfer and change in control issues arising from the liquidation.
  - Restructuring Registered Product Contracts.
    - Communicate with SEC staff and legal counsel regarding plans to restructure insurer’s registered product contracts, and should seek necessary approvals from SEC staff.
  - Continuing to “Evergreen” Prospectuses and File Required Reports.
    - Keep prospectuses up to date if the insurer continues to sell registered products or receive premiums in receivership.
  - Continue to comply with periodic reporting obligations of the 1934 Act.
- Redeemability
  - Communicate with SEC staff and legal counsel about any anticipated disruptions in payments or processing redemptions funded by any separate account registered under the 1940 Act.
  - Resolutions of Blocks of Business.
    - Where a “pre-packaged receivership” that results in the immediate sale/transfer of the registered product business is not possible, consideration should be given to:
      - Restructuring the registered product contracts and cease accepting premiums.
      - Offering an exchange of the insurer’s registered product contract.
      - Offering to buy back the insurer’s registered product contracts.
    - Consult with SEC staff and legal counsel regarding above implementation of above considerations.

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## I. INTRODUCTION

The closure of a receivership—i.e., the termination of the receivership proceeding in the supervisory court—represents the culmination of the efforts of the receiver to complete those duties and wind up the insolvent insurer’s affairs as quickly and efficiently as possible. This applies whether the receivership proceeding is one of rehabilitation or liquidation, domiciliary or ancillary.

The conclusion of the affairs of the insurer, both from an asset and a liability standpoint, has to be accomplished in such a way that each of the statutory responsibilities of the receiver has been fully, fairly and promptly addressed. Planning for the closure of the estate should begin at the outset of the receivership proceeding. The receiver must establish and coordinate the legal, administrative, claims handling and accounting functions and set up the related reporting systems to facilitate the closure process. For a discussion of these functions, see Chapter 1—Takeover and Administration. A review of Chapter 5—section on Governmental Agencies, is also advised.

Guidelines within this chapter are based largely upon the NAIC Insurers Receivership Model Act (IRMA).

## II. CLOSING REHABILITATION PROCEEDINGS

### A. General

Rehabilitations usually become liquidations or, less frequently, come to a point where control over the insurer is turned back to original or successor management. In a successful rehabilitation, there is a transition to normal operations that evolves from negotiation with former or proposed management and other constituencies. That negotiation is so unique to a particular rehabilitation effort that there is little in the way of guidelines to offer. There will generally be a final accounting and reporting process to the rehabilitation court and an application for termination of the formal proceeding. Accordingly, the receiver should lay the groundwork early for the timely discharge of the receiver, as rehabilitator, and the termination of the rehabilitation proceedings.

### B. Closing the Rehabilitation Proceeding

Anytime the rehabilitator or the former directors of the insurer believe the purposes of the rehabilitation have been accomplished, a petition may be filed in the receivership court for an order terminating the rehabilitation, discharging the rehabilitator and restoring the company to private management. The court is also permitted to issue a termination order on its own motion. Before the company can be released from rehabilitation, Section 901 of IRMA requires that any funds paid by the guaranty associations must be repaid or the associations must have agreed to a repayment plan.

The order of discharge should include a release of the rehabilitator, agents, successors and assigns from all claims that may be asserted by creditors of the estate.

The rehabilitator and new management will want to determine and reach agreement on entitlement to and the value of the net operating losses pertaining to insurers which are part of holding company systems which have filed consolidated tax returns and consider other tax ramifications of the transactions.

The preparation of a final accounting by the rehabilitator and new management is necessary. The accounting will include what was originally agreed to between the parties as of the date of disposition to closing.

Under Section 404 of IRMA, the rehabilitator is allowed to file a petition to liquidate the insurer if the rehabilitator determines that further rehabilitation efforts would be futile or would increase the risk of financial loss to policyholders, creditors or the public. If the rehabilitator imposes a moratorium on the payment of policy benefits for six months without filing a rehabilitation plan, IRMA requires the

rehabilitator to file a liquidation petition.

Section 405 of IRMA further requires the rehabilitator to reserve assets so that the estate can continue claims payments for a short time after liquidation while the guaranty associations prepare. This is particularly true for workers compensation indemnity and medical payments and first party medical benefits under no-fault automobile insurance.

Coordination and reporting by and between the liquidator and the affected guaranty funds are critical. The Uniform Data Standard (UDS) was designed to facilitate this reporting. Prior to filing the petition to liquidate, the rehabilitator should ensure that the estate will have the ability to transmit claims and premium data via UDS to the impacted guaranty funds that will be triggered by liquidation. For further discussion of UDS and the coordination and function of guaranty associations, refer to Chapter 6—Guaranty Associations.

### **III. CONSIDERATIONS PRIOR TO CLOSURE OF A LIQUIDATION**

#### **A. Legal**

##### **1. Illiquid Assets and Causes of Action**

There may be both assets and causes of action that may not be cost beneficial for the liquidator to pursue. Since the duties of the liquidator include marshaling and liquidating assets for the benefit of the creditors of the insolvent insurer, it is advisable for the liquidator to obtain court approval of any decisions regarding abandonment of assets where marshaling or liquidating is not possible. The liquidator may also wish to consider negotiating with guaranty associations for the transfer of assets and causes of action to the guaranty associations as distributions in-kind. See IRMA Section 802C.

##### **2. Termination of Proceedings**

Pursuant to Section 902 of IRMA, when the liquidator has liquidated and distributed all assets that can be economically justified, the liquidator shall apply to the liquidation court for an order approving a final distribution of assets, closing the estate and discharging the liquidator. The order may set aside funds for post-closing administrative costs and provide for in-kind distribution of assets, if appropriate. The liquidator should consider formal corporate dissolution in the application unless the domiciliary state receivership statute dissolves the corporate entity by operation of law.

##### **3. Record Retention**

The liquidator should identify the various types of documents in his/her possession and determine the appropriate length of time that the documents should be preserved. In many cases, it may be appropriate to review and deal separately with the documents in different categories, e.g., the insurer's pre-receivership records, the insurer's post-receivership records, the records of the liquidator, etc.

Counsel should determine whether the destruction of these categories of documents is governed by the state law concerning the destruction of public or governmental documents, or by state law concerning business documents generally. In certain situations, state law and/or the IRS may require that records be maintained for a specific period of time. Ethical standards for attorneys, as well as others may require retention periods. Federal regulation for record retention, if applicable, may also affect certain retention periods, e.g., Medicare health insurance records. Certain documents may need to be permanently preserved, perhaps through the state archival process.

Once the legal requirements of the domiciliary state and any other states where the insurer did business have been reviewed, the liquidator should recommend to the court specific retention periods and procedures.

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,”<sup>1</sup> tax free exchanges,<sup>2</sup> multiple contract issues<sup>3</sup> and contract dates and testing for compliance,<sup>4</sup> to name a few, and specifically relate to Internal Revenue Codes 72 and 7702.

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<sup>1</sup> (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, 1992-1 CB 875, as modified by Rev. Proc. 92-44A, 1992-1 CB 876; (Let. Rul.) 9335054.

<sup>2</sup> 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.

<sup>3</sup> 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

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

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issued. The newly-received contract is not "grandfathered" back to the issue date of the original annuity for this purpose. Let. Rul. 9442030.

<sup>4</sup> 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.



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 1<sup>st</sup> 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 1<sup>st</sup> Circuit panel’s ruling in *Ruthardt vs. United States of America* (see Chapter 9—Legal Considerations, section on Federal Government Claims) affirmed a Massachusetts district court’s decision. In this litigation, the federal government challenged two aspects of the Massachusetts liquidation statute. First, the government argued that the liquidation priority provision in the statute is preempted by federal law to the extent it provides for payment of guaranty association claims ahead of claims of the federal government. The federal government also argued that the state’s statutory bar date for filing claims against the insolvent insurer’s estate does not apply to claims of the federal government. The federal district court ruled that the provision affording priority to guaranty association claims under the Massachusetts statute is a provision enacted for the purpose of regulating the business of insurance and is therefore shielded from federal pre-emption in accordance with the McCarran-Ferguson Act. With respect to the claims bar date, the district court concluded that it was bound by a controlling 1993 First Circuit decision finding that the benefits provided to policyholders by a state’s claim bar date were too tenuous for that provision to constitute the regulation of the business of insurance subject to the McCarran-Ferguson protections. The Court of Appeals affirmed on both issues.

Generally, taxes are, at most, an expense of administration if the taxes arise during the period of administration (as distinguished from unpaid taxes for periods ending before commencement of liquidation) and are incurred by the estate, i.e., imposed on income from which the estate derived some benefit. Decisions regarding the payment of computed taxes should only be made after consultation with legal counsel.

#### 4. Filing of Tax Returns

The entry of an order of liquidation does not terminate the existence of the insurer for tax purposes, regardless of the impact the order may have under state law. The taxable entity remains in existence until the liquidation is complete, i.e., all the assets have been distributed. Accordingly, the liquidator must attend to the continued filing of tax returns during the liquidation proceeding, which may include several taxable years. Therefore, the liquidator should recognize the need to undertake tax planning.

As set forth above, it is possible that over the period of administration, an insolvent insurer may lose its status as an insurance company or become exempt from taxation altogether. Since these classifications are based on a testing of the company’s activities and reserve characteristics, as activities cease, premium diminishes and insurance obligations are ceded under assumption reinsurance arrangements, the company may begin to fail these tests. The liquidator should anticipate the occurrence of this, and plan for the attendant consequences (reserve restoration, etc.).

If the insurance company placed in liquidation is the common parent of a group that has been filing consolidated returns, the receiver may have to continue filing on that basis. If the company was a subsidiary in a consolidated group, it is arguable that an order of liquidation should cause a termination of membership in the group. It should be noted that the only apparent pronouncement in this area is a 1985 private ruling (LTR 8544018) in which the IRS held that continued inclusion in a consolidated group is required of an insurer throughout the period of administration. However, among

the consequences of entering an order of liquidation are the facts that the liquidator is given the power to exercise all shareholder rights (Section 504A(16) of IRMA), the receiver may contemporaneously dissolve the corporate existence under state law (Section 503) and the shareholders, in their capacity as owners, become creditors of the estate (Section 501). Any one of these conditions, and certainly all of them in combination, would seem to indicate that the parent company no longer has any stock ownership interest in the insurer, much less any voting rights. Furthermore, considering that this is a permanent stockholder displacement rather than a mere suspension of rights, the ruling seems rather 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.

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 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 LIQUIDATION 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 §802 C).

Reinsurance recoverables will have been commuted or otherwise collected prior to closure, including the resolution of disputes or arbitration proceedings.

#### 2. Liabilities

All liabilities, through the proof of claim process, must be quantified and either allowed or disallowed by the supervising court.

##### a. Claim Filing and Adjudication

The proof of claim and claim adjudication processes are complete as mandated in Article VII of IRMA, and the liquidation court has entered appropriate claim determination orders. The liquidator may want to consider the procurement of a formal written release from the federal government as a part of the claim adjudication process.

##### b. Classification of Claims

The liquidator has grouped claims by priority class pursuant to Section 801 of IRMA and has calculated the asset distribution percentage by class of creditor. With regard to partial and final distributions, the liquidator will want to make sure that policy claimants not covered by guaranty associations are afforded equal treatment with claims of guaranty associations.

c. Claim Adjudication Process

Claims adjudication and administration procedures are discussed in detail in Chapter 5—Claims. An important objective that will facilitate closure is for the liquidator to establish a tracking system to capture proof of claim adjudication results. The tracking system information should include:

- Name and address of claimant, organized by class;
- Claim number;
- Claim amount and priority classification;
- Status;
  - Allowed;
  - Denied;
  - partially allowed; and
  - determination;
- Liquidator's recommendation;
- Court determination; and
- Results of objections.

The tracking system should be continually updated as contingent claims mature and as the liquidator and the liquidation court deal with contested claims. The system tracking proof of claim amounts should reconcile with respective balance sheet amounts at any point in time. In short, the system should allow data to be kept current going forward so that reporting is fast and the calculation of amounts for claim recommendations to the court is simplified. The NAIC has developed ClaimNet, an on-line proof of claim submission system, which can be used by receivership offices.

The Uniform Data Standard (UDS) reporting system is discussed in detail in Chapter 6—Guaranty Association. UDS provides for the reporting of policy and claim information between guaranty funds and receivers. The data provided by UDS may be integrated with the liquidator's claim tracking system to maintain current guaranty fund claim amounts. Again, these amounts should reconcile with the respective balance sheet amounts at any point in time.

Depending on the size of the liquidation and available assets, it may be economically preferable to petition the liquidation court to dispense with the claims adjudication process for certain classes if distributions to such classes are unlikely. Keep in mind, however, that the claimant's right to object to the classification of his claim would not be affected.

Ongoing litigation of excess or non-covered claims may impede closure. Moreover, with regard to third party claims against insureds to which the typical insolvency injunction does not extend,

the liquidator must determine, based on the nature and size of the litigation, whether to defend. The risk of potential diluted distributions to other Class 3 creditors should be considered by the liquidator.

The insured or the third party may file a claim in the liquidation. The claims must be resolved and included as components of the liquidator's recommendations prior to closure. See Sections 801 and 802 of IRMA.

Pursuant to Section 705 of IRMA, claims that are contingent, unliquidated or immature may be allowed and may participate in all distributions declared subject to the criteria set forth in Section 705. The liquidator should consider commuting remaining treaties and facultative certificates on existing reserves with the assistance and approval of the liquidation court. Contingent claims must be resolved and included as components of the liquidator's recommendations under Section 802 of IRMA prior to closure.

An alternative to the traditional approaches of quantifying long tail IBNR claims to facilitate interim and final distributions and thereby expedite closing, is a process commonly known as "claims estimation." For a more detailed discussion of the claims estimation concept, see IRMA Section 705. Claim estimation can raise issues when seeking to collect reinsurance covering those claims. Procedures for settling reinsurance through commutation based in part on estimated claims are described in detail in IRMA Sections 614 and 615.

Pursuant to Subsection 701B of IRMA, late claims may be allowed and may participate in distributions declared to the extent that the orderly administration of the liquidation is not prejudiced provided stated criteria are met. Late filed claims that do not meet the criteria are placed into priority class.

### 3. Litigation

All litigation must be concluded. In the event litigation has resulted in the liquidator receiving a judgment against a party or if the liquidator is collecting restitution payments from any party, the liquidator may also consider placing such assets in a liquidating trust or negotiating with guaranty associations for the transfer of assets to the guaranty associations as distributions in kind. As discussed in Subsection C.3. below, the distribution must be allocated in a manner that will afford equal treatment to guaranty funds and other priority claimants.

### 4. Ancillary Proceedings

Ancillary proceedings must be closed or to a point where there is no continuing financial or legal impact on the domiciliary proceeding. All general and special deposits held by the ancillary receiver should be accounted for, i.e., transferred to its state's guaranty fund, returned to the liquidator, or otherwise appropriately disbursed.

## C. Administration of the Closing Process

### 1. Order Approving Termination of Proceeding

As discussed herein, and as specified in Section 902 of IRMA, the liquidator should apply to the liquidation court for an order approving a final distribution of assets, closing the estate and discharging the liquidator.

Specific issues to be addressed in the order may include:

- All major transactions, procedures and expenditures of the estate which were not previously approved by the court;
- The expense reserve set for final and post-closure expenses;
- Amounts to be paid in final distribution to claimants;
- Arrangements for storage or destruction of records and the reservation of funds to pay these expenses;
- Assignment of and the valuation of any distributions of assets in-kind to any claimants;
- Release of the receiver and his agents from further liability; and
- Provision that the proceeding will automatically terminate upon the completion of the above issues with the liquidator's filing of a "Closing Statement." The closing statement is simply a statement advising the court that all of the issues have indeed been resolved.

## 2. Final Expenses

The liquidator has made provision for the final expenses necessary to close the estate. To the extent possible, these Class 1 and Class 2 expenses should be paid in advance of closure. Examples of expenses to be estimated, agreed to and paid in advance are as follows:

- Legal fees and professional fees pertaining to the preparation of the final accounting to the liquidation court;
- Fees pertaining to the preparation of federal and state tax returns, and possibly final audit, pursuant to Section 905 of IRMA;
- Expenses pertaining to the storage and destruction/disposition of records after the termination of the liquidation;
- Legal fees pertaining to the termination of the liquidation proceeding and dissolution of the corporate entity;
- Final salaries and other administrative expenses necessary to wind up the affairs of the estate including but not limited to:
  - Final inventory preparation;
  - Interfacing with tax advisors on final tax preparation;
  - Oversight of records destruction;
  - Final distributions—cutting and processing checks;
  - Responding to inquiries relative to final distribution;
  - Final bank fees; and
  - Unclaimed property report generation; and
- Administrative expenses of guaranty funds (Class 2 claims under IRMA).



### 3. Calculation of and Final Distribution

A date must be selected upon which the liquidator will make a final distribution to creditors. The date of final distribution is important because the liquidator usually attempts to assure that no additional transactions, such as cash receipts and disbursements, will occur subsequent to that date, and no additional expenses will be incurred, thus avoiding the preparation and filing of additional federal and state income tax returns. In effect, every task should be completed and every open issue resolved, except for the distribution of remaining monies. Alternatively, remaining cash assets can be transferred to a liquidating trust.

A good deal of planning must precede the preparation of final distribution amounts to creditors. Since Class 1 and Class 2 creditors can generally be satisfied in full, the final distribution percentage is calculated by dividing total assets available for distribution for a particular class (typically Class 3 policyholders for direct insurance writers or Class 4 for mortgage or financial guaranty insurers) by the amount of claims in a particular class as approved by the liquidation court. Generally, the distribution percentage for Class 3 claimants is less than 100%, but if Class 3 claims can be paid in full, then the calculation is applied to the next lower priority class that cannot be paid in full. Also, the calculation is complicated by the need to reserve sufficiently for administrative expenses to close the estate and expenses incurred after the distribution is made, if any.

A useful internal tool to provide a snapshot of asset distribution by creditor class at any time during the receivership is the interim Liquidating Balance Sheet (LBS). See Exhibit 10-1 for an example.

The interim LBS allows the receiver to periodically adjust assets to liquidated values based on the best and latest information available, and apply the liquidated asset values to liabilities by creditor class, thereby projecting distribution percentages at each balance sheet date.

There may have been previous interim or partial distributions from the estate that will need to be taken into account when calculating the final distribution percentage. Early access advances may have been made directly or indirectly to guaranty funds and directly to non-covered or excess claimants by order of the liquidation court and should be accounted for at or before final distribution is made. If partial distributions were made to guaranty funds, but not to non-covered/excess policyholder claimants, the final distribution calculations must take this into consideration so that all Class 3 creditors are treated equally.

In the event guaranty funds received early access distributions of funds or other assets in excess of the final distribution percentages to which they are entitled, the early access assets must be returned to the liquidator prior to the payment of a final distribution. The return of early access amounts by the guaranty fund is mandated by Section 803 of IRMA and typically by the Early Access Agreement executed pursuant to other early access laws. The fact that distributions made to non-covered/excess policyholders may not be collectible later if those policyholders received too much, is probably a good reason to take special care in calculating the amounts of any distributions to claimants other than guaranty funds.

It should not be necessary to hold up the closure of the estate simply because certain assets have not been reduced to cash. Section 802C of IRMA allows distributing assets in-kind provided the creditor and liquidator agree on the value and the receivership court approves the distribution.

Once the final distribution amount has been determined, the funds to be distributed should be aggregated into a single checking account. The bank must be consulted in advance to provide final service charges and other debit amounts to enable the liquidator to determine the exact amount of remaining funds to be distributed. The bank should be provided with a listing of final distribution payees and amounts. Once all checks clear, the account should be closed. Checks for final distribution amounts that do not clear will need to be reported as Unclaimed Property (see subsection C6 of this section). In preparation for a final distribution, the final LBS will set forth distribution percentages by

creditor class. Note the accrual for estimated expenses necessary to close the estate. These estimated expenses are detailed in subsection C2 of this section.

#### 4. Reporting to the Liquidation Court

Throughout the liquidation process, financial reporting to the liquidation court is important, but it becomes more so as the liquidator starts to plan for closure. Many liquidators file quarterly or semi-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 reporting requirements under IRMA are set out in §117.

This reporting process enables the liquidation court and creditors to keep abreast of the proceeding and its major issues, and simplifies the ultimate final accounting to the liquidation court prior to closure.

#### 5. Final Accounting

As part of the termination proceedings, the liquidator will file with the liquidation court a final accounting that discusses the disposition of major issues during the liquidation and has a summary of significant events, key orders entered by the liquidation court, pending issues, if any, and distribution percentages to remaining creditor classes, along with detailed schedules reflecting creditors, early access and partial distribution amounts previously paid, if any, and final distribution amounts. The liquidator should consider filing basic financial statements with the court (balance sheet and income statement) as well as an inception to date summary of cash receipts and disbursements. The distribution plan should be pursuant to the liquidation court's orders regarding the liquidator's claim recommendations. The filing of the final accounting will have been preceded by requisite notice to the appropriate parties.

#### 6. Unclaimed and Withheld Funds (Escheat Items)

Uncashed checks or drafts that have not been negotiated prior to a final distribution should be handled in accordance with the applicable state unclaimed property laws or Section 804 of IRMA, as appropriate.

#### 7. Other Required Reporting

Final distributions may require reporting to the IRS as 1099 Miscellaneous Income to the recipient or as other reportable income as determined by tax counsel.

In the event the liquidated company continued to have employees through its final year, certain employer reporting such as W-2 forms, quarterly wage and tax forms, etc. must be completed post-closure. If there were employees retained by the insolvent company, health insurance and any other such benefits must be terminated prior to closure. If a 401k plan was in existence prior to liquidation, closure of the plan may require a letter of determination from the IRS for plan termination.

#### 8. Final Tax Returns

The liquidator will make arrangements with its tax advisors to complete and file the final tax return subsequent to the closure of the estate. A final expense for tax preparation should be included as part of the expense reserve.

Records must be accessibly maintained during the preparation of the returns.

#### 9. Corporate Dissolution

The liquidator will comply with any statutory provisions and file any necessary documents to permanently delete the company from applicable agencies. This may include other jurisdictions in which the company maintained a license to operate. The order terminating the liquidation and discharging the liquidator should be provided to the agencies in order for them to close their files.

#### 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 inquiries.

### V. EXHIBITS

*Exhibit 10-1: Interim Liquidating Balance Sheet*

*Exhibit 10-2: Closing Liquidating Balance Sheet*

**ABC LIFE INSURANCE COMPANY**  
**INTERIM LIQUIDATING BALANCE SHEET**  
**AS OF DECEMBER 31, 2008**

	12/31/2008 STATEMENT VALUE	ADJUSTMENTS	ADJUSTED VALUE	CLASS 1 ADMIN.	CLASS 2	CLASS 3	CLASS 4 & HIGHER
<b>ASSETS</b>							
BONDS	872,142	10,282	882,424			882,424	
CASH IN OFFICE	100		100			100	
CASH ON DEPOSIT	15,275		15,275			15,275	
SHORT-TERM INVESTMENTS	2,580,915		2,580,915	331,888	769,841	1,479,186	
OTHER INVESTED ASSETS	85,415		85,415			85,415	
PREMIUM TAX REFUNDS	10,038		10,038			10,038	
(1) EARLY ACCESS (ESTATE ASSETS)	0	34,785	34,785			34,785	
INVESTMENT INCOME DUE	19,672		19,672			19,672	
AGGREGATE WRITE-INS	26,795	(9,734)	17,061			17,061	
<b>TOTAL ASSETS</b>	<b>3,610,352</b>	<b>35,333</b>	<b>3,645,685</b>	<b>331,888</b>	<b>769,841</b>	<b>2,543,956</b>	<b>0</b>
<b>LIABILITIES</b>							
POLICY & CONTRACT CLAIMS (LIFE)	201,047		201,047			201,047	
POLICY & CONTRACT CLAIMS (A&H)	355,209		355,209			355,209	
SURRENDERS	43,722		43,722			43,722	
(1) ACCOUNTS PAYABLE GUARANTY FUND	3,671,806	34,785	3,706,591		769,841	2,936,750	
COMMISSIONS DUE & UNPAID	76,285		76,285				76,285
GENERAL EXPENSES DUE & UNPAID	152,685		152,685				152,685
TAXES, LICENSES AND FEES	21,875		21,875				21,875
AMOUNTS HELD AS AGENT	102,698		102,698				102,698
REMITTANCES NOT ALLOCATED	10,815		10,815				10,815
PHASE III TAX	726,892		726,892				726,892
ADMINISTRATION EXPENSE	136,729	195,159	331,888	331,888			
<b>TOTAL LIABILITIES</b>	<b>5,499,763</b>	<b>229,944</b>	<b>5,729,707</b>	<b>331,888</b>	<b>769,841</b>	<b>3,536,728</b>	<b>1,091,250</b>
<b>% OF DISTRIBUTION</b>				<b>100.00%</b>	<b>100.00%</b>	<b>71.93%</b>	<b>0.00%</b>
<b>DOLLAR DISTRIBUTION</b>							

(1) Net Policyholder liabilities conveyed via assumption agreement less estate assets

**Exhibit 10-2: Closing Liquidating Balance Sheet**

**ABC LIFE INSURANCE COMPANY  
CLOSING LIQUIDATING BALANCE SHEET  
AS OF DECEMBER 31, 2008**

	12/31/2008 STATEMENT VALUE	ADJUSTMENTS	ADJUSTED VALUE	CLASS 1 ADMIN.	CLASS 2	CLASS 3	CLASS 4 & HIGHER
<b>ASSETS</b>							
CASH ON DEPOSIT	15,275		15,275			15,275	
SHORT-TERM INVESTMENTS	1,850,915		1,850,915	28,624	769,841	1,052,450	
PREMIUM TAX REFUNDS	10,038		10,038			10,038	
(1) EARLY ACCESS (ESTATE ASSETS)	0	34,785	34,785			34,785	
(2) EARLY ACCESS (CASH)	0	1,500,000	1,500,000			1,500,000	
<b>TOTAL ASSETS</b>	<b>1,876,228</b>	<b>1,534,785</b>	<b>3,411,013</b>	<b>28,624</b>	<b>769,841</b>	<b>2,612,548</b>	<b>0</b>
<b>LIABILITIES</b>							
POLICY & CONTRACT CLAIMS (LIFE)	10,000		10,000			10,000	
POLICY & CONTRACT CLAIMS (A&H)	105,646		105,646			105,646	
SURRENDERS	33,947		33,947			33,947	
(1,2) ACCOUNTS PAYABLE GUARANTY FUND	2,622,191	1,534,785	4,156,976		769,841	3,387,135	
COMMISSIONS DUE & UNPAID	76,285		76,285				76,285
GENERAL EXPENSES DUE & UNPAID	152,685		152,685				152,685
TAXES, LICENSES AND FEES	21,875		21,875				21,875
AMOUNTS HELD AS AGENT	102,698		102,698				102,698
REMITTANCES NOT ALLOCATED	10,815		10,815				10,815
PHASE III TAX	726,892		726,892				726,892
ADMINISTRATION EXPENSE	15,872	12,752	28,624	28,624			
<b>TOTAL LIABILITIES</b>	<b>3,878,906</b>	<b>1,547,537</b>	<b>5,426,443</b>	<b>28,624</b>	<b>769,841</b>	<b>3,536,728</b>	<b>1,091,250</b>
<b>% OF DISTRIBUTION</b>				<b>100.00%</b>	<b>100.00%</b>	<b>73.87%</b>	<b>0.00%</b>
<b>DOLLAR DISTRIBUTION</b>							

(1) Net Policyholder liabilities conveyed via assumption agreement less estate assets

(2) Represents cash distribution on November 20, 2008

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**CHAPTER 11 – STATE IMPLEMENTATION OF DODD-FRANK RECEIVERSHIP**

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## I. INTRODUCTION

As extraordinarily remote a set of circumstances necessitating it may be, under § 203(e) of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, 18 USC § 5383(e) (Dodd-Frank Act), state insurance Commissioners, their designated deputy receivers and Guaranty Funds are charged with the enormous responsibility of resolving a systemically important insurance company. Those circumstances by definition would be unique and extraordinary. The circumstances also by definition would bring enormous time pressure with high stakes for the U.S. economy and the policyholders and creditors of the particular insurance company in receivership. Responding to those unique challenges would require advanced planning and analysis, which this Chapter addresses, by describing four baseline implementation areas for Commissioners, deputy receivers and guaranty funds to consider.

After a general introduction to the Dodd-Frank insurance receivership framework, the analysis in this chapter focuses on the following considerations:

- 1) Establishing processes at the state level to ensure the state receivership mechanism will respond effectively to a Dodd-Frank receivership.
- 2) Analyzing and preparing for the situation in which an insurance company is a subsidiary or affiliate of a covered financial company.
- 3) Describing national coordination initiatives to ensure the national state-based systems provide further support to administering a Dodd-Frank receivership.
- 4) Developing state laws that will ensure that state mechanisms can effectively initiate and administer a Dodd-Frank receivership.

## II. OVERVIEW OF DODD-FRANK INSURANCE RECEIVERSHIP FRAMEWORK

The Dodd-Frank Act was enacted on July 21, 2010.<sup>1</sup> Title II of the Dodd-Frank Act<sup>2</sup> 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”<sup>3</sup> 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)<sup>4</sup>; 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)<sup>5</sup>; or any subsidiary of

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<sup>1</sup> Public Law 111-203, 12 U.S.C. 5301 *et seq.*

<sup>2</sup> §§ 201 to 217, 12 U.S.C. 5381 *et seq.*

<sup>3</sup> § 201(a)(11); 12 U.S.C. 5381(a)(11).

<sup>4</sup> 12 U.S.C. 1841(a).

<sup>5</sup> 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....”

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.<sup>6</sup>

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.<sup>7</sup> The Dodd-Frank Act defines the term “covered financial company”<sup>8</sup> as a financial company for which the Secretary of the Treasury (Secretary) in consultation with the President has made a determination under § 203(b).<sup>9</sup> However, if the financial company is an insurance

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<sup>6</sup> § 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 80% of the total consolidated revenues of such company, including any revenues attributable to a depository institution investment or subsidiary.

<sup>7</sup> 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.

<sup>8</sup> § 201(a)(9).

<sup>9</sup> § 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.

company<sup>10</sup> 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.<sup>11</sup>

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.<sup>12</sup> 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).<sup>13</sup>

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."<sup>14</sup>

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.<sup>15</sup> Upon the appointment of the FDIC as receiver over such subsidiary, the subsidiary

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<sup>10</sup> 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).

<sup>11</sup> § 203(a)(1)(C); 12 U.S.C. 5383(a)(1)(C).

<sup>12</sup> § 202(a)(1); 12 U.S.C. 53823(a)(1).

<sup>13</sup> § 203(e); 12 U.S.C. 5383(e).

<sup>14</sup> § 203(e)(3); 12 U.S.C. 5383(e)(3).

<sup>15</sup> § 210(a)(1)(E)(i); 12 U.S.C. 5390(a)(1)(E)(i) provides:

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.<sup>16</sup>

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.<sup>17</sup> The statute does not provide precise guidance as to how the FDIC would coordinate with the state insurance receiver of the insurance company if the subsidiaries or affiliates' operations are integral to the operation of the insurance company. Examples are management or service companies (when the insurer has no employees of its own), or third-party administrators (if the subsidiary has contracts with the insurance company), or if the insurance company and the subsidiary are jointly obligated to third parties (such as under a lease). In such instances, it is unclear how the state insurance receiver would protect the interests of the insurer. The appointment of the FDIC as receiver of an insurance company subsidiary may leave the insurance company parent in a weaker financial condition. To protect these operations, the states, through NAIC, must implement procedures for immediate initiation and administration of state insurance receiverships with a high degree of coordination with the FDIC, applicable guaranty funds and others.

### **III. STATE LEVEL PROCESS FOR IMMEDIATE INITIATION OF STATE INSURANCE RECEIVERSHIP**

#### **A. Rapid Response Protocol**

Most states have enacted statutes governing the conservation, rehabilitation and liquidation of insurance companies that are patterned after one of three model acts that have been adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) or by the NAIC over the years: the Uniform Insurers Liquidation Act (Uniform Act); the Insurers Rehabilitation and Liquidation Model Act; and the Insurer Receivership Model Act (#245) (IRMA). NAIC Model Acts uniformly require that the chief insurance regulator of the insurer's domiciliary state (Regulator) be appointed receiver of the insurer to administer the receivership under court supervision.

Title II of the Dodd-Frank Act does not change state liquidation statutes. Nevertheless, the state Dodd-Frank responsibilities require state statutes that assure immediate execution of state receiverships necessary to effectively respond to a national crisis. If there is a federal determination that an insurance company meets the § 203(b) standards codified in 12 U.S.C. § 5383(b), then the Dodd-Frank Act anticipates that the insurance company would be placed immediately into receivership pursuant to state law, 12 U.S.C. § 5383(e). Subject to certain exceptions (notably for insurance companies), the Dodd-Frank Act does not contemplate a receivership for the purpose of rehabilitation or reorganization. See footnote 7, *supra*. Under state law, the form of receivership is not limited to liquidation. And Section 203(e)(1) of the Dodd-Frank Act, 12 U.S.C. § 5383(e)(1), explicitly refers to both rehabilitation and liquidation of insurance companies in the insurance company context.

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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.

<sup>16</sup> § 210(a)(1)(E)(ii); 12 U.S.C. 5390(a)(1)(E)(ii).

<sup>17</sup> § 204(c); 12 U.S.C. 5384(c).

If state regulators do not file the appropriate action within 60 days of the federal determination, then the FDIC has the authority to stand in the place of the state regulator for purposes of initiating the appropriate action under and pursuant to state law, § 203(e)(3), 12 U.S.C. § 5383(e)(3). Regulators, receivers, the courts and other interested persons should not plan to rely on the 60-day window. Immediate state action will be required in most Dodd-Frank insurance company receivership scenarios. Even in the unlikely event that the FDIC filed the state court action due to the passage of 60 days, state laws continue to require that the Regulator be appointed as receiver of an insurance company and that the receivership be conducted under state law.

This section outlines the steps individual states should take to create a rapid response protocol, organizational structure and coordinated interagency effort to immediately initiate a Dodd-Frank receivership and, in any event, meet the 60-day requirement under Title II of Dodd-Frank. The steps include:

- Advanced planning
- Coordination with the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and National Conference of Insurance Guaranty Funds (NCIGF)
- State-federal coordination with proper deference to state insurance regulators and receivers in the orderly liquidation of any insurance company
- Creation of a contact list and executive committee to coordinate receivership implementation
- Formal communication protocols
- Procedures for immediate initiation of receivership and contacting attorneys general
- Procedures or rules for expedited judicial review

## **B. Advanced Planning**

State regulators have long recognized that state receivers who expect to successfully administer a receivership must become familiar with the insurer's operations, business and structure as soon as possible. Ch. 1, § V (A), NAIC *Receivers Handbook for Insurance Company Insolvencies* (2009) (Receivers Handbook). The FDIC recognizes that advanced communication and planning is critical to a resolution that mitigates significant risk and minimizes moral hazard in a Dodd-Frank scenario. If there are multiple proceedings, coordination of those proceedings is essential to resolution of a Dodd-Frank scenario as much or more than in a traditional dual liquidation/bankruptcy scenario.

There are both existing and developing mechanisms in place for both state and federal regulators to consider the impact of the Dodd-Frank Act in the course of regulation. These mechanisms also assist regulators, the NAIC and, at the appropriate time, receivers to have advance (even if separate) direction and warning of the potential for a Dodd-Frank receivership affecting an insurance company. Beginning with the designation of companies as Federal Reserve Board-supervised nonbank financial companies under § 113(a) and spanning all the way to determinations of the Secretary under 12 U.S.C. § 5383(b), and encompassing all regulation in between, both state and federal regulators ideally will be provided with information sufficient to take some pre-receivership regulatory protective action, when necessary, and also engage in some level of advance receivership planning.

Indeed, state regulators may know in advance of federal regulators that significant financial problems exist in an insurance company. State regulators, therefore, may have opportunity for advance receivership 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; NOLGHA 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 confidentiality 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<sup>18</sup> (where applicable) or confidential Corrective Action Plans, can be used confidentially by state regulators as early planning tools.

Although the Dodd-Frank Act does not expressly require that a determination made under § 203(b) with regard to an insurance company be communicated to the Regulator (the determination is expressly required to be communicated to the FIO, FDIC, Federal Reserve and the covered financial company, and that information is confidential), that basic communication is implied as part of the FDIC's consultation obligations under § 204(c), 12 U.S.C. § 5384(c), and is obviously necessary to the orderly initiation of a Dodd-Frank receivership. Procedures should establish, at a minimum, that the recommendation and determination is immediately communicated in all cases to the NAIC as a central coordination point for state regulators and receiver, and also directly to the domestic Regulator when the company is itself an insurance company and the insurance regulators when there is an insurance company subsidiary or affiliate of a covered financial company. Discussions with the relevant federal actors should focus on state receivership planning and advance warning under the confidentiality constraints of the Dodd-Frank Act.

### **C. Internal Procedure for Presenting Federal Determination to Commissioner and for Immediately Initiating Receivership**

Whether a receivership is expected, preplanned or arises unexpectedly, state insurance regulators and receivers must be prepared internally for the immediate initiation of a receivership well before the expiration of 60 days where there is a federal systemic risk determination as to an insurance company.

In general, as discussed above, under 12 U.S.C. § 5383(a), the FDIC and the Board of Governors of the Federal Reserve System (Federal Reserve), on their own initiative or at the request of the Secretary, recommend that the Secretary appoint the FDIC as receiver for a covered financial company. The recommendation to place an insurance company or a financial company of which the largest domestic subsidiary is an insurance company into receivership is made by the Federal Reserve and the director of the 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).

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<sup>18</sup> The NAIC Model Insurance Holding Company Act requires that annual reports to regulator identify material risk within the holding company systems that could pose a financial or reputational contagion to the insurer.

If such a determination is made, the Secretary notifies the covered financial company of the determination pursuant to 12 U.S.C. § 5383(c) and 12 U.S.C. § 5382(a)(1)(A)(i). There is no exact time limit for the notice, but the expectation is that the notice will be immediate.

Once the determination is made, if the company consents to the determination, the FDIC's appointment as receiver is immediate., 12 U.S.C. § 5382(a)(1)(A)(i). If there is no consent, then the Secretary, upon notice to the covered financial company, shall petition the U.S. District Court for the District of Columbia under seal for an order authorizing the Secretary to appoint the FDIC as Receiver, 12 U.S.C. §§ 5382(a)(1)(A)(i), (ii). The Court has 24 hours to determine whether the Secretary's determination that the covered financial company is in danger of default and satisfies the definition of a financial company is arbitrary and capricious, 12 U.S.C. § 5382(1)(A)(iv). If the Court determines the Secretary's findings are not arbitrary and capricious and that the company is a covered financial company, then the Court shall enter an order immediately authorizing the Secretary to appoint the FDIC as Receiver, *Id.* If the Court fails to make a determination within 24 hours, the petition is granted by operation of law, and the Secretary shall appoint the FDIC as receiver, 12 U.S.C. §§ 5382(a)(1)(A)(v)(I), (II). The Court's determination is subject to a limited scope and expedited appeal process, but not to stay or injunction, 12 U.S.C. §§ 5382(a)(1)(B), (a)(2). See Flowcharts, (Exhibit 11-A and 11-B).

One exception is that if the covered financial company is an insurance company or an insurance company subsidiary or affiliate of a covered financial company, the rehabilitation or liquidation of such company, and any insurance company subsidiary or affiliate of such company, shall be conducted as provided under state law, 12 U.S.C. §§ 5383(e)(1), (2). In that case, the Regulator has 60 days from the date on which the 12 U.S.C. § 5383(a) determination is made—not communicated—to file the appropriate judicial action in state court to place the insurance company into orderly liquidation under state law, or else the FDIC shall have the authority to make the filing. 12 U.S.C. § 5383(e)(3). The Dodd-Frank Act does not expressly require entry of a liquidation order in 60 days (or ever for that matter), but entry of a receivership order well in advance of the 60-day expiration must be the Regulator's goal in order to be consistent with the federal framework seeking to swiftly resolve company failure that threatens the national economy.

### 1. Internal Discussions

As referenced above, the first discussion that must occur is, minimally, notice of the federal determination from the Secretary or other federal representative to the state Regulator. That notice should be immediate.

However best interlocking with federal processes, discussions must occur as to how the federal government prefers to coordinate and plan for notice. For example, regulators may pre-identify themselves and other persons to be notified. NAIC mechanisms may also be useful to effect fast multi-state notice. Once the state regulator receives notice of the federal determination, the Internal Procedures in the domiciliary state, discussed more specifically below, are triggered if those procedures have not already been triggered as the result of advanced planning. There will be a critical need to respect statutes requiring confidentiality of non-public information in the hands of regulators in this and other preplanning processes. The notice will also likely trigger formal discussions and procedures with stakeholders outside the domiciliary state, but those procedures are not discussed at length in this section.

### 2. Key Elements of Initial Due Diligence

As in all receiverships, the Regulator who expects to successfully prosecute a receivership action must become familiar as soon as possible with the insurer's overall operations and business, as must any potential special deputy receivers and staff. Ch. 1, § V(A), *Receivers Handbook*. This cooperation and advance planning among the Regulator, the receiver and ideally also the company itself is especially 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.<sup>19</sup>

The circumstances of a Dodd-Frank receivership will dictate the priorities in the initial response once the significant risk to the financial stability of the U.S. is identified. Coordination and information sharing with the federal government, needless to say, will drive much of the early activity and due diligence. Beyond those initial priorities, a number of items will inevitably be a part of any initial due diligence process. Among priority due diligence items in a Dodd-Frank receivership will be for the receiver to meet with the Regulator's staff and possibly also key company personnel as soon as possible to discuss Resolution Plans to the extent they are available, as well as the perceived causes of the insurer's difficulties, the insurer's "place" in the overall corporate structure and its relationship to the systemically important company, and receivership options best suited to accomplish an orderly resolution and liquidation. See Ch.1, § V(A) Receivers Handbook.

In the Dodd-Frank scenarios, as in all receiverships, the Receiver must be able to readily assess which assets are the insurer's assets. There must be a prompt review and analysis of the interaction and agreements between the insurer and its affiliates and vendors—service agreements, management agreements, key employment agreements, pooling agreements and other similar arrangements. See Ch. 8, 9 Receivers Handbook. In particular, identification and analysis of qualified financial contracts and the impact of any termination and netting rights must be conducted. There must be a prompt assessment by the Receiver of the potential for a successful rehabilitation of the insurance company prior to or in connection with liquidation. Information from state and federal regulators can greatly assist the Receiver. It is also important for the Receiver to meet with the insurer's officers and/or directors, when possible. While these are elements of nearly all insurance receiverships, the receiver should plan for a faster and more focused analysis under the urgent circumstances a Dodd-Frank receivership of an insurance entity presents.

### 3. Attempt to Broadly Pre-Identify Theoretical Scenarios and Responses

As referenced above, Resolution Plans, Contagion Reports or other regulatory mechanisms exist by which companies confidentially file with the Regulator their plans in the event of a § 203(b) determination as to the failure of an insurer or related entity. Using these or other regulatory mechanisms, such as financial examination, the Regulator can broadly pre-identify theoretical scenarios and responses for actual or potential systemically important companies in the state.

### 4. Internal Procedure for Initiating State Receivership, Including Procedure for Early Consultation with the State Attorney General or Other Stakeholders

- a. Assuming there is an external procedure for communicating the federal determinations and/or prior proceedings to the domestic Regulator, the Regulator must, in turn, trigger internal procedures for filing the appropriate judicial action seeking liquidation or rehabilitation within 60 days of the determination.
- b. Most Regulators and Receivers have established internal procedures for contacting the chief liquidation officer, consulting with the attorney general or others needed to file a state receivership action and for notifying the Court once the action is filed. These internal procedures should be adapted, strengthened and memorialized for Dodd-Frank scenarios to provide for heightened and expedited notice and court action. In some states, statutory or rule change will be required to adapt to a Dodd-Frank scenario. For example, if the state requires a public or non-public bidding process for the appointment of a Receiver, that process must

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<sup>19</sup> [www.fdic.gov/bank/analytical/quarterly/2011\\_vol5\\_2/lehman.pdf](http://www.fdic.gov/bank/analytical/quarterly/2011_vol5_2/lehman.pdf).



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:

- 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.

**D. Procedure for Rapid Consultation with the State Attorney General or Other Counsel Required to Prepare and Make the Initial Filing**

1. In all 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 is required to swiftly transition a systemically risky insurance company to receivership under state law.
2. In some cases, national coordination with Attorneys General 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 and/or qualified outside counsel who can respond to the magnitude of a Dodd-Frank receivership. This could ensure immediate consultation with attorneys needed to prepare and make the required filing in state court and execute the receivership under the urgent circumstances presented by a Dodd-Frank receivership.
5. Special attention should be devoted to those special cases in which the federal courts may also be involved, such as the insolvency of a risk retention group or the resort to Chapter 11 of the bankruptcy code by the parent or an affiliate of the troubled insurer that could result in the Section 362 automatic stay impeding accelerated proceedings.

**E. Other Considerations**

1. States and the NAIC should develop pre-screened/outlined court documents.
2. In some states, statutory amendments may be required or favored to assure that a federal determination under § 203(b) or consent at the federal level is grounds for liquidation. Potential changes are discussed below in section VI. Notwithstanding that, there are provisions in the NAIC models and Model #245 that can be incorporated into pre-screened court administrative documents for receiverships prompted by systemic risk determinations, such as:
  - a. Rehabilitation may be the best first step for all or part of an insurance company subject to a Dodd-Frank receivership, especially if there is a filed resolution plan providing for the orderly transfer, reinsurability or runoff of policyholder liabilities. Liquidation may be required if there is a critical need to trigger guaranty funds and an order of liquidation. Plus, a finding of insolvency is required by state law for that trigger. All receivership mechanisms should be considered in consultation with any applicable guaranty funds. In any case, rapid but sophisticated analysis of how a state receiver is going to close or resolve the insurance company must occur. This includes what liquid assets exist to run the receivership; what assets are (un)encumbered, including what liens have been taken by the FDIC; how assets can be sold or liquidated; how claims are going to be filed, determined and paid; and what is the effect of qualified financial contracts..
  - b. The following grounds for receivership or liquidation in most current state codes could provide grounds for an insurance company receivership order in the event of a federal determination and can be incorporated into a consent, model complaint and order along with other grounds that may exist (i.e., insolvency):

- 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. 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.

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<sup>20</sup>, 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 depository 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,<sup>21</sup> 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

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<sup>20</sup> 12 U.S.C. 1813(w)(6).

<sup>21</sup> 12 U.S.C. 1813(w)(5).

- (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.<sup>22</sup> If an insurance company is owned by a covered financial company, it is, therefore, an asset of the covered financial company, and the FDIC can transfer its ownership. The Dodd-Frank Act does not specify any conditions or limitations on the FDIC's power to transfer ownership, such as obtaining the approval of the domiciliary regulator. Thus, it appears that compliance with Insurance Holding Company System Regulatory acts is not contemplated, nor is compliance with other state laws governing ownership (for example, limitations on foreign ownership). It is possible that § 210(a)(1)(G) preserves state authority because comparable authority allowing the FDIC to transfer assets to a "bridge financial company" specifically excludes state approval. Whereas § 210(a)(1)(G) provides that the FDIC can make a transfer "without obtaining any approval, assignment or consent. . .," § 210(h)(5)(D), governing transfers by the FDIC to a bridge financial company, provides that a transfer is effective " . . . *without any further approval under Federal or State law*, assignment, or consent with respect thereto."<sup>23</sup> 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.<sup>24</sup>

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

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<sup>22</sup> § 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.

<sup>23</sup> § 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 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 and 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.

<sup>24</sup> § 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.

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 divided by the subsidiary) to provide capital to the insurer, or transfer of an affiliate or subsidiary whose operations are essential to or interwoven with the operation of the insurer.

The Dodd-Frank Act also provides that the FDIC may transfer the assets of a covered financial company for which it has been appointed as receiver to a "bridge financial company." As noted above, the transfer may be made without approval under "State Law." Again, the FDIC does not appear to be bound by any provisions of Insurance Holding Company System Regulatory acts or other state laws. Transfer of an insurer or its affiliates to a bridge financial company raises the same issues regarding ownership and operation as are raised by the FDIC's power to otherwise transfer ownership. Transfer to a bridge financial company contemplates a further transfer or other disposition of assets when the status of the bridge financial company terminates.<sup>25</sup> 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<sup>26</sup>. The contemplated purposes include: making loans to the covered financial

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<sup>25</sup> 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
- (D) the expiration of the period provided in paragraph (12), or the earlier dissolution of the bridge financial company, as provided in paragraph (15).

<sup>26</sup> § 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;

company or any "covered subsidiary"<sup>27</sup>; purchasing assets of a covered financial company or covered subsidiary<sup>28</sup>; selling or transferring all or any part of "such acquired assets, liabilities or obligations" of a covered financial company or covered subsidiary<sup>29</sup>; and making payments to certain creditors<sup>30</sup>. 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<sup>31</sup>, 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.<sup>32</sup> 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.

<sup>27</sup> Subsection (d)(1), *supra*.

<sup>28</sup> Subsection (d)(2), *supra*.

<sup>29</sup> Subsection (d)(5), *supra*.

<sup>30</sup> Sections 210(b)(4), 210(d)(4) and 210(H)(5)(E).

<sup>31</sup> See § 203(b).

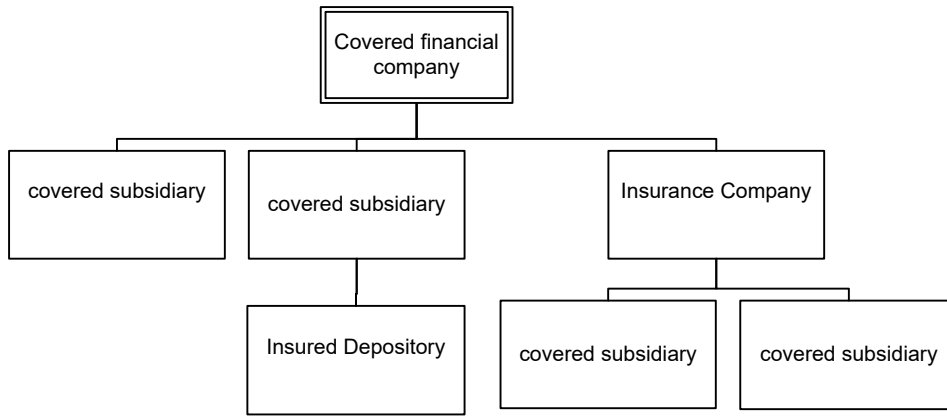
<sup>32</sup> § 201(a)(9) - Covered Subsidiary. -- The term "covered subsidiary" means a subsidiary of a covered financial company, other than ---

(A) an insured depository institution;

(B) an insurance company; or

(C) a covered broker or dealer.





The FDIC adopted Regulation § 380.6<sup>33</sup> 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

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<sup>33</sup> 12 C.F.R. § 380.6

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 [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).

In order to assist the states in this review, the Dodd-Frank Receivership Implementation (E) Working Group prepared the *Guideline for Implementation of State Orderly Liquidation Authority* (“Guideline”). See (Exhibit 11-C.) The Guideline is intended to provide guidance and serve as a template for potential state law drafting revisions. The Guideline provides that any of the triggers for a Dodd-Frank receivership under 12 U.S.C. § 5382(a), either consent by the company, entry of an order by U.S. District Court for the District of Columbia, or by operation of law under 12 U.S.C. § 5382(a)(1)(A)(v), see flowchart (Exhibit 11-A), constitute automatic grounds for rehabilitation or liquidation under state law. The Guideline also mirrors the Dodd-Frank Act by establishing timing and procedural rules for the expeditious entry and implementation of receivership orders that support both the policy goals of the Dodd-Frank Act and federal regulators, as well as the extraordinary responsibilities of state regulators for ensuring policyholder protection while resolving a systemically important insurance receivership.

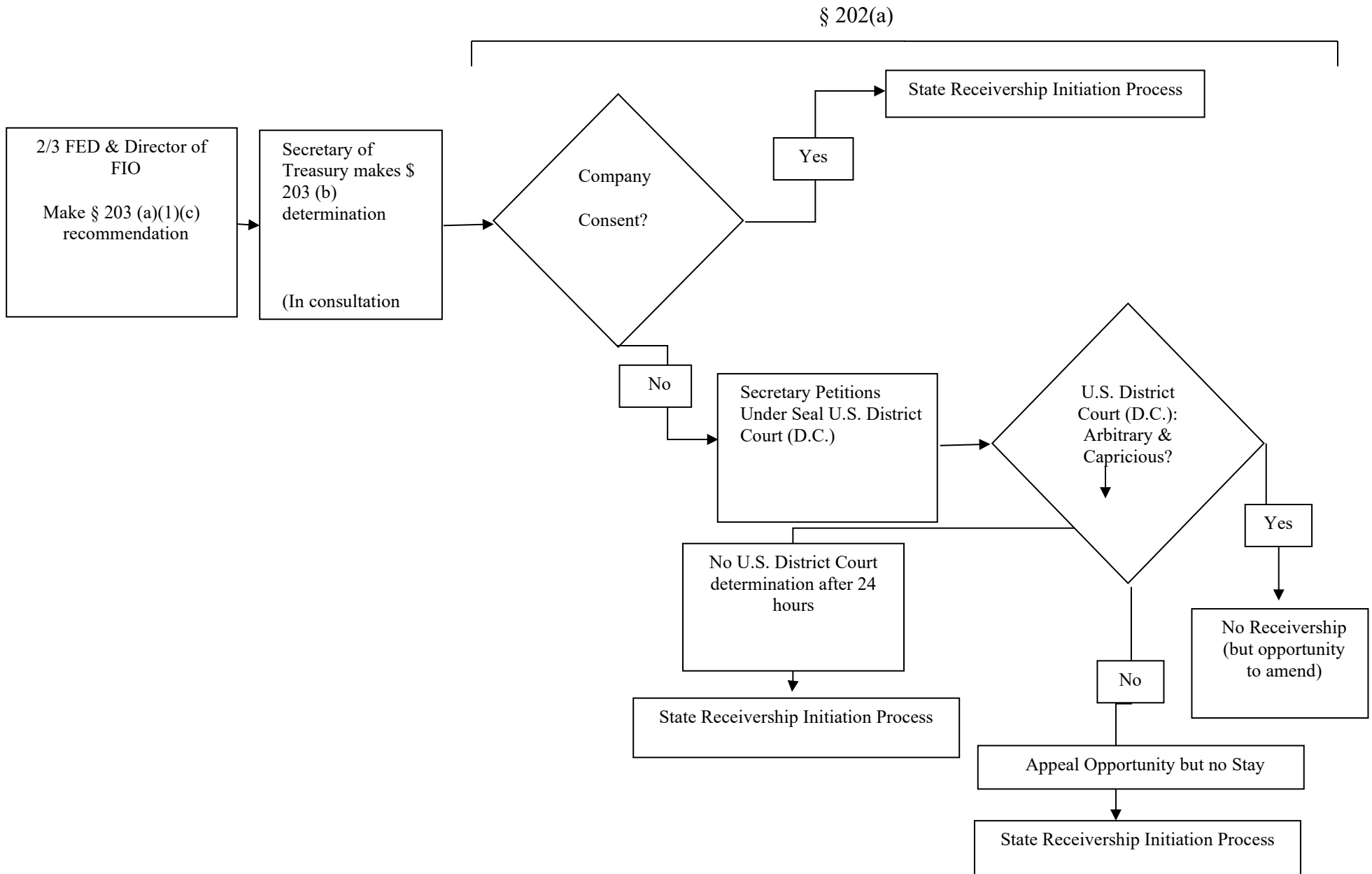
## **VII. EXHIBITS**

*Exhibit 11-A: Initiation of Orderly Liquidation of Insurance Company Under Dodd-Frank*

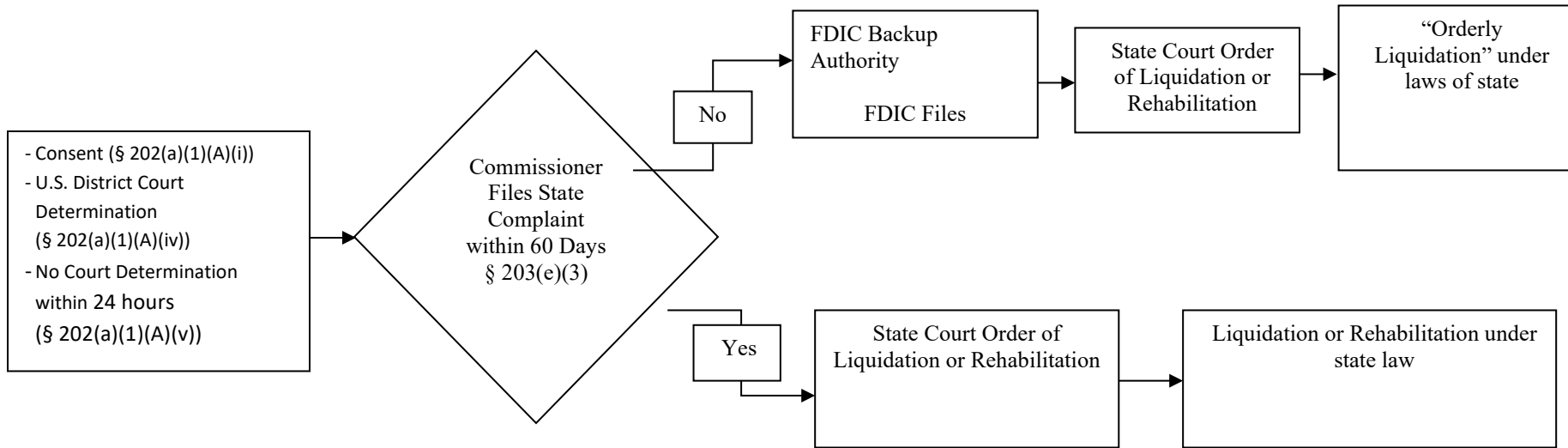
*Exhibit 11-B: State Receivership Initiation Process*

*Exhibit 11-C: Guideline for Implementation of State Orderly Liquidation Authority*

Exhibit 11-A: Initiation of Orderly Liquidation of Insurance Company Under Dodd-Frank



STATE RECEIVERSHIP INITIATION PROCESS



***Exhibit 11-C: Guideline for Implementation of State Orderly Liquidation Authority***

GUIDELINE FOR IMPLEMENTATION  
OF STATE ORDERLY LIQUIDATION AUTHORITY

**Drafting Note:** Title II of Dodd-Frank, Pub. L. No. 111-203, provides for the orderly liquidation of certain financial companies, including qualifying insurance companies, with the FDIC generally seeking the appointment as receiver. However, in the case of qualifying insurance companies, the liquidation or rehabilitation of such a financial company will be conducted as provided under state law pursuant to 12 U.S.C. § 5383(e). If, at the end of the 60-day period provided for under 12 U.S.C. § 5383(e)(3), the commissioner (or other appropriate regulatory agency) has not filed the appropriate state judicial action to place the insurer into orderly liquidation, the FDIC shall have the authority to stand in the place of the commissioner and file the appropriate judicial action in the appropriate state court to place the insurer into orderly liquidation under the laws and requirements of the state. The following statutory language is not an amendment to the NAIC receivership models, but is intended as a Guideline for use by those states seeking to review their authority under existing state law for purposes of initiating rehabilitation or liquidation proceedings in accordance with the federal statute:

**[ ] Orderly Liquidation Authority**

In accordance with Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 with respect to an insurance company that is a covered financial company, as that term is defined under 12 U.S.C. § 5381:

- A. The commissioner may file in the [insert proper court] court of this state a petition for an order of rehabilitation or liquidation on any of the following grounds:
- 1) Upon a determination and notification given by the Secretary of Treasury (in consultation with the President) that the insurance company is a financial company satisfying the requirements of 12 U.S.C. § 5383(b), and the board of directors (or body performing similar functions) of the insurance company acquiesces or consents to the appointment of a receiver pursuant to 12 U.S.C. § 5382(a)(1)(A)(i), with such consent to be considered as consent to an order of rehabilitation or liquidation; or
  - 2) Upon an order of the United States District Court for the District of Columbia under 12 U.S.C. § 5382(a)(1)(A)(iv)(I) granting the petition of the Secretary of the Treasury concerning the insurance company under 12 U.S.C. § 5382(a)(1)(A)(i); or
  - 3) A petition by the Secretary of the Treasury concerning the insurance company is granted by operation of law under 12 U.S.C. § 5382(a)(1)(A)(v).
- B. Notwithstanding any other provision in this Act or other law, after notice to the insurance company, the receivership court may grant a petition for rehabilitation or liquidation within 24 hours of the filing of a petition pursuant to this section.
- C. If the court does not make a determination on the petition for rehabilitation or liquidation filed pursuant to this section within 24 hours after the filing of the petition, it shall be deemed granted by operation of law upon the expiration of the 24-hour period. At the time that an order is deemed granted under this section, the provisions of [cite to applicable state law addressing rehabilitation or liquidation] shall be deemed to be in effect, and the receiver shall be deemed to be appointed [optional: affirmed] and have all of the applicable powers provided by [refer to applicable state law addressing rehabilitation or liquidation], regardless of whether an order has been entered. The receivership court shall expeditiously enter an order of rehabilitation or liquidation that:

- 1) Is effective as of the date that it is deemed granted by operation of law; and
  - 2) Conforms to [cite to applicable state law addressing rehabilitation or liquidation], as applicable.
- D. Any order of rehabilitation or liquidation made pursuant to this section shall not be subject to any stay or injunction pending appeal.
- E. Nothing in this section shall be construed to supersede or impair any other power or authority of the commissioner or state courts under this Act.