

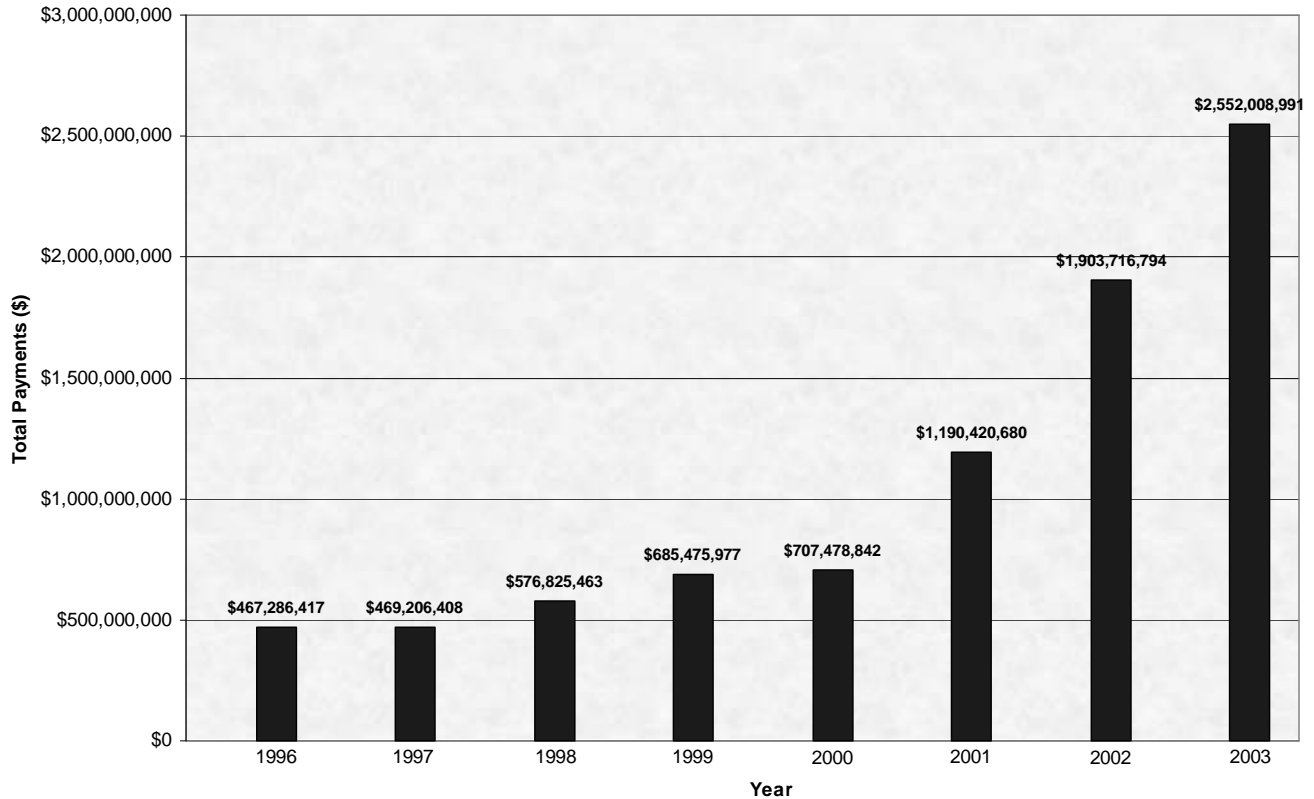
*THE NATIONAL CONFERENCE
OF INSURANCE GUARANTY FUNDS*

**NECESSARY REFORMS TO STRENGTHEN
STATE PROPERTY AND CASUALTY INSURANCE GUARANTY FUNDS
TO MEET THE CHALLENGES OF THE 21st CENTURY**

*A Report Prepared by the
NCIGF Board Task Force On Insolvency Issues*

A Call To Action

Guaranty Fund Payments



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Introduction and Executive Summary

The purpose of this Task Force Report is to provide regulators, legislators, insurance company executives, and trades, legislators -- all major stakeholders in the insurance insolvency system -- with a foundational understanding that the property & casualty insurance guaranty funds are a limited safety net, having only finite resources to reimburse those claimants who seek to recover from an insolvent insurer who are least able to bear the cost of an uninsured loss. When state legislatures created the guaranty fund mechanism, they did not intend to create an “entitlement” that guarantees the complete performance of an insolvent insurer’s obligations regardless of the identity and status of the claimant, and without regard to the nature of the claim. Such a system would be much broader and far more expensive than the focused safety net that state legislatures have authorized. Moreover, for many practical and public policy reasons, the guaranty fund system is not and should not be considered to be a “bail out” for state regulatory problems.

We hope that all readers take away from this Report a better understanding of the nature and purpose of the guaranty fund system. It is also our aspiration that each stakeholder gain an understanding of the difficult lessons to be learned from the large commercial insolvencies arising from the most recent downturn in the market cycle. These large and complex insolvencies have placed unprecedented stresses and challenges on the guaranty fund system. While the system has responded well with the limited tools and resources presently available, some clear lessons and urgent calls to action have emerged from these recent experiences. Reforms in the system, which are sorely needed, can be most effective if those reforms are devised in light of the lessons that emerged from the collective experience of the state property and casualty guaranty funds.

Regulators, legislators, receivers, and insurance companies all have an interest in a better-functioning guaranty fund system. Effective protection of insurance consumers requires the cooperation of regulators and guaranty funds to make the system work better. In order to maximize the assets of the system, a regulator’s timely decision regarding what action to take with respect to a troubled company is critical. Working together regulators and guaranty funds can make the liquidation process as painless as possible, recognizing that necessarily there will be some pain for everyone. Our focus must be our primary mission: helping those claimants and policyholders who cannot help themselves and are least able to bear the cost of an uninsured loss.

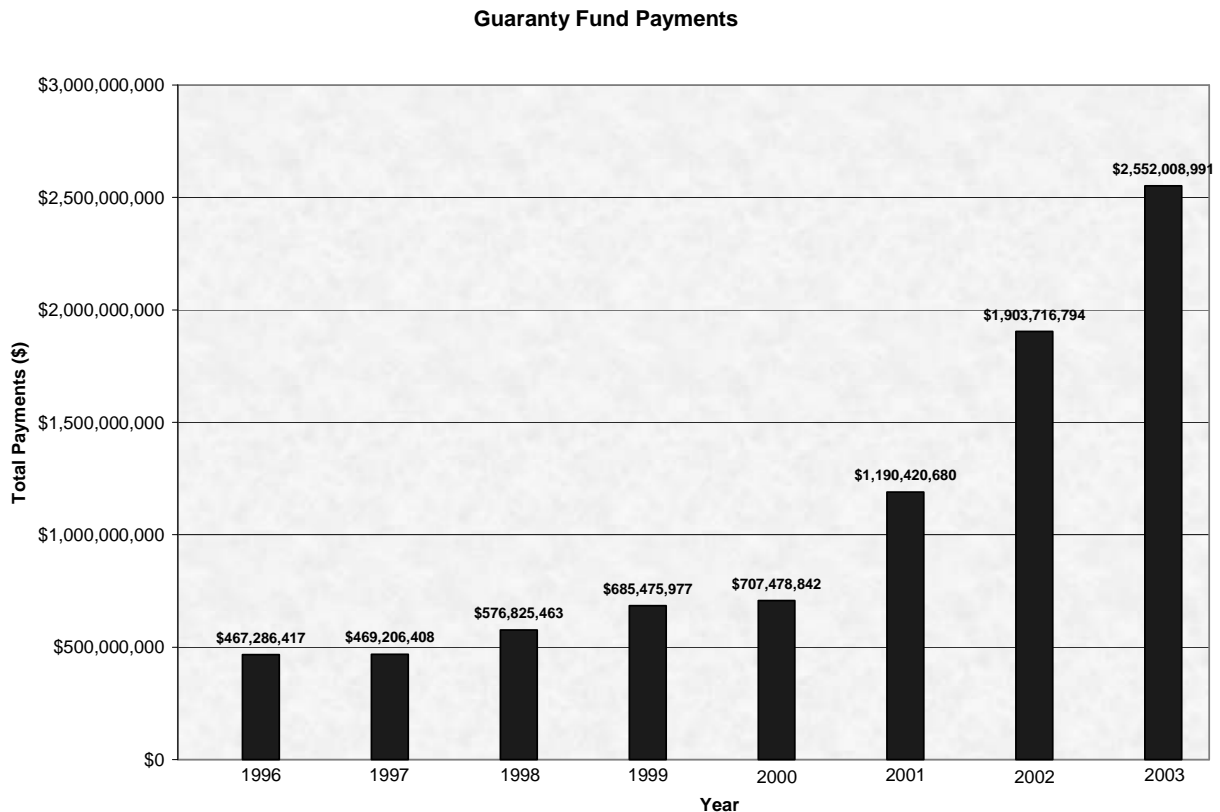
Insurance insolvency is an important area of public policy determined by state legislatures, with input from various knowledgeable sources. The guaranty fund system provides significant protections to those persons least able to bear the cost of an uninsured loss, but does so at a significant cost. Insurance insolvency is not only important but also an obscure, technical area of law that is easily overlooked. The system needs to be updated to ensure the continued integrity of the safety net, which will foster the essential, continued trust and confidence of the insurance-consuming public that their policies provide needed protections, even if the insurer becomes insolvent.

Insurers’ active participation in the guaranty fund system is essential to assure effective and efficient management of guaranty funds. The insurance insolvency process presently comes at a high cost to insurers and has the potential to cost insurers and the insurance consuming public much more. Insurers and guaranty funds working together can make sure that these insolvency costs are kept as low as possible, while also assuring that these limited resources are directed to where the need is greatest. Insurers can assist to obtain the necessary reforms, including changes in state laws, that will make the goal of having a cost-effective system an attainable one.

The insurance insolvency system works best if liquidators and guaranty funds share common and reasonable expectations and cooperate effectively. The harsh realities of modern commercial insolvencies present unprecedented challenges for both liquidators and guaranty funds and, unfortunately, can put liquidators and guaranty funds at cross-purposes. The reforms outlined in this Report are intended to address and mitigate, if not completely resolve, some of these difficult issues.

Other industry participants, particularly those in sales and service functions, may be in a position today where they believe that the problems described in this Report do not apply to them, at least not directly and immediately. The unintended consequences of recent changes in the insurance markets may provide incentives to disregard the financial strength of insurers, or at least to minimize the importance of this factor in consideration of short term gains. In the long run, however, all industry participants will bear the costs, directly or indirectly, of the insurance insolvency system.

The urgency of addressing needed insurance insolvency reform is demonstrated by the increasing burden the property and casualty guaranty funds have been asked to shoulder over the past few years. The chart below shows the total system “payout” for each of the last eight years:



While insurance company failures are inevitable, increasing costs of these failures are not. The reforms suggested in this Report are intended to reverse this trend, while maintaining the core integrity of the guaranty fund safety net.

I. WHERE WE STARTED

A. Development of Insolvency Laws

Since at least the early 20th century, property and casualty insurance companies with financial solvency problems have been regulated by state-specific delinquency statutes. While it is not the purpose of this Report to provide an encyclopedic survey of the history of insurance insolvency laws, the present problems -- including the root causes of the present high cost of the insolvency system -- are best understood in their historical context. Accordingly, the appropriate starting point for this discussion is an overview of the laws specifically addressed to insurance insolvency in the form of Insurance Liquidation Statutes and Guaranty Fund Statutes.

Insurance Liquidation Statutes

Virtually all modern insurance liquidation statutes share common roots, initially in equity courts. The modern receivership law of almost every state is based on either or both of the following two model acts: The Uniform Insurers Liquidation Act (“UILA”) and the Insurers Supervision, Rehabilitation, and Liquidation Act (subsequently superseded by the “Insurer’s Rehabilitation and Liquidation Model Act,” the “Model Liquidation Act”). The UILA was promulgated in 1939 by the National Conference of Commissioners on Uniform State Laws to address issues arising out of liquidation of insurers that have assets and liabilities in more than one state. In large part, it was drafted in response to problems identified from the insurer insolvencies that occurred during the Great Depression. Approximately twenty-four (24) states have adopted the UILA.¹

The Model Liquidation Act was promulgated by the National Association of Insurance Commissioners (the “NAIC”) in 1969, based in large part on Wisconsin’s liquidation statute as revised in 1967. The Model Liquidation Act delinquency proceedings short of liquidation, as well as liquidation of multi-state insurers, provide an administrative and substantive framework within which to conduct such proceedings. Approximately thirty-two (32) states and the District of Columbia have adopted the Model Liquidation Act in substantially the same form, and almost all of the remaining states have adopted some provisions of the Model Liquidation Act.² Notably, the

¹ See e.g., Ala. Ins. Code §§ 27-33-1 *et seq.*; Alaska Ins. Code §§ 21.78. 020 *et seq.*; Ariz. Ins. Code §§ 20-611 *et seq.*; Ark. Ins. Code §§ 23-68-101 *et seq.*; Del. Ins. Code §§ 20-5901 *et seq.*; Maine Ins. Code §§ 4353 *et seq.*; Md. Ins. Code §§ 9-201 *et seq.*; Mo. Ins. Code §§ 375-950 *et seq.*; Nev. Ins. Code §§ 686B.030 *et seq.*; N.J. Ins. Code §§ 17:30C-1 *et seq.*; N.M. Ins. Code §§ 59A-41-17 *et seq.*; N.Y. Ins. Code §§ 7408 *et seq.*; Okla. Ins. Code §§ 1901 *et seq.*; R.I. Ins. Code §§ 27-14.4-1 *et seq.*; Wash. Ins. Code §§ 48.99.010 *et seq.*; W.V. Ins. Code §§ 33-10-1 *et seq.*; Wyo. Ins. Code §§ 26-28-101 *et seq.*

² See Ala. Ins. Code §§ 27-32-1 *et seq.*; Alaska Ins. Code §§ 21.78.010 *et seq.*; Ariz. Ins. Code §§ 20-611 *et seq.*; Ark. Ins. Code §§ 23-68-101 *et seq.*; Cal. Ins. Code §§ 1010 *et seq.*; Col. Ins. Code §§ 10-3-501 *et seq.*, §§ 10-3-401 *et seq.*; Conn. Ins. Code §§ 38a-903 *et seq.*; Del. Ins. Code §§ 5901 *et seq.*; D.C. Ins. Code §§ 31-1301 *et seq.*; Fla. Ins. Code §§ 631.001 *et seq.*; Ga. Ins. Code §§ 33-37-1 *et seq.*; Haw. Ins. Code §§ 431:15-101 *et seq.*; Idaho Ins. Code §§ 41-3301 *et seq.*; Ill. Ins. Code §§ 5/187 *et seq.*; Ind. Ins. Code §§ 27-9-1-1 *et seq.*; Iowa Ins. Code §§ 507C.1 *et seq.*; Kan. Ins. Code §§ 40-3605 *et seq.*; Ky. Ins. Code §§ 304.33-010 *et seq.*; La. Ins. Code §§ 22:731 *et seq.*; Me. Ins. Code §§ 4351 *et seq.*; Md. Ins. Code §§ 9-201 *et seq.*; Mass. Ins. Code §§ 180A *et seq.*; Mich. Ins. Code §§ 500.8101 *et seq.*; Minn. Ins. Code §§ 60B.01 *et seq.*; Miss. Ins. Code §§ 83-24-1 *et seq.*, §§ 83-24-1 *et seq.*; Mo. Ins. Code §§ 375.1150 *et seq.*, §§ 375.535 *et seq.*; Mont. Ins. Code §§ 33-2-1301 *et seq.*; Neb. Ins. Code §§ 44-4801 *et seq.*, §§ 44-120 *et seq.*; Nev. Ins. Code §§ 696B.010

original Wisconsin act provided for a very specific priority of distribution for claims against the estate. Loss claims under policies were afforded “Class 3” treatment ahead of general creditors, with only administrative expenses and employee wages being afforded superior Class 1 and 2 treatment respectively. The institution of these specific categories was a departure from the common law standard of treating all claimants at the same priority and the less precise provisions of the UILA which provided only for claims for a particular class of claimants resident in a foreign state to be “preferred” if such claims would likewise be preferred in that claimant’s state. (The UILA also permitted owners of special deposit claims to have a priority claim on such deposit and owners of secured claims to take first on that security.) Commentary that accompanied the original Wisconsin bill stated with regard to Class 3 “This class contains the claims central to the social role of insurance. The typical policy is not an ordinary mercantile contract, but one of great public importance.” Wisconsin Laws of 1967, Chapter 89, §§200.08 *et seq.* (current version at Wis. Stat. §§645.01 *et seq.*). Most modern insurance liquidation acts adopt a priority distribution scheme very similar to that set out in the Wisconsin act, providing a well-established statutory priority for policy claimants over general creditors that is now nearly universal. This policy claim priority provided a measure of policyholder protection even before guaranty funds were created in most states. Policyholder claims under these provisions generally receive some partial recovery on their claims.³

While both the Model Liquidation Act and the UILA have evolved over time through general and state-specific amendments and other refinements, by and large the statutes that are presently on the books are very similar in structure and function to those laws when they were first enacted. The core concepts of both the UILA and the Model Liquidation Act were formed based upon experience from the Great Depression and immediate post-World War II era. The statutes, and the body of case law decided under them, are thus generally reflective of the liquidation of traditional insurers.⁴

Guaranty Fund Statutes

The concept of a property and casualty guaranty fund system was first introduced by the NAIC in 1969 with its promulgation of the Post-Assessment Property and Liability Insurance Guaranty Association Model Act (the “NAIC Model Act”). The Wisconsin Insurance Security Fund statutes promulgated in 1969 served as a basis for the NAIC Model Act. *See* Wisconsin Laws of 1969, Chapter 144, §§646.01 *et seq.* (current version at Wis. Stat. §§646.01 *et seq.*). All states and the District of Columbia, Puerto Rico and the Virgin Islands have since enacted laws providing for the establishment of a post-insolvency assessment property and casualty insurance guaranty fund.⁵ (While New York has a property and casualty guaranty fund, it is a pre-insolvency assessment fund.)

et seq.; N.H. Ins. Code §§ 402-C:1 *et seq.*; N.J. Ins. Code §§ 17B:32-31 *et seq.*, §§ 17:30C-1 *et seq.*; N.M. Ins. Code §§ 59A-41-1 *et seq.*; N.Y. Ins. Code §§ 7401 *et seq.*; N.C. Ins. Code §§ 58-30-1 *et seq.*; N.D. Ins. Code §§ 26.1-06.1-01 *et seq.*; Ohio Ins. Code §§ 3903.01 *et seq.*; Okla. Ins. Code §§ 1801 *et seq.*, §§ 1901 *et seq.*; Or. Ins. Code §§ 734.010 *et seq.*; Penn. Ins. Code §§ 40-11-101 *et seq.*; R.I. Ins. Code §§ 27-14.3-1 *et seq.*, §§ 27-14.4-1 *et seq.*; S.C. Ins. Code §§ 38-27-10 *et seq.*; S.D. Ins. Code §§ 58-29B-1 *et seq.*; Tenn. Ins. Code §§ 56-9-101 *et seq.*; Tex. Ins. Code Art. 21.28 *et seq.*; Utah Ins. Code §§ 31A-27-101 *et seq.*; Vt. Ins. Code §§ 7031 *et seq.*; Va. Ins. Code §§ 38.2-1500 *et seq.*; Wash. Ins. Code §§ 48.31.030 *et seq.*, §§ 48.99.010 *et seq.*; W.V. Ins. Code §§ 33-10-1 *et seq.*; Wis. Ins. Code §§ 645.01 *et seq.*; Wy. Ins. Code §§ 26-28-101 *et seq.*

³ *See, e.g.*, Ariz. Ins. Code § 20-629; Ga. Ins. Code § 33-37-41; Ill. Ins. Code § 5/205; N.Y. Ins. Code § 7434.

⁴ Within the last decade, there was an unsuccessful attempt to reform insurance receivership law through the use of an interstate compact and enactment of the Uniform Receivership Law adopted by the Interstate Insurance Receivership Compact Commission in September 1998. No state has enacted the Law.

Such state laws are in large part based on the NAIC Model Act, but there have been significant variations among the states.

In those states that have adopted the NAIC Model Act concepts, most guaranty funds are governed by a board of directors elected by the member insurers consisting of the property and casualty insurers that are licensed to do business in the state and write any of the lines of insurance to which the NAIC Model Act applies.⁶ Guaranty funds are generally organized as not-for-profit, unincorporated legal entities created by state statutes to assume and pay certain policy claim obligations of member insurers that are found to be insolvent by their domiciliary state courts (the “covered claims”). All insurers licensed to transact insurance business in a state for the lines of coverage protected by the guaranty fund are required to become members of such guaranty fund. For the most part, property and casualty funds become obligated, or, are “triggered” by a final order of liquidation with a finding of insolvency. A minority of states has a different triggering mechanism, the most common of which is a finding of insolvency only.⁷

After an insolvency, there is a transition period in which certain claims payment responsibility shifts from the insolvent company to the guaranty funds. Since a guaranty fund does not receive any asset distributions from the receiver for some further (often significant) period of time, the guaranty fund obtains the initial funds to pay the covered claims of the insolvent insurer in that state by assessing its member insurers to pay a percentage (typically capped at 1 to 2%) of their net direct written premiums⁸ in the state. While the administrative details of these assessment mechanisms vary somewhat among the various guaranty funds, each member insurer is typically assessed separately for each of the following three insurance accounts maintained by the guaranty fund: (i) the workers’ compensation insurance account; (ii) the automobile insurance account; and (iii) the account for all other property and casualty insurance. Other guaranty funds may have these accounts combined in as few as one unitary account. Member insurers may be able to recoup their guaranty fund assessments in one of the following three ways as provided by applicable state statutes: (i) increase of premium rates for policies sold in the state;⁹ (ii) set-off against the premium tax obligations imposed by that state;¹⁰ or (iii) imposition of surcharges on premiums for insurance policies written in the future.¹¹ Thus, at the end of the day, the cost of insolvencies is ultimately born by state taxpayers and insureds.¹²

⁵ All general references made to guaranty funds in this Report refer to property and casualty guaranty funds.

⁶ Because the purpose of this is to discuss the need for reform of the law setting forth the scope of the guaranty fund coverage and not to discuss the structure of the guaranty funds, for more information on guaranty funds generally, please refer to the NCIGF website at www.NCIGF.org. A general description of the guaranty funds is attached in Appendix E.

⁷ More information about specific triggering mechanisms for each property casualty fund is available on the NCIGF website at www.NCIGF.org.

⁸ “Net direct written premium” is typically defined as gross premium direct business written in the state in question, less return premiums and dividends paid or credited. Premiums on contracts of reinsurance are excluded.

⁹ *See, e.g.*, . Col. Ins. Code § 10-4-516; Fla. Ins. Code § 631.64.

¹⁰ *See, e.g.*, Ariz. Ins. Code § 20-674; Tex. Ins. Code Art. 21.28-C(Sec. 21).

¹¹ *See, e.g.*, Cal. Ins. Code § 1063.14; N.J. Ins. Code § 17:30A-16.

¹² One important variation from state to state is that, instead of maintaining separate accounts for different lines of insurance, some states have established separate guaranty funds to protect certain lines of insurance, most notably

The clear intent behind the NAIC Model Act was to use these limited assessment resources primarily to protect those insureds least able to bear the cost of an uninsured loss. This limited “safety net” intention is congruent with the environment in which the guaranty fund system was initially conceived. A rash of insolvencies in the early 1960s among automobile insurers that covered the substandard market prompted the Congress to introduce the bill that would have established a federal property and casualty guaranty fund. The bill was first initiated by Senator Thomas Dodd, who served on the Antitrust and Monopoly Subcommittee (the “Subcommittee”) of the Senate Judiciary Committee. Faced with the prospect of federal intrusion into an industry traditionally regulated by the states, the NAIC promulgated the NAIC Model Act in 1969, and virtually all of the states quickly passed similar guaranty fund legislation.¹³ Although the insolvencies occurring at the time of the creation of the guaranty fund system involved almost exclusively insurers writing in the substandard automobile insurance market, the NAIC Model Act and the state guaranty fund laws were written nonetheless to cover most property and casualty lines.

At the same time, the insolvency of a large commercial insurer was viewed as almost impossible to occur. There was certainly no “track record” available at the time to inform the decision to extend coverage to the commercial market segment, with policyholders as varied as main street storefronts to Fortune 500 conglomerates. Additionally, subsequent developments in commercial lines products were difficult, if not impossible, to foresee at that time, and the state guaranty fund laws were never expected to cover such products. The report on the hearing of the Subcommittee held on June 25, 1968 discussing the need for a safety net to cover insurer insolvencies suggests that such safety net was intended to protect individual policyholders and claimants rather than large commercial insureds. For example, in that hearing, Senator Dodd advocated the need for the safety net by stating that individuals who are driven by the unstable market force to high risk insurers “must face the fact that their families can never be secure by their fireside knowing that the insurance company standing between any judgment and their home may become insolvent.”¹⁴ In these circumstances, the insurance industry joined the very short list of industries where successful competitors are asked, as a cost of doing business that is ultimately passed to state taxpayers and insureds, to bear the financial burden to pay for losses associated with failed competitors.

Since the guaranty funds’ inception in the 1960s, their role has evolved significantly to become much more expansive, largely as a result of the insurance industry’s accelerated evolution of its insurance products and the courts’ broad interpretation of policy coverage. As the Congressional hearing discussed above confirmed, the guaranty fund system first came into existence to cover insolvencies that were mainly restricted to automobile insurers and fire insurers that operated in a limited geographical area and had primarily individual or small business policyholders. Automobile and fire insurance claims were prompt, definite, local and quickly resolved. Over the past two

workers’ compensation insurance. For example, Florida, New York, Pennsylvania and New Jersey all have a workers’ compensation insurance guaranty fund to protect claimants of insolvent workers’ compensation insurers. Some of these workers’ compensation guaranty funds are significantly older than the standard NAIC property-casualty guaranty funds, and date back to the late 1930s. As might be expected, these older statutes and funding mechanisms differ somewhat from the NAIC Model Act concepts, but the essential purposes are the same. *See, e.g.*, Penn. Stat. Ann., Title 40, § 1051, *et seq.* (“Pennsylvania Workers Compensation Security Act”).

¹³ *See* Michael P. Duncan, *Property-Liability Post Assessment Guaranty Funds*, 2 Issues in Insurance (4th edition 1987).

¹⁴ *See* Hearings on S. Res. 233, Part 13, Automobile Liability Insurance before the Subcommittee on Antitrust and Monopoly of the Committee on the Judiciary United States Senate, 90th Cong. (1968).

decades, however, property and casualty insurer insolvencies have increasingly involved large, multi-state insurers writing commercial insurance coverage, such as commercial general liability, fleet automobile or products liability coverage, to name a few. As a result, the insureds affected by insolvencies have changed from predominantly individuals and small businesses in local or regional markets to include a substantial number of large, national and international commercial enterprises. Such commercial policies are complex, long-tailed, unpredictable and geographically broad. Additionally, the financial sophistication and complexity of the commercial lines products themselves have evolved to a level where the dividing line between traditional insurance and much more complex corporate financing schemes has been blurred, a development that was unforeseeable at the outset of the guaranty fund system.

B. The Traditional Property and Casualty Business Paradigm Was the Foundation for the Insurance Insolvency Laws

The property and casualty business, by its nature, was for many decades a very traditional one. Traditional approaches to policy rating and statistical plans led to standardized products and underwriting approaches. Many of the assumptions about the traditional property and casualty insurance business, which represent how the insurance business was conducted 40 or more years ago, formed the foundation for the insurance insolvency laws. These foundational assumptions, however, in many cases no longer reflect the current insurance industry practice and products. Many of these traditional practices have greatly evolved and diversified in reaction to increasingly sophisticated and volatile financial markets and sophisticated policyholder demands for more responsive, customized, and cost-effective products.¹⁵

Standard Policy Forms Evolve Into Customized Programs

Traditionally, property and casualty insurance policies were underwritten using standard policy forms. Coverage was not only standardized, but the economic substance of the insurance transaction tended to be standardized as well: it was assumed that the premiums collected from the policyholders were calculated to fully cover loss exposure and expenses (together with income from investments and traditional reinsurance), and that the insurer itself would underwrite, administer and handle all claims arising under its policies. Based on such traditional insurance policy concepts, there was a relatively limited number of factors that could cause an insurer insolvency. These included an insolvency of one or more reinsurers, an unexpected and concentrated catastrophe, bad investment decisions, reckless or incompetent management, bad underwriting or fraud. In this traditional world, the risk factors faced by the guaranty funds were relatively finite. Insolvencies were more straightforward and most of the important issues and administrative questions were answered by the regulatory framework, including the insurance insolvency laws. Also in this traditional world, the use of individually negotiated arrangements, sometimes known as manuscript policies, was quite rare. Only the very largest of commercial risks had as any important part of their insurance coverage such individually tailored arrangements.

Over the last couple of decades, the traditional product uniformity in the commercial insurance marketplace has been on the decline. More and more property and casualty insurance

¹⁵ This Report undertakes merely to describe certain insurance industry practices as perceived through the lens of recent commercial insolvencies. These descriptions do not necessarily reflect the views of all members of the Task Force or any insurance companies or other organizations which they may represent. Nor should any comments be seen as a regulatory judgment whether any such practices are good or bad.

policies have been written as customized programs, which are contractually complex arrangements individually designed and tailored to meet the needs and desires of specific corporate policyholders. While the traditional property and casualty insurance policies still exist and are a critical part of these programs, they are often being written as merely one part of a complex financially-structured insurance program composed of several policies, each typically insuring various types of risks of a large commercial insured. Additionally, various other endorsements, contracts and financial instruments all interact together with the traditional policies to fashion a customized cash flow, security and collateral arrangement, and premium and funding structure. For such insurance programs, the payment structure is often negotiated for the entire program and not for the individual policies, and often include various loss-sensitive products or other deferrals of premium or other funding obligations. Thus, when this kind of an insurance program includes policies issued by an insurer who becomes insolvent, assets that have traditionally been available to the insurer's estate may not be immediately available (or liquid) to cover the losses for which guaranty funds become responsible as they assume their statutory responsibility to pay certain individual policy claims.

New Loss-Sensitive Products

The traditional concept of an insurance policy transferring all, or substantially all, risk of loss in exchange for an up-front, pre-determined premium, has also declined in use over the last decade or two.¹⁶ The structure of certain property and casualty insurance products typically issued to large commercial insureds has become much more sophisticated and resembles corporate financing vehicles rather than traditional "paid up front" insurance products which transfer all insurance risk. For example, some insurance policies typically covering workers' compensation, commercial automobile and general liability exposures of a large commercial insured provide, on their face if viewed alone, coverage on a first dollar basis. Such policies are written, however, subject to endorsements setting forth deductibles that are large in amount, typically \$250,000 or more per claim, for which the insured agrees to be financially responsible. Under these arrangements, typically referred to as "large deductible" policies, although overall the insured has agreed to retain most of the claims exposure, the insurer under the policies is often legally responsible to pay all claims within the deductible if the insured does not do so. The insurer therefore usually requires the insured to post collateral in favor of the insurer to secure the insured's payment and other obligations under these arrangements. Collateral may be held in a variety of arrangements, sometimes by the insurer and sometimes by third parties, of varying complexity and sophistication. Other kinds of endorsements and contractual arrangements, ranging from self-insurance retentions to complex captive reinsurance arrangements, have resulted in customized risk transfer and risk financing arrangements, many of which still include a traditional policy as an integral part of the overall structure -- thus complicating guaranty fund coverage and administration.

Use of Third Party Administrators

Because holders of loss sensitive policies often retain most of the claims exposure, such policyholders often prefer to designate, in conjunction with their insurer, a third-party administrator (a "TPA") to provide the various administrative and claims handling services for the policies rather

¹⁶ The traditional departure from this concept was retrospectively rate policies, which adjusted premiums periodically in proportion to actual loss experience under the policy. These were traditionally available only to larger commercial policyholders. Other products, such as certain large deductible policies, achieve similar financial results.

than having such services performed by the insurer. Often, a given TPA is already providing various services for the policyholder in connection with its other policies or in other states where the policyholder is self-insured. As an added incentive, when a policyholder chooses to utilize the services by a TPA, such policyholder often receives a discount from the insurer on the premiums to reflect the insurer not incurring the claims-handling costs. These discounts may exceed the amount charged by the TPA. In the foregoing example, once the insurer issues large deductible policies, it no longer performs many of the functions typically provided by an insurer in the past.

Diverse Electronic Claims Data Displaces Physical Files

Another assumption about the traditional concepts of insurance policies that no longer reflects the current insurance industry practice is that the insurer maintains claims information and data (collectively, “claims files”) in the form of paper documents in easily identifiable locations, as in the past. Receivers in recent years have increasingly faced challenges in locating claims files of the insolvent insurer because more and more claims files are stored in an electronic form, sometimes in multiple systems and in different formats. Moreover, due to the increased use of TPAs, claims files are no longer fully under the possession or control of the insurer. Receivers frequently encounter TPAs that do not cooperate with the receivers’ request for the claims files. Because it is crucial for the guaranty funds to obtain claims files to pay covered claims, the difficulty of locating claims files severely and adversely affects the guaranty funds’ ability to provide necessary and prompt claimant protection. Additionally, with modern information systems now in place at the guaranty funds, it is perhaps equally critical that the guaranty funds receive from the liquidator the best, most accurate data possible concerning the outstanding claims and liabilities of the insolvent company, in conjunction with the related physical files.

C. Discussion of How Well Insolvency Laws Have Worked

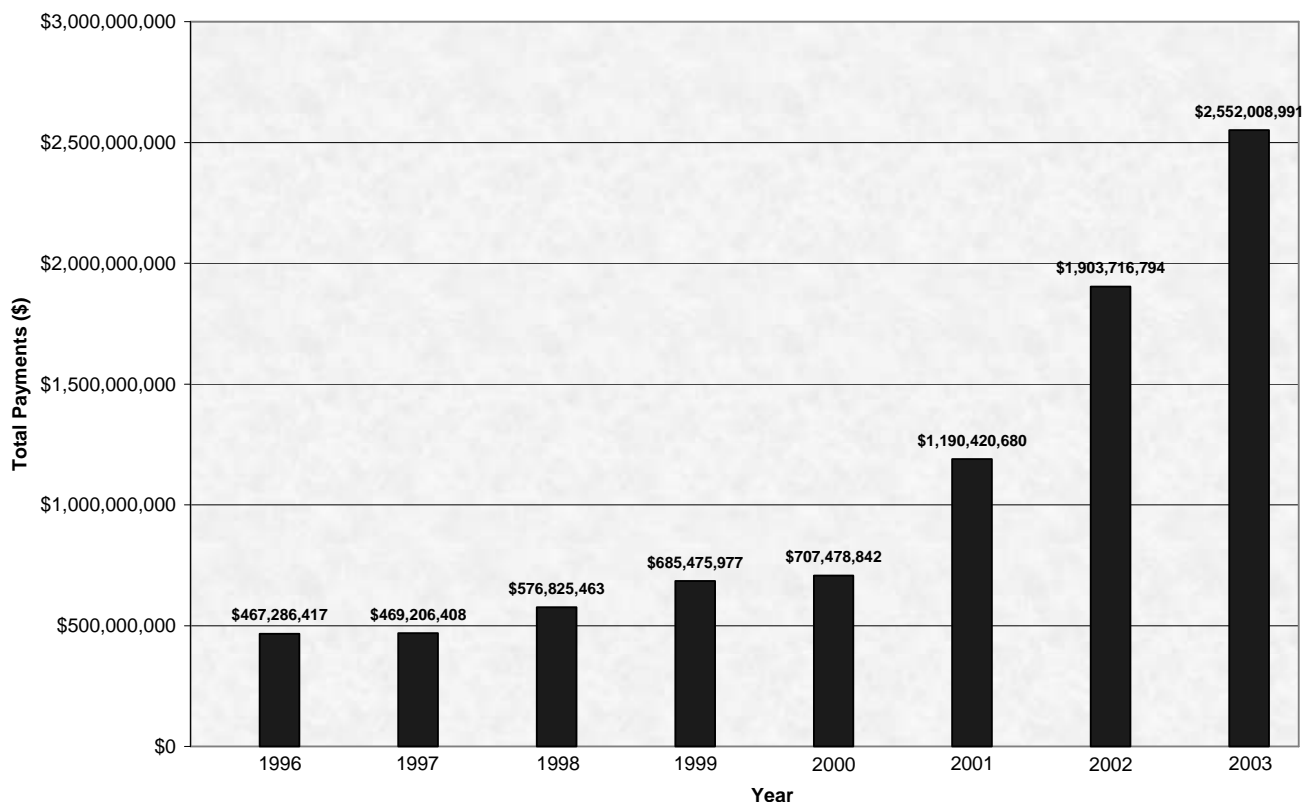
The Scope of the Guaranty Fund Safety Net

The guaranty fund system has effectively provided a huge and important safety net for victims of insurer insolvency over the last three decades. The gross payment statistics effectively depict the significant scope of the safety net: from 2001 to 2003, the guaranty funds paid out more than \$5.5 Billion, fueled in large part by the insolvencies of Reliance Insurance Company, Legion/Villanova Insurance Company, PHICO, HHH, Reciprocal of America, Superior National, Fremont, Home Insurance Company, and Highland Group, among others. The final figure for 2003 alone exceeds \$2,550,000,000.¹⁷

As the chart on the following page dramatically demonstrates, the amount of funding necessary to operate vast safety net has increased dramatically in the last several years:

¹⁷ The National Conference of Insurance Guaranty Funds regularly surveys its members for statistical information regarding guaranty fund payments and assessments, among other information. The figures in the charts and tables on the cover and on pages 2, 10, and 20 are compiled from these surveys. While the data is generally very reliable, a small amount of the data, especially for more recent years, is estimated and is thus subject to minor refinements and corrections. None of these refinements or correction would materially affect the clear trends shown in the referenced charts and table. Data for 2004 has not been compiled as of this writing.

Guaranty Fund Payments



To place this chart in some further context, note that since 1969 there have been over 400 property and casualty insurers placed into liquidation by state insurance commissioners. In each instance, state guaranty funds have effectively stepped in to adjust and pay the claims of policyholders and claimants affected by those insolvencies. From the inception of the system until 2000, the guaranty funds had paid covered claims totaling more than \$10 billion. ***In 2001 to 2003 alone, guaranty funds have paid out an amount equal to approximately one half of that prior thirty-year total.*** This recent spike in payments has in some cases stressed the guaranty fund workers' compensation assessment accounts, and the insurers paying assessments on workers' compensation premiums. In fact, projected fund payouts in a small number of states have greatly exceeded available capacity and those guaranty funds have had to resort to legislative revisions to permit tapping other assessment accounts, borrowing, and other measures to meet these obligations. Insurers paying heavy workers' compensation assessments have done so while at the same time bearing their own often significant losses in the workers' compensation line of business. Additionally, insurers have been faced with increased assessments from residual market pools and the like at the same time guaranty fund assessments are at their peak.

The present trend, both in terms of the difficult workers' compensation market and the high frictional costs associated with the line, is expected to continue for some time. In particular, guaranty fund assessments can be expected to remain at or near their current high level for the next

several years -- continuing to strain resources in some states.¹⁸ While member insurance companies of state guaranty associations have willingly met their assessment obligations, many have been prompted by these assessments to question whether the scope of guaranty fund obligations have expanded well beyond the original safety net function that the NAIC Model Act originally intended to provide. In addition to being presented with claims from individual policyholders and other claimants who clearly have no other viable means of addressing their insolvency losses, the guaranty funds have been faced with claims from large commercial entities, complex coverage programs and multi-million dollar exposures, no small part of which are the result of the changes in the commercial insurance marketplace described throughout this Report.

Through this evolution, the cost and scale of the guaranty fund system has grown to exceed the expectations that were reasonably foreseeable when the legislation was enacted in most states. Steps need to be taken to manage insurers so that insolvency liabilities are brought down to a reasonable level. Further, coverage parameters need to be refined so that the original purpose of the guaranty funds is realized. Those who have no other means of addressing their losses should continue to be protected. System capacity should be preserved to pay claims to these individuals by limiting or eliminating claims of large commercial entities that can make a sophisticated decision on their choice of coverage and can bear their own losses when a company does become insolvent.

Financial Resources of Guaranty Funds

Having paid billions of dollars in claims, guaranty funds have sought to recover as much of their payments as possible from the assets of the insolvent insurer's estate. Estate recoveries usually occur many years after the guaranty funds have paid claimants and often result in recovery representing only a fraction of what the guaranty funds have paid for the covered claims. Through 2003, guaranty funds have recovered from insolvent insurers' estates slightly more than 33% of their payments. Thus, almost 70% of the cost of insolvencies incurred by the guaranty funds is passed on to member insurers through assessments.¹⁹ As mentioned above, it is intended that the member insurers recoup all or almost all of the assessments from the state taxpayers and/or the insurance buying public under the following three different methods:

- (i) through the statutory provisions that allow an insurer to include the cost of past assessments for insolvencies as a component of premiums charged to insureds for policies ("rates and premiums" provision);
- (ii) through the statutory provision that allows the insurer to offset amounts due for premium taxes by assessments paid, usually over a three to five year period ("premium tax offset" provision); and
- (iii) through the statutory provision that allows an insurer to pass on the cost of assessments by including in premium notices a charge separate from premiums for each policy written ("policyholder surcharge" provision).

Of the guaranty fund statutes of the various states and territories, approximately thirty (30) jurisdictions have a rates and premiums provision, approximately twenty (20) jurisdictions have a

¹⁸ The annual amounts of assessments and capacity implications are discussed further below in Section II. C.

¹⁹ See NCIGF Assessment and Financial Information available at <http://www.ncigf.org/>.

premium tax offset provision, and five (5) jurisdictions have a policyholder surcharge provision. Solvent insurers fund the initial cost of the guaranty fund system. Based on such recoupment methods, the cost of insolvencies is ultimately born by insurers, who may pass on a substantial portion of these costs to state taxpayers and policyholders. As can be seen from the figures set forth above, the overall social cost of the system is significant.

Limited Beneficiaries of the Guaranty Fund Safety Net

The guaranty fund system was intended to benefit those least able to absorb the loss of insurance insolvency, and not to pay all policy claims of the insolvent insurer. From the beginning, the NAIC Model Act never provided that guaranty funds would pay all policy claims in their entirety. As stated in the commentary to the NAIC Model Act, the purpose of the promulgation of the NAIC Model Act was to “provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer....” (Emphasis added.) The original intent behind the creation of guaranty funds to cover only “certain” and not all insurance policies and claims is reflected in the various provisions of the NAIC Model Act. For example, Section 8(A)(1)(a) of the NAIC Model Act provides that the guaranty fund is obligated to pay covered claims, except workers’ compensation benefits, in an amount not to exceed \$300,000 (or the policy limit if less than \$300,000), a maximum limit that has been adopted in the vast majority of the states as a statutory cap. In addition, Section 3 of the NAIC Model Act excludes from its protection the following lines of insurance: life, annuity, health or disability insurance, fidelity or surety bonds, credit insurance, vendors’ single interest insurance or collateral protection insurance, warranties or services contracts, title insurance and ocean marine insurance, to name a few.

Moreover, in a further confirmation and refinement of these limitations on guaranty fund coverage, the NAIC Model Act was amended in the 1980s to allow guaranty funds to recover payments made to third party claimants from a high net worth policyholder.²⁰ High net worth for these purposes was defined as in excess of \$50 million. Such policyholders were viewed as sophisticated enough to assess the risk of insolvency in buying insurance. Further, this high net worth provided them with the necessary “cushion” to bear insurance insolvency losses on their own. As further discussed below, many states enacted this high net worth exemption. Other state guaranty funds, however, do not have this high net worth exemption, creating certain coverage anomalies further discussed below.

Thus, as expressed in the NAIC Model Act, the guaranty funds do not, and were never intended to, cover all obligations of the insolvent insurer, nor do they guarantee policy obligations of the insolvent company in full. Rather, the guaranty funds were created primarily to protect those least able to bear the cost of an uninsured loss -- mainly personal lines insureds, small business policyholders and individual third-party claimants -- who usually lack sophistication to select a financially solid insurer or who otherwise lack a financial cushion outside of insurance coverage. The guaranty funds have so far successfully achieved the goal for which they were originally created.

The benefits of the guaranty fund system, however, have been conferred upon many other claimants and types of claims who cannot fairly be said to fall within the core group of intended beneficiaries as envisioned at the inception of the system. For example, multi-state commercial

²⁰ NAIC Model Act, § 11(b).

insurer insolvencies are significantly more expensive and inherently more time-consuming than those covering single-state or regional insolvencies. More importantly, the policyholders and many claimants involved in such insolvencies are a quantum leap different as well -- generally larger, more sophisticated entities with substantial financial resources. Because the current state guaranty fund system was built primarily on experience with small, local, or regional insolvencies, it was neither designed nor originally expected to handle some of the more complex issues arising out of large national or international insolvencies.

Based on the original intent behind the creation of the guaranty fund system and the public policy grounds, large commercial policyholders were never the contemplated beneficiaries of the guaranty fund coverage. Large commercial policyholders are better equipped than personal lines policyholders to evaluate the financial strengths of insurers or have the access to professional guidance in the selection of a financially-solid insurer. Further, generally such large policyholders are also more capable of absorbing uninsured losses than policyholders in other lines. If such large commercial policyholders know that they will not bear the full cost of the insolvency of their insurer, they are more likely to ignore the financial weaknesses of the insurer in their selection process and to focus solely on the price.

To balance the price paid by solvent insurers to guaranty funds with the magnitude of insolvency liabilities, there must be realization that insolvencies cannot be completely absorbed by the remaining solvent insurance industry, their policyholders, and state taxpayers -- some of the losses must be borne by others. The guaranty fund capacity should be focused and used more effectively by limiting the nature, scope and extent of covered claims. Guaranty fund protection should be channeled only to those who cannot protect themselves and thus are most in need of protection.

Guaranty Fund Coverage of Commercial Lines Insolvencies in the Past

The scope of coverage by the guaranty fund safety net originally intended for unsophisticated personal lines policyholders changed dramatically in 1979 upon the insolvency of Reserve Insurance Company ("Reserve"). As the first insolvency of a major commercial carrier with business written in every state, Reserve raised problems that had not been contemplated by the drafters of the NAIC Model Act.²¹ The insolvency of Reserve was followed by the insolvencies of Transit (1985), Midland (1986), the Mission Companies (1987), Integrity (1987), and American Mutual (1989). These companies wrote coverages for large commercial insureds such as Union Carbide, General Electric, 3M and Dow Chemical, among others. Multi-million dollar claims were presented to the guaranty funds for liabilities resulting from mass torts, environmental clean up cost, asbestos related diseases and the like.

Claims presented by these large commercial insureds tested the guaranty fund safety net in a new way and added many new complexities to the claims adjustment/adjudication process. Often, the coverages written by the insolvent insurer resulted in potential guaranty fund liabilities in several states. Also, because of complex products liability exposure or masses of APH²² claims, a typical large insured had multiple "layers" of coverage invoked on their claims with insolvent carriers

²¹ National Association of Independent Insurers, *Insurer Insolvency: Public Policy Recommendations for Improvement*, A Report of the NAII Task Force on Solvency to the NAII Board of Governors 28 (1989).

²² Asbestosis, Pollution, and other Health hazards.

participating at various levels in various years. Policyholders and claimants attempted to “forum shop” in order to obtain maximum judgments against the guaranty funds. As a result, guaranty fund statutory provisions requiring the exhaustion of all other insurance enacted in most of the states became critically important to guaranty fund coverage defenses. Covered claim definitions and limits that were originally drafted with an intention to cover an individual insured or other claimant presenting a single claim to a guaranty fund were used to assert that an insured was entitled to multiple “covered claim” recoveries, often rendering the “per-claim” cap for non-worker’s compensation claims an uncertain and often ineffective means of limiting guaranty fund exposure. Because of the complexity of the issues, the dollar amounts involved and the potential exposures for multiple guaranty funds, it became apparent that “global settlements” among the various involved guaranty funds and the insured would be a practical necessity. Several such settlements have been negotiated and implemented through the coordinated efforts of the guaranty funds with generally successful results.

While clearly the guaranty fund statutes were not drafted with a view to potential exposures resulting in claims from large commercial insureds, the results of guaranty funds’ encounters with such entities are mixed. In some cases the guaranty funds paid out extremely large amounts on the claims of the large commercial enterprises. In other cases, courts applied the guaranty fund statutes in a way that the insured recovered only a small fraction of the amount originally claimed. The following is a very brief summary of some of the issues arising from guaranty funds and various commercial exposures. A more detailed discussion is provided in Appendix A.

i. Mass Tort and APH Exposures

On several occasions the guaranty funds have been faced with multi-million dollar claims for liabilities on mass tort and APH exposures. Probably the most notable example among these cases is the Union Carbide case, in which claims against three insolvent carriers affording total policy coverages of \$32,500,000 were presented to the Connecticut Insurance Guaranty Association (“CIGA”).²³ In this matter the court held that CIGA’s covered claim limit of \$300,000 applied to each of the individual underlying claims for the incident giving rise to such claims.

More recent case law involving the application of per-claim caps has served to limit the guaranty fund liability under similar, though not identical, fact patterns. Certain statutory amendments have been enacted to address the issue of applying these caps, but these statutory clarifications have generally been on a state-by-state basis.

ii. Residency and Jurisdiction Issues

Insureds have often tried to stretch the law in their efforts to recover against the guaranty funds by attempting to establish that they should be considered “residents” of a particular state for the purpose of coverage under the guaranty fund statutes. In Clark Equipment Co. v. Massachusetts Insurers Insolvency Fund,²⁴ Clark attempted to obtain coverage from the Massachusetts Insurers Insolvency Fund (the “Massachusetts Fund”) based on the Massachusetts residency of some of the tort claimants who had asserted claims against it. The Massachusetts Supreme Judicial Court

²³ Connecticut Ins. Guar. Ass’n v. Union Carbide, 585 A. 2d 1216, 1219 (Conn. 1991).

²⁴ 666 N.E. 2d 1304 (Mass. 1996).

pointed out that because the underlying tort claimants in the matter were not asserting claims against the Massachusetts Fund, they were not “claimants” within the meaning of the Massachusetts guaranty fund statutes. Clark, although it was asserting claims, was not a Massachusetts resident. Therefore, Clark’s claims were not “covered claims” within the meaning of the Massachusetts guaranty fund statute.²⁵ Insureds have also unsuccessfully argued that they were residents for purposes of guaranty association coverage because they were subject to the jurisdiction of that state’s courts.²⁶

iii. Guaranty Associations’ Non-Duplication of Recovery Provision in the Context of Commercial Coverage

From the inception of the 1969 model bill developed by the NAIC, guaranty fund acts have typically contained a provision that made the guaranty fund coverage secondary to any applicable solvent insurance coverage. The exhaustion of other coverage provision serves as a means to decline coverage when other resources are available to the claimant and preserve guaranty association assets for those who need it most. In other words, the guaranty fund may “set-off” other coverage from its obligation, in contrast to the normal situation where insurance recoveries do not have this effect due to the “collateral source” rule.²⁷ This reversal of the normal “collateral source” approach serves as one important limitation on guaranty fund exposure.

A typical provision would read as follows:

- (1) Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his right under such policy. Any amount payable on a covered claim under this Act shall be reduced by the amount of recovery under such insurance policy.
- (2) Any person having a claim or legal right of recovery under any governmental insurance or guaranty program which is also a covered claim, shall be required to exhaust first his right under such program. Any amount payable on a covered claim under this Act shall be reduced by the amount of any recovery under such program.
- (3) 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, he shall

²⁵ *Id.* at 1307. A similar result was reached in *T & N, plc v. Pennsylvania Ins. Guar. Ass’n*, 44 F. 3d 174, 176 (3rd Cir. 1994).

²⁶ Conversely, claimants have also tried to recover from out-of-state guaranty funds through litigation in the claimant’s home state, arguing that because guaranty funds, by statute, stand in the shoes of the insolvent insurer to the extent of covered claims, that they may be brought in to a foreign jurisdiction. A majority of the courts have rejected this argument, but a minority courts have embraced it. *See, generally, General Electric Co. v. California Insurance Guaranty Association*, 997 S.W.2d 923 (Tex. App. 1997).

²⁷ The “collateral source” rule bars a defendant from introducing evidence of payments to a claimant from a non-party to the litigation, such as an insurer, thereby essentially allowing a plaintiff to recover the same damages twice. Over 20 states have addressed this common law rule with statutes reversing it to some degree.

seek recovery first from the Association of the location of the property, and if it is a workers' compensation claim, he 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.

Accordingly, under these provisions, a claimant is required to collect (and exhaust) any benefits he may be entitled to under an insurance policy issued by another solvent insurer. Additionally, the guaranty fund is entitled to a credit against its liability for the amounts received from another insurer. These protections typically also extend to the policyholder of the insolvent insurer as well, who thus receives some of the protection bargained for in the purchase of insurance.

Exercise of the guaranty fund's exhaustion and set-off rights becomes more difficult when the insured presenting the claim has a complex system of insurance coverage with various insurers participating on the same layer and on multiple excess layers. Moreover, the complexity is compounded by the trigger mechanisms and coverage issues presented by typical APH claims. Interpretation of guaranty fund obligations vis-à-vis other solvent coverage often depends on policy specific provisions. For example, when an excess policy called for the coverage to be triggered when the insurer's obligation was in "excess of primary policy limits," many courts held that the excess carrier was not obligated to "drop down."²⁸ In contrast when the policy language provided that the coverage was excess over "amounts recoverable" or "collectible" under primary policies, the courts found that the underlying carrier's insolvency resulted in no amounts being recoverable and thus required the excess insurer to drop down and provide coverage for the loss.²⁹ Later decisions broadened the traditional coverage analysis to include consideration of other policy clauses and conditions. One commentator noted that cases on these issues demonstrated a "remarkable lack of uniformity."³⁰

Additional questions arose regarding whether the excess coverage should drop down only to the point of guaranty fund limits or serve as a complete substitute for the primary coverage, thus extinguishing guaranty fund obligations. Courts have examined these issues with diverse results.³¹ A different but related issue arises when several carriers participate in the same layer. Some courts have made the solvent carriers responsible for only a prorated share of the liability.³² These courts have erroneously treated the guaranty funds as if they were a solvent insurer, rather than a source of last resort.

iv. Other Issues

Other issues that the guaranty associations have confronted in the context of commercial insolvencies include the scope of the associations' duty to defend and guaranty association coverage

²⁸ See, e.g., Wells Fargo Bank N.A. v. Calif. Ins. Guar. Ass'n, 45 Cal. Rptr. 2d 537 (Cal. Ct. App. 1995).

²⁹ See, e.g., Sifers v. General Marine Catering Co., 892 F. 2d 386, 401-403 (5th Cir. 1990).

³⁰ Forney, K., Editor, Annotated Model Insurance Guaranty Act, p. 171 (Distributed by The National Conference of Insurance Guaranty Funds, 2004).

³¹ See, e.g., Nasello v. Transit Cas. Co., 530 So. 2d 1114 (La. 1988); but see Weaver v. Kitchens, 556 So. 2d 120 (La. Ct. App. 1990).

³² Revco v. Government Employees Ins. Co., 791 F. Supp. 1254 (N.D. Ohio 1991).

for entities that self-insure when an excess policy is triggered. These are discussed in more detail in Appendix A attached hereto.

II. WHERE WE ARE NOW

A. Current State of the Property and Casualty Industry and the Changes in the Nature of the Business

As mentioned above, increasingly sophisticated insurance products such as complex large deductible policies and structured captive programs enabled the policyholders of various lines of property and casualty insurance policies to retain significant claims exposure and thereby reduce premiums. Because under these arrangements the insurer transfers significant portions of the ultimate financial risks directly or indirectly back to the policyholder, the reduced premiums for such policies by design do not provide sufficient assets to fund all anticipated claims payments when due. Rather, premiums under such policies are often substantially reduced to reflect a much smaller transfer of risk and the lower administrative costs paid to the insurer for issuing a policy that is primarily to comply with certain regulatory requirements to obtain insurance, rather than handle and pay claims within the coverage. The insurer's technical legal responsibility for the claims payment in the event the policyholders fail to pay their claims is often secured by collateral in various forms posted by the policyholders, instead of payment of premiums that become assets of the insurer.

Traditionally, the underwriting insurer performed various operating services for its policies such as claims handling, loss administration reporting, medical utilization review, rehabilitation services and the like. In recent times, however, more and more such operating services are performed by TPAs (or, in some instances, other additional service providers) pursuant to side agreements between the insurer and the policyholder and between the insurer and a TPA. As mentioned above, an increasing number of commercial policyholders are retaining financial risks under their insurance policies and often prefer to designate, in conjunction with their insurer, a TPA rather than having such services performed by the insurer. Such arrangements appear more desirable to many policyholders when a given TPA is already providing administrative services for a policyholder for earlier policies, or for self-insurance arrangements in some jurisdictions. Also, when the policyholder chooses to utilize the services of a TPA, such policyholder often receives a discount from the insurer on the premiums. Despite the fact that certain insurance arrangements come very close to being the financial equivalent to self-insurance, in the event of the insolvency of the insurer, current state guaranty fund laws often require coverage of such arrangements by the insurance guaranty funds, and guaranty funds are not equipped, funded, nor intended to provide all such services.

Another major change is the increased use of alternative risk transfer mechanisms. One example of alternative risk transfer mechanisms is offshore captive insurance business, which provides reinsurance coverage for certain commercial policies such as large deductible policies. As further described later in this Report, a large deductible policy is a commercial policy designed to lower the cost of insurance by incorporating a large deductible within the statutorily mandatory insurance policy. In the more elaborate programs, to insure the deductible layer, an off-shore insurer sometimes issues a deductible reimbursement policy to the issuer of the large deductible policy, under which the off-shore insurer reimburses the issuer for losses within the deductible paid by such issuer. The loss exposure under such deductible reimbursement policy is funded by cash collateral, premium or letter of credit posted by the policyholder.

Such collateral may be held by another entity to be managed, often located offshore. In order to receive underwriting profit produced under the large deductible arrangement and investment income generated from certain kinds of collateral or related deposits, the policyholders purchase a series of shares of such entity pursuant to a shareholders agreement. Such profit and income are periodically distributed to the policyholder-shareholders in the form of a dividend. In some cases in the past, the offshore entity failed to make sound investments and lost a portion of the collateral, but because it was located offshore, the entity was out of reach by the U.S. regulators and other complications have arisen. In the worst case scenario, the insurer and the offshore entity may become insolvent, but neither the receiver nor the policyholder can gain control of the collateral because the offshore entity is subject to the insolvency law and/or banking law of such foreign jurisdiction. In summary, this kind of arrangement can leave guaranty fund obligations severely under-funded in terms of assets available from the insolvent insurer's estate.

B. Evolution of the Insolvency Laws

To address the evolving nature of the insurer insolvencies that increasingly included large commercial policyholders, the NAIC Model Act was amended in 1987 to exclude protection under policies for insureds that have a net worth in excess of \$50 million. Such net worth provisions serve as one reasonable limit on claims of large (usually commercial) insureds, in effect preserving guaranty fund capacity for smaller insureds who are least able to absorb an uncovered loss. There are two types of net worth provisions, an "exclusion-type" provision and a "subrogation-type" provision. The exclusion-type provision has the effect of excluding from guaranty fund coverage claims of or against insureds whose net worth exceeds a certain dollar amount. The subrogation-type provision usually applies to third party claims and requires the guaranty fund to first pay the claim, but then recover such payment from insureds whose net worth exceeds the limit. Approximately thirty-three (33) state guaranty funds plus the District of Columbia guaranty fund have adopted some form of net worth provisions (see Appendix B attached hereto).

Also, while each state's guaranty fund law is tailored to some degree, all 50 states and the District of Columbia currently exclude certain lines or types of insurance from coverage similarly and in addition to the line exclusions provided in the NAIC Model Act.³³ For example, many states' guaranty fund laws exclude, on the property and casualty side, coverage for self-insured groups and punitive damages. New Jersey has a separate guaranty fund to cover insolvent surplus lines insurers.³⁴ Also, Iowa excludes from the definition of a "covered claim" a claim under a policy "with a deductible or self-insured retention of two hundred thousand dollars or more" with certain limited exceptions.³⁵

Another change to state insolvency laws granted guaranty funds early access to or interim distributions from the insolvent insurer's estate to fund administration and claims expenses incurred by the guaranty funds in connection with insolvencies. Such early access distributions are typically based on guaranty association claims paid and reserved and are distributed after the guaranty association has executed an agreement to repay the estate if the association received more than its proportionate share of estate assets. While the majority of the states enacted an early access

³³ Summary information about excluded lines is available on the NCIGF web site, <http://www.ncigf.org/>.

³⁴ See N.J. Rev. Stat. § 17:22-6.70, et seq. (2003), covering certain medical malpractice and property claims.

³⁵ Iowa Ins. Code § 515B.2(4)(b)(6).

provision, these provisions have not worked as well as desired. Some receivers have been reluctant to release estate funds and taken a conservative approach in evaluating the availability of estate funds for this purpose. Other receivers appear to be taking an extremely conservative approach to assuring that the estate retains sufficient funds to pay all administrative costs and claims with priorities higher than the guaranty fund claims. Further, receivers fear that if they overpay, they may have difficulty obtaining the return of those overpayments from the guaranty funds. On the other hand, to the extent estate assets are available it makes infinitely more sense to fund guaranty association claim payments out of such assets rather than by means of larger assessments to member insurers. It is important to recognize that insurer assessments are passed on to the insurance buying public. To the extent that estate assets can be made available in greater quantities earlier in the process, the burden of assessment is reduced. Early access distribution of estate assets should be viewed as the primary means to fund post-liquidation liabilities of the insolvent insurance company. Experience with current statutes demonstrate that the laws in place are in need of revision to insure that estate contributions to payment of guaranty association covered claims are maximized in every case.

C. Current Challenges Presented for the Guaranty Funds

The insurance insolvency laws were originally drafted to regulate insolvencies arising out of the relatively finite factors associated with the traditional insurance policy structure. Courts have struggled to apply the conventional legal concepts, which are largely based on the traditional property and casualty insurance business, to the complex commercial insurance arrangements where a traditional insurance policy is only one of the key inter-related documents and, in total, the substance of the overall transaction does not reflect traditional insurance. Because the guaranty fund system was created in response to small and regional insolvencies, the current wave of insolvencies involving large commercial multi-state insurers have presented various challenges to the guaranty funds, largely arising from these unforeseen complexities. The discussion of the cost for covering such large insolvencies by the guaranty funds and the challenges facing the guaranty funds specific to various recent insurance products are set forth below.

High Cost of Coverage for Commercial Insureds

While the NAIC Model Act was promulgated in response to the rash of insolvencies of several personal lines carriers, the major insurer insolvencies that occurred in the late 1980s and 1990s mostly involved insurers that issued commercial liability policies to large, multi-state corporations. Such insolvencies triggered the guaranty fund protection for many of large environmental and mass tort liability such as asbestos, breast implants, and the like. Due to the long-tail nature of such risks, policies were being triggered decades after they were written. Considering that the guaranty fund system was originally established to protect personal lines insureds and small businesses, the cost of guaranty fund protection for commercial insureds is too high.

Several guaranty funds, since the end of 1985, have approached or nearly approached the maximum assessment amount allowed in a given year in one or more accounts. Such funds resolved their capacity problems by obtaining legislative authority to increase the amount of assessment or to use money from other claim accounts. In some cases, the guaranty funds borrowed funds against future years' assessment. For example, in 1991, only the guaranty funds of the States of Louisiana and Rhode Island assessed up to their limit of two (2) percent. In 2003, approximately 20 states

assessed at or very near their cap amount in one or more accounts. In 2002, net assessments from the guaranty funds reached all-time-high in the amount of approximately \$1.2 billion. Information available at this point for 2003 indicates that, after three years of dramatic growth, assessments will remain almost at this same level.³⁶ The increase since the mid-1990's is striking.

Year	Assessments	% Increase (Decrease)
1996	\$240,700,235	—
1997	\$330,312,281	37%
1998	\$359,698,765	9%
1999	\$229,616,192	(36%)
2000	\$389,698,765	70%
2001	\$784,777,668	99%
2002	\$1,332,474,056	70%
2003	\$1,067,097,660	(20%)

With these levels of assessments, some view the guaranty fund system as an industry-funded social insurance scheme that may have created a substantial moral hazard problem akin to the moral hazard of bank deposit insurance. Such problem seems most likely to manifest itself when an insurer continues to operate while insolvent or almost insolvent. Such insurers face the same perverse short-term incentives that were faced by some of the savings and loans during the 1980s. Because the near-insolvent insurers need more time to write their way out of insolvency, such insurers have the incentive to very aggressively price their insurance policies to write a large volume of potentially risky policies in order to obtain needed cash, just as savings and loans had the incentive to offer attractive deposit rates to increase the deposits and make risky loans. Policyholders, if assured of claims payments by an unlimited and certain safety net, may be more willing to purchase such discounted policies without regard to the financial strength of their insurer. At least one recent academic study has concluded that guaranty funds contribute to moral hazard problems and higher insolvency costs, despite some provisions to give buyers incentive to seek financially sound insurers³⁷ Anecdotal evidence presented to the Task Force suggests some degree of consumer indifference may be present for workers' compensation insurance in some high cost jurisdictions without net worth exemptions.

Guaranty Funds' Challenge of Covering Recent Loss-Sensitive Products

i. Large Deductible Policies

Guaranty funds are frequently faced with the challenge of being required to cover certain specific products and/or business models that were developed after the inception of the guaranty

³⁶ NCIGF assessment data, collected by member survey. Small portions of most recent data are estimated.

³⁷ M. Grace, R. Klein & R. Phillips, "Managing Cost of Property Casualty Insurers Insolvencies in the U.S." (Georgia State University 2002).

fund system. Such new products often subject the guaranty funds to exposure that potentially exceeds the insolvent insurer's exposure. For example, receivers of certain ongoing insolvencies have attempted to hold the guaranty funds responsible for providing the dollar one coverage of the large deductible policies without transferring to the guaranty funds the same financial rights of policyholder reimbursement and collateral posted by the policyholders. Thus, requiring guaranty funds to protect the policyholders under large deductible policies results in the provision of coverage by the guaranty funds that would not have been provided by the insurer (even if the insurer did not become insolvent) because such policyholders have retained their claims exposure. Holding guaranty funds responsible to pay such claims without reimbursement, in effect, causes the guaranty funds' assessments to be used to subsidize the ultimate recovery of non-covered claimants against the insolvent insurer's estate. An arrangement under which a policyholder retains most of the claims exposure, all services for the policy are provided by a TPA and the only function provided by the insurer is underwriting of the policy, is not affected by the insolvency of the underwriting insurer in the same way the traditional policy structure would be. It makes no sense to treat such arrangements as if they were.

ii. Certain Kinds of Speciality Program Business

The term "program business" is a general term that is widely used by many insurance companies in their marketing. For present purposes, we are focused on one of the term's core meanings -- a book of direct insurance business systematically assembled around a particular kind of underwriting or industry segment expertise.³⁸ Program business in this sense is often earmarked by a focus on a specialty line of coverage, such as professional liability or animal mortality, or it can be focused on other industry or commercial groups that share similar risk characteristics and require similar underwriting expertise and/or claims services. Almost always, program business is produced by agents and brokers devoted to and specializing in the particular line or segment. Quite often, program business is produced and serviced from inception to closure by a highly specialized Managing General Agent ("MGA"). In some instances, program business is written in conjunction with certain kinds of alternative risk transfer mechanisms discussed in this paper, such as industry specific or association-sponsored captive reinsurance vehicles.

When the issuer of program business policies becomes insolvent, the guaranty funds face a variety of non-traditional legal and administrative challenges. First, the identification and collection of claims files and data can be difficult, and may produce jurisdictional disputes, especially if the files and data are in the possession of an MGA. By its nature, the MGA may be highly independent of the policy-issuing insurer, and may have little incentive to cooperate with the receiver or the guaranty funds. Additionally, where an important part of the program involves industry or line-specific claims handling expertise, guaranty funds must both obtain that claims expertise and integrate it with their own set of statutory defenses. Further, to the extent that the risk of loss is shifted back to the insured or a group of insureds, the policyholder will resist guaranty fund control of their claims servicing, while still wanting the benefits of guaranty fund protection. Some commutation or other consensual modification of guaranty fund coverage may be a mutually advantageous outcome in some circumstances. Overall, these programs require creativity and ingenuity to be handled effectively in an insolvency setting.

³⁸ Depending on context, the term program business can have varied meanings. Only one kind of generic program business discussed in the text is addressed here.

iii. Captive Programs and Fronting Policies

In both fronting policies and certain kinds of captive programs, the traditional insurance policy was issued with the clear understanding that it would not bear the ultimate risk of loss for the coverages afforded. As we have seen, however, the insurance insolvency system places primary significance on a standard form insurance policy that is assumed to transfer risk from the policyholder to the insurer in exchange for a premium. Fronting policies and certain kinds of captive programs can undermine in varying degrees, from a little to a lot, the critical assumption that the direct policy is the key risk-transfer mechanism in the transaction with the policyholder. The role of the direct policy is diminished by (a) shifting the financial risk of loss back to the policyholder (or its dedicated assets in the form of collateral) through the captive reinsurance mechanism, and (b) reducing as much as possible any underwriting risk that remains at the level of the fronting policy.

Present law does not clearly define how the insurance insolvency system should address and resolve captive programs and fronting arrangements, especially where substantially all the financial risk of loss is ultimately transferred back to the policyholder (or its affiliates) through the captive mechanism and the fronting policy serves little or no function other than to satisfy regulatory requirements for having coverage from an admitted insurer. It is difficult to discern what public policy goals are served when the insolvency of the fronting company serves as sufficient cause to upend and unbundle an otherwise viable captive program when all of the other moving parts are fully solvent and functional. Traditional insurance insolvency law arguably would do so, and transfer responsibility for payment of the claim to the guaranty funds. “Recovery” from the “insolvent estate” based on payment of such claims -- even though the recovery would be 100% from the policyholder assets in the captive arrangement -- would be deferred in the interest of “equality” of treatment of all policy claimants against the estate and the recoveries from such assets redirected into estate general assets to “maximize” the recovery of all claimants, not just the claimants under the captive policyholder’s policy. Such results certainly can be incongruent with pre-insolvency expectations of the policyholder, and in certain circumstances may well work to the detriment of the claimants the system is intended to protect.

In the Legion insolvency, the supervising Commonwealth Court is working with various unconventional legal theories in an attempt to make the post-insolvency reality match these pre-insolvency expectations and the judicial perception of the real substance of the overall transactions. Without passing judgment on the merits of that particular case, the uncertainties the case has created show that conventional rules regarding reinsurance cut-throughs need to be re-examined. The traditional view that standardized insurance policies are given primacy in insolvency need to be re-evaluated from a public policy perspective with these less traditional kinds of products in mind. The guaranty funds may have no important public policy role to fulfill where a fronting policy, or similar arrangements, takes all of the insurance risk out of an admitted policy that is not critical to the financial mechanism that funds claims payments and that continues to work, despite the fronting insurer’s insolvency.

The Task Force recommends that this category of insurance products be the subject of further study and analysis, with the potential goal of developing an exclusion of certain kinds of captive and fronting programs from guaranty fund coverage. Given the growth and diversity of captive programs and fronting arrangements, the challenge will be to craft an appropriately tailored

and workable exclusion, once adequate information about the products in the marketplace is more fully developed and understood.

iv. Matching Limits Policies

Another example of the evolving nature of the insurance industry is the increased use of matching limits policies, which have deductibles that are the same amount as the policy limit for a given claim. While these policies serve a similar function to self-insurance, they are preferred in some circumstances because of economic reasons. Such policies are procured not to cover claims exposure but primarily to meet regulatory requirements imposed under laws such as state workers' compensation and financial responsibility laws. By issuing these kinds of policies, insurers take on the credit risk of the policyholder against third-party claimants in exchange for modest premiums and hopefully adequate collateral. As was true for large deductible policies, the insurer's insolvency should not affect the claims payments because the policyholders retain the risks. Upon such insurer's insolvency, however, the guaranty funds are often exposed to claims liabilities greater than those originally accepted by the insurer, especially when the collateral posted by the policyholder is not sufficient, or the receiver attempts to absorb the collateral into the insolvent estate. Thus, to the extent that there is presently guaranty fund coverage for such policies, the Task Force recommends that further consideration be given to amending the guaranty fund statutes to exclude some or all matching limits policies from guaranty fund coverage when there is no effective transfer of underwriting risks from the policyholder to the insurer, especially where the policyholder remains solvent.

v. Professional Employment Organizations

The guaranty funds' responsibilities changed even further with the introduction of professional employment organizations ("PEOs"). PEOs are employee leasing organizations that lease employees to employers and provide associated support with benefits and insurance programs. PEOs provide these services for a variety of reasons, many very legitimate, especially for smaller employers or for employers with varied or cyclical staffing needs. On the other hand, many PEOs have functioned to provide employees to employers with a bad loss record as a method of improving the effective experience rating modification for workers' compensation and reducing premiums. To obtain employee health insurance or workers' compensation insurance at a more favorable price, employers with an unfavorable loss record often lease employees from PEOs and thereby borrow the PEOs more favorable experience rating modification as well. Additionally, PEOs often procure large deductible policies and retain claims exposure. In the recent insolvencies, guaranty funds were exposed to significant liabilities under such large deductible policies because PEOs operate as a cash-flow business and typically possess very few assets. Unless such large deductible policies were very well collateralized, PEOs cannot pay the claimants, and the lessor-employer may or may not be held responsible. Guaranty funds are exposed to risks of covering PEO employees when not enough premiums had been collected by the insolvent insurer or premiums were manipulated and suppressed due to fraud. A PEO-type arrangement is susceptible to fraud because the PEO's payroll, and thus premium, are not easily predicted accurately. The NAIC and the IAIABC³⁹ have produced a joint report that examines some of the difficulties associated with PEOs and workers compensation coverage, especially data reporting and record keeping concerns. The Task Force urges continued study of this difficult problem, which tends to

³⁹ International Association of Industrial Accident Boards and Commissions.

grow in hard markets, and thus can focus itself in marginal insurance carriers -- carrying the potential for magnification of the problem with insolvency. The Task Force also urges additional steps to distinguish the legitimate uses of PEOs as a valuable business tool from the questionable practices that exacerbate insurance insolvency problems.

vi. Excessive Administrative and Operational Burdens on Guaranty Funds

The increasing trend of extensive use of TPAs by the policyholders adds administrative and operational burdens on the guaranty funds, to the extent that these burdens materially exceed guaranty funds' typical level of responsibility to adjust and pay covered claims. Oftentimes, even with the full cooperation of the liquidator, who bears this responsibility, the identification and location of the TPAs with the relevant claims files proves difficult and time-consuming. Moreover, TPAs are unregulated in certain states and may refuse to cooperate with the receiver's or guaranty fund's request to obtain the claims files, all resulting in jurisdictional disputes. TPAs may refuse to recognize and abide by the orders of courts in other jurisdictions, resulting in waste of estate assets and inconsistent claims administration. In some circumstances, even if the claims files are in the insolvent insurer's possession, such insurer's management is often opposed to the liquidation proceeding and thus will be uncooperative in the transfer of claims files to the guaranty funds. Only through careful pre-liquidation planning can the excessive burden of transferring claims files to guaranty funds be avoided.

Adverse Effects of Some Regulatory Practices on Guaranty Funds

There are several challenges regulators face in developing and implementing effective strategies to deal with insurers that show warning signs of perilous financial condition. The threshold challenge involves early identification of financial problems. Historically, insurance regulation has utilized an approach that relies heavily on review of historical financial data to predict future problems. Tri-annual examinations review financial statements and data from prior years. Desk audits by regulators involve examination of just-filed quarterly or annual financial statements. Ratio analysis also utilizes historical data to develop financial ratios which, when falling outside of certain ranges, can indicate potential problems. If an insurer were an automobile, in one sense this would be akin to only looking out the back window to see where the insurer is going. One of the great challenges presented by this approach is that problems sometimes are not identified early enough for corrective measures to be effectively implemented. The NAIC has endorsed a regulatory modernization plan that embraces the notion of a more risk-based approach to regulation. It is intended to earlier and more comprehensively determine the various risks facing an insurer. (This initiative is discussed in more detail in the next section of this Report.)

When regulators do timely recognize financially troubled insurers, some regulators may find it difficult to take any formal action for various reasons. The financially troubled insurer often argues that given more time, it can write additional business to rebuild its financial footing. Any public regulatory action against the insurer will scare away potential policyholders and thus be counterproductive. Also, the policyholders may need more time to replace their policies with insurers that are more financially solid. Moreover, the longer the insurer is in business, the more claimants will get paid because, once rehabilitation proceedings commence, in most cases some or all claims do not get paid. Notwithstanding these important considerations, a delay in regulatory action often results in the intensification of the overall damage resulting from the insolvency. Troubled insurers, desperate for short-term cash flow, have a strong incentive to write a large quantity of

potentially risky business by under-pricing both their competitors and the true risk assumed, which only deepens their ultimate financial troubles.

It is fairly common for a regulator to take action on a troubled company in an informal fashion, at least initially. There are contacts and meetings with the insurer in an attempt to determine the nature and extent of its problems and also whether it is possible to reach agreement on solutions to be implemented. These discussions are usually held on a confidential basis. A number of regulators have available as a tool administrative supervision statutes that permit confidential action to be taken, such as a prior review/approval procedure for any material transactions.⁴⁰ While due to their very nature information on such activities is not generally available, there likely have been many successful interventions of this sort, such that further regulatory action was not necessary. These untold success stories notwithstanding, we know that in many cases it becomes absolutely necessary for a regulator to take more formal action.

Taking decisive public action against a troubled insurer can also be very difficult for a regulator because of the perception that, should insolvency occur, the liquidation of an insurer amounts to a regulatory failure. The regulatory goal sometimes seems to have been one that is unattainable – the absence of insurer insolvencies. We submit that it is necessary for goals related to addressing the problems of troubled companies to be dramatically revised. This point is also discussed more fully in the next section.

Once the domiciliary regulator decides that a formal regulatory action must be taken against the financially troubled insurer, the typical next step is to place such insurer into conservatorship or rehabilitation by obtaining a court order to enable the regulator to obtain control over operations of the insurer. The current system of conserving or rehabilitating financially troubled insurers has been criticized as seldom successful in bringing such insurers back to health. The placement of a financially troubled insurer into conservatorship or rehabilitation often occurs only when it is too late to rescue the company, and the public nature of many formal actions scare away informed insurance buyers. Moreover, for most parts of the market cycle the competitive market does not allow a financially troubled insurer with material problems the extra profits needed to recover. Thus, delayed or protracted attempts to rescue financially troubled insurers usually accomplish little other than dissipating the remaining assets of the insurer. Early detection of financially troubled insurers and swift action to either rescue (if early enough) or liquidate (if too late) such insurers is crucial because it can significantly reduce further ultimate overall damage from the insolvency.

When the domiciliary regulator decides that the insurer in rehabilitation cannot be rescued, the next course of action is to obtain a court order for liquidation to wind up the business of the insurer. To avoid any preferential treatment of claimants, the insurer's claims payments (and payment to defense counsel defending liability claims) are immediately stopped so that the receiver can assess the extent of the difference between the value of the assets and the total amount of all claims owed by the insolvent insurer. The regulator faces another challenge upon liquidation because the bedrock principle of insurer liquidation is equity among competing claims against the estate when not all claims will be paid in full. Excessive emphasis on achieving absolute equality can result in delayed decision-making with respect to the insurer's assets and liabilities and in some circumstances can cause inefficient use of time and money.

⁴⁰ See, e.g., Ill. Ins. Code §§ 5/186.1 et seq.; Fla. Ins. Code §§ 624.80 et seq.

Once liquidation triggers the guaranty fund protection, the regulators' earlier reluctance to take a swift, formal action against financially troubled insurers and the protracted and unsuccessful nature of the rehabilitation process are transformed into formidable challenges to be faced by the guaranty funds. The delayed formal action and unsuccessful rehabilitation attempts often deepen the insolvency and create more unpaid claims for the guaranty funds to cover, and contribute to delaying early access distribution to the guaranty funds and depriving the guaranty funds the available resources to pay the covered claims.

Thus, once an insurer is found to be in a hazardous financial condition, it is crucial for regulators to determine quickly whether remedial action is feasible and, if not, to place the insurer in receivership. For orderly transition of an insolvent insurer to rehabilitation or liquidation, extensive cooperation and coordination between the receiver and the guaranty funds becomes imperative. Historically, the relationship between the receiver and the guaranty funds has been criticized as in need of significant improvement. Specifically, the following problems in connection with the receiver's performance of its duties have arisen in some insolvencies and have hindered the guaranty funds' ability to provide protection:

- (i) delays and errors in providing guaranty funds with claims files, appropriate claims data, and estimates of potential liabilities on which an assessment can be based;
- (ii) refusal to allow guaranty funds to process payment of claims without using the domiciliary receiver's prescribed proof of claim or satisfying other unreasonable administrative conditions;
- (iii) failure to seek court approval for early distribution of assets to guaranty funds within the required time;
- (iv) problems in administering the process for reporting appropriate claims and incidents to the reinsurers to preserve rights of recovery under reinsurance agreement;
- (v) problems concerning pursuit and recovery of subrogation and salvage;
- (vi) failure to accord the administrative expenses of guaranty funds the same priority as administrative expenses of the receiver and delays in reimbursements; and
- (vii) imposition of unnecessarily burdensome requirements on the guaranty fund as a claimant against the estate.

All of the problems identified above make the guaranty funds' ability to provide protection more difficult and thus more costly. Particularly, since many of these problems arise at the early stage of the liquidation, they can significantly disrupt the claims payment stream to the policyholders and claimants.

Unlike the regional and local insolvencies that the guaranty fund system was originally designed to address, recent insolvencies involve large insurers that transact insurance business in multiple states and countries. An insolvency of a large multi-state insurer often invokes receivership

proceedings in both the domiciliary state and states where the insurers are licensed to transact insurance business, and disputes often arise among receivers of various states. For example, a domiciliary receiver may object to the establishment of an ancillary receivership for political reasons. Disputes can also occur when the domiciliary receiver finds that the procedures implemented by an ancillary receiver are in violation of the uniform laws governing the relationship between domiciliary and ancillary receiverships. An insolvency of a large multi-state insurer may also involve disputes among the receiver and the guaranty funds due to the receiver's preferential treatment of its domiciliary guaranty fund over guaranty funds of other states. For example, in one particular instance, a domiciliary receiver provided early access to its domiciliary guaranty fund while disbursing no assets to other state guaranty funds.

As well as the challenges the receivers and the guaranty funds face, there are challenges facing the liquidation courts. Receiverships are supervised by local state courts that do not encounter such cases often and may lack expertise, or the time to develop expertise, necessary to adjudicate the complex financial problems of a multi-state or international insurer. Compounding this, the courts also often lack an understanding of the urgency associated with insurance insolvencies. Some courts may be reluctant to make difficult decisions with respect to the dissolution of a corporate entity and reluctant to accept judicial responsibility for actions statutorily required of them. Particularly, some courts have struggled in deciding whether to issue rehabilitation or liquidation orders when faced with opposition from the insolvent insurer's management. Such opposition is alleged to be one of the primary causes of the great delay between when the regulators recognize an insurer to be in hazardous financial condition and when a regulatory action is taken. Such delay should be minimized because it may result in a significant increase in guaranty fund costs through additional unfunded liabilities that are incurred while the dispute goes on and assets are dissipated.

The challenges to regulators, receivers and guaranty funds collectively are formidable but can be met. The proposals advocated in this Report are intended to minimize the adverse impact of these challenges through increased cooperation and effective regulatory action, as well as legal reforms.

III. WHERE WE NEED TO GO

A. Reforming the Goals of Solvency Regulation

The NAIC has recognized the need for reform in solvency regulation and has undertaken a regulatory modernization plan to make solvency regulation more effective and more efficient. The plan involves a greater focus on measuring the risk exposure and inadequate surplus level of troubled companies earlier in time, when regulatory tools provide regulators with more options in addressing the problem. This reform effort is important and critical, and needs to move quickly to ensure that confidence is maintained in state regulation of insurer solvency, and to assist the guaranty fund system in the fulfillment of its role in protecting policyholders and claimants.

An important part of the NAIC reform effort will be defining realistic and attainable goals for solvency regulation. While the perception has been shifting, an attitude has historically existed that a regulator is performing successfully only if there are no insolvencies during his or her

“watch.”⁴¹ While everyone wants to avoid insolvencies, the absence of business failures is not possible in an active insurance market with many aggressive competitors and vigorous price competition. Even under more protective regulatory environments of the past, there have been over 400 insurer insolvencies in the last three decades. Preventing all insurer insolvencies is simply impossible. A realistic, pragmatic, and attainable solvency goal is required. The focus should be on minimizing the cost of the inevitable business failures and liquidations that result, and in those cases assuring that guaranty fund protection is available for the appropriate policy claimants: those who are least able to bear the loss themselves.

Role of the Regulator

How and when to take early action with troubled companies is a subject that needs careful study. In the present climate, for the reasons discussed above, some regulators may find it difficult to place a company in liquidation and will tend to give the company additional time. The decision to liquidate, while difficult, should be timed such that remaining company resources, rather than extensive guaranty fund member assessments, fund the lion's share of all policyholder liabilities. Early monitoring and intervention in appropriate circumstances may do much to avoid a potential insolvency or, if insolvency cannot be avoided, such early involvement may do much to preserve remaining assets so that the burden on the guaranty associations' funding mechanisms is not so great. A long list of factors that the NAIC believes may indicate that an insurer is in financial trouble is set forth in Appendix C attached to this Report. It is important to note that the NAIC does not consider the existence of one or more of these long list of factors as conclusive: “Both operational and financial conditions need to be considered together with other corroborative information to reach a conclusion as to whether an insurance company is a Troubled Insurance Company.”⁴² The additional information to corroborate these findings might be obtained through communications with other insurance departments or through requests for additional information from the insurance company itself.⁴³

It is important to acknowledge in this discussion two additional realities that may hamper a regulator's ability to effectively regulate a financially troubled company. The first is that insurance department resources may be very limited.⁴⁴ In some cases, a department will not have the resources to monitor and intervene when the troubled company is a large, sophisticated entity with complex business arrangements. The second is that the insurance commissioner, as a practical matter, often has to balance the interest of the general insurance-buying public and the interest of its constituents who may rely on the troubled company for jobs or have significant financial interests in preserving the company as a going concern. There is often no simple answer to the difficult and complex regulatory judgments that must be made in such circumstances.

⁴¹ “NAIC Wants More, Not Fewer, Companies in Receivership.” *Best Wire Services*(February 24, 2004) This report covers remarks of Mike Pickens, a past President of the NAIC, addressing a meeting of state insurance commissioners in Washington, D.C. Mr. Pickens is quoted as saying “Receivership is thought of as a dirty word, something you don't utter in polite company. We want to change that. What we'd like to avoid is the idea that receiverships are to be avoided at all costs.”

⁴² Troubled Insurance Company Handbook, p. 22 (National Association of Insurance Commissioners, 2001).

⁴³ Id., pp. 20-22.

⁴⁴ See Wall Street Journal Interactive Edition, January 14, 1998 “Indiana's Insurance Regulators Have Little Budget or Clout.”

One possible means for addressing the limitations of an insurance department staff in regulating companies is, under appropriate circumstances, making use of outside consultants to assist the department in various areas. (If possible, larger states may want to consider having a troubled company specialist on staff.) Outside consultants could provide specialized services in such areas as legal, accounting and auditing, actuarial, underwriting, investments, and business planning to name a few. If these specialists are used judiciously, the cost will be more than offset by preventing the liquidation of the company, or reducing the deficit that would have to be assumed by the guaranty funds. The NAIC's Troubled Company Handbook suggests that appropriate statutory authority should be in place both to permit an insurance department to engage such consultants and, importantly, to require the subject company to pay for such services.⁴⁵

Despite recent signs of a shift in perception regarding insolvency, regulators may still find they are under significant pressure to “save” the company rather than initiate an insolvency proceeding. Indeed, if a viable approach can be put in place to resuscitate the floundering company, member companies of guaranty funds would strongly applaud such efforts. Regulators should be encouraged to think “outside the box” in developing creative strategies that will avoid liquidation. Too often, however, the “White Knights” that solicit regulators merely present proposals that are meagerly financed and are thus not realistic, serving only to delay and distract from efforts to prepare the company for liquidation.⁴⁶ In such cases, the Task Force suggests a “dual-track” approach. In other words, to the extent resuscitation remains potentially viable, the regulator should vigorously pursue this effort. At the same time, the regulator should prepare the company for possible liquidation and an orderly transition of claims to the guaranty funds. In this way, the disruption of payments to policy claimants is minimized if the liquidation of the company is the ultimate outcome.

In any case, it is critically important that regulators act decisively and not suffer paralysis in weighing varying policy considerations. If it appears that a company is salvageable, aggressive steps should be taken upon the first signs of trouble to correct problems that could ultimately lead to liquidation. Once it is determined that such efforts are most likely to be futile, the company should be put in to liquidation while significant assets remain to pay claims.

Role of the Guaranty Associations

The primary role of the property and casualty guaranty associations is to pay statutorily-defined “covered claims” after the company is found to be insolvent and ordered liquidated. From time to time, property casualty funds have been asked to play a part before a company is liquidated. For example, sometimes guaranty funds have been asked to opine on the validity of a run off plan that could potentially permit the continued payment of policyholder claims without liquidation and guaranty association funding. Guaranty funds have agreed to make such a technical review on a limited number of occasions. At times guaranty funds have been asked to provide financial support to efforts to “bail out” a company or delay or prevent liquidation. As the guaranty associations are

⁴⁵ Troubled Insurance Company Handbook, pp. 43-45.

⁴⁶ In some past situations, schemes have been put forth which call for a guaranty fund “back stop” if liabilities of an assuming carrier exceed certain thresholds. The guaranty funds consume much energy educating regulators on the lack of statutory authority for such a mechanism.

triggered only upon an order of liquidation with a finding of insolvency⁴⁷ or similar mechanism, such financial assistance from guaranty fund coffers is outside of statutory parameters and the guaranty funds have declined, and must continue to decline, to make guaranty fund monies available under such circumstances. The most important pre-insolvency function of the guaranty funds is as an active partner of the regulator in planning for an orderly transition if liquidation proves inevitable. As further detailed below, extensive planning with respect to claims files, information systems and data transfer, products and lines of coverage, among many other items are important to enable the guaranty funds to accomplish the orderly transition that the statutory scheme contemplates. Focus on early dual track planning in large or complex insolvencies will pay very large dividends.

B. Cooperation/Coordination in Regulator's Liquidation of Insurers

The regulators and the guaranty funds share a common goal of protecting the interests of insureds and claimants. In the case of a liquidation, this common goal includes minimizing any disruption in the flow of policy benefits, such as time-sensitive wage indemnity and medical benefits under workers' compensation coverage from the disruption. In order for the guaranty funds to be able to carry out their critically important role of protecting insureds and claimants by paying covered claims promptly, information, cooperation and a coordination of efforts are needed from the regulator and receiver (if different) to ensure an orderly transition to liquidation. An orderly transition must include cooperating with guaranty funds and providing needed information so that guaranty funds are in a good position to discharge statutory obligations promptly upon being triggered. As the business of the insolvent insurers has become more complex, the need for pre-liquidation planning has grown proportionately. Guaranty funds need to commence their own planning well before liquidation, and the only way that can occur is if the receiver provides the guaranty funds some early warning of the liquidation on a confidential basis. Also, since guaranty funds cannot pay claims prior to being triggered by a liquidation order and a transfer of responsibility can be completed, it is critical that an orderly transition includes a plan to satisfy the obligation of the part of the receiver to meet critical policy obligations until the transfer of orderly electronic data, related physical files, and payment responsibility can be completed.

While some state receivership staffs consist of experienced, knowledgeable and dedicated individuals, the multi-state nature of recent insolvencies have revealed an inconsistent level of expertise by receivership staffs in various jurisdictions. Where expertise in critical positions is lacking, the performance of the entire receivership staff can be impeded. To the extent that the failure of coordination and cooperation between the receiver and the guaranty funds is caused by the regulators' lack of expertise and understanding, educating regulators is vital to functioning of the guaranty fund safety net. In this connection, regulators must be educated to wisely marshal the assets of the insolvent insurer to minimize the damage due to its insolvency, and to assure that adequate liquidity remains to fund the transition to guaranty fund claims payment.

C. Large Deductibles and Other Loss Sensitive Programs

With the exception of two states that have recently enacted clarifying legislation,⁴⁸ there is unquestionably a need to clarify the rights and obligations of policyholders, the receiver and the

⁴⁷ More information on the specific statutory triggers for each jurisdiction's guaranty association is available on the NCIGF's website www.ncigf.org.

⁴⁸ S.B. 815, 188 Reg. Sess. (Pa. 2004); H.B. 5928, 93rd Gen. Assembly (Ill. 2004).

guaranty associations with respect to “large deductible” insurance policies and related agreements written for large commercial insureds (often Fortune 500 companies or similar large companies) by commercial lines insurers that become insolvent. Without clarifying legislation, a potential dispute exists between the property & casualty guaranty associations and the receivers of insolvent large commercial insurers. Most commercial lines insurers wrote substantial amounts of large deductible business during the last ten to fifteen years, especially for workers’ compensation coverage. Clarifying legislation is needed because insurance receivers have taken inconsistent positions concerning the guaranty associations’ entitlement to deductible reimbursements on claims paid by them.

Large deductible insurance typically covers workers’ compensation, commercial auto and general liability exposures of a large commercial insured, and is written subject to deductibles that are large in amount, typically \$250,000 or more per claim, for which the insured using different approaches agreed to be financially responsible. Under these arrangements, although overall the insured has most of the claims exposure, the insurer under the policies is legally responsible to pay all claims within the deductible if the insured does not do so. The insurer therefore usually requires the insured to post collateral in favor of the insurer to secure the insured’s payment and other obligations under these arrangements. Frequently, larger insureds directly fund obligations within the deductible by directly funding a TPA’s claims payment account, rather than reimbursing the insurer after payment.

In order to be consistent with the public policy of the NAIC Model Act, guaranty associations should have the same rights and benefits that the insolvent insurer would have received under the large deductible arrangements, whether in the form of access to collateral or reimbursements from or payments by insureds, with the result that the guaranty associations end up in the same place that the insurer would have, had it not become insolvent. Stated differently, the guaranty associations’ insurance obligations should be no greater than those of the insurer on large deductible claims, but for the insolvency. By placing the guaranty associations in this position, it is both possible and appropriate to leave in place the pre-solvency arrangements through which insureds agreed to fund claims within the deductible, which is what the insureds had originally bargained for.

Liquidators may argue that the benefits of the insureds’ responsibilities should flow into the estate, ultimately to the benefit of all creditors. Neither applicable law nor equity should allow this result. It does not make sense for the guaranty funds to have substantially more financial exposure than the insolvent insurer would have had on large deductible claims if it had remained solvent. It also does not make sense to disturb the insured claim funding arrangements that have been in place and working well pre-insolvency.

The Task Force believes that legislation clarifying that the guaranty funds should receive the benefits of insured reimbursement obligations is the proper resolution of the matter, especially when one considers that the guaranty funds are simply a “pass-through” mechanism for allocating costs of insurance insolvencies. Guaranty funds are funded by assessments to insurers writing insurance in the various states. The economic burden of these assessments is passed along to ordinary insurance consumers (including personal lines auto and homeowner insureds) in most states in the form of higher premium costs. In some other states, through tax credits, the state taxpayers bear the cost of funding the guaranty associations. Regardless of the mechanism, it is an irrefutable fact that the

general public, insurance consumers or taxpayers, bear most of the ultimate economic burden of the “guaranty fund safety net” in insurance insolvencies.

Making deductible reimbursements general assets would result in larger distributions to other policyholder level insureds (“non-covered insureds”), and smaller distributions to the benefit of the group absorbing the cost of the guaranty funds, which includes personal lines insureds and state taxpayers. In most states, there are two principal categories of non-covered insureds: (1) Commercial insureds who purchased “surplus lines” policies written on an unlicensed basis (this kind of insurance business is conducted between sophisticated parties and is largely unregulated, and is not covered by any guaranty fund except for one – New Jersey), and (2) Insureds whose net worth exceeded guaranty fund maximum limits (\$50 million in roughly half the states) and whose claims are therefore not covered by a guaranty fund.

In balancing the interests affected by an insolvency of any commercial lines insurers, shifting the economic burden away from a group that likely will be made up of mostly commercial insureds to a group that includes typical holders of homeowners and auto policies and state taxpayers is an undesirable result. It cannot be good public policy to shift the cost from sophisticated parties in a much better position to absorb insolvency losses to ordinary consumers who are much less able to absorb such costs.

Simply put, the benefits of insureds’ reimbursement obligations and insureds’ collateral on large deductible business should stay connected to related claims that are being paid, just as it was before the insolvency of a commercial lines insurer. To the extent that the guaranty fund of the domiciliary state or another state pays large deductible claims, that guaranty fund should receive the same benefits from insured claim obligations that the insolvent insurer would have received but for the insolvency. Accordingly, the Board Task Force has proposed legislation that appropriately clarifies the rights and obligations with respect to large deductible policies.

D. High Net Worth Provisions

As explained above, almost all of the fifty six (56) property casualty insurance guaranty funds in the United States and its possessions are funded through indirect contributors from the insurance buying public or from state taxpayers. While the guaranty fund mechanism spreads the cost of insurance insolvencies widely over a large number of people, the total cost is not insignificant. As a matter of good public policy, this aggregate cost needs to be limited in some rational fashion and the limited financial resources of the guaranty funds channeled to those least able to bear the cost of an uninsured loss.

Accordingly, guaranty funds are designed to be a safety net for those least able to absorb loss, and not an absolute guarantor of all the obligations of the insolvent company. One important limitation on guaranty fund coverage that is consistent with the safety net design is the exclusion of high net worth policyholders from the protections afforded by the system primarily through exclusions of first party claims and subrogation reimbursement on third party claims. Such limitation of coverage is consistent with good public policy that has been the basis of the guaranty fund system since its inception as described earlier in this Report. The exemption of high net worth insureds achieves a substantial reduction in cost to those who provide the financial support for the guaranty funds, thereby making more funding available to protect the average insurance consumer.

High net worth insureds are almost always sophisticated commercial enterprises having both substantial risk management resources on their own and access to the best national and international insurance brokers. They have the capability to select their insurers carefully in the first place, select an insurer on the basis of an informed assessment of financial strength, and accept the consequences of such choices. More critically, high net worth insureds are in a much better position than the average consumer to absorb the financial loss through their own resources, if their carefully chosen insurer becomes insolvent. Certainly, it makes no sense to have average policyholders or typical state taxpayers, who unquestionably do not have these kinds of resources and advantages, absorbing insurance insolvency losses for the high net worth policyholders.

Approximately twenty-two (22) guaranty funds, including some very large guaranty funds such as those in California, Florida, New York and Massachusetts, to name a few, presently do not have net worth provisions. The net worth provisions should be universal for at least two reasons. First and most important is the public policy justification discussed above. This sound public policy should be the law in all states. Second, however, is the need to eliminate the anomalies that can arise from multi-state commercial lines policies implicating states with and without the provisions. These anomalies can be created by the provisions in guaranty fund statutes designed to coordinate their respective benefits when more than one state's guaranty fund may apply to a particular claim. Without congruity of net worth provisions, the policyholders in state A may wind up funding the guaranty fund benefits of claimants residing in state B, when state B's public policy decisions intended to have the high net worth policyholders absorb the financial loss themselves. Any such interstate "exporting" of financial burden for high net worth policyholders needs to be minimized, if not eliminated altogether. Not only does this unintended "exporting" of losses represent bad public policy, but it also places political and administrative stresses on the guaranty fund system itself. The overall cost of the guaranty fund safety net can be reduced and the anomalous results of asking one state's guaranty fund to pay for claims excluded from protection in another can be avoided if the high net-worth provisions were enacted in every jurisdiction with relative uniformity.

While it may be difficult to implement the net worth provision due to the fact that it is often difficult to ascertain a privately-held policyholder's net worth, the guaranty funds should aggressively apply the net worth provision by sharing data among themselves. Such sharing of policyholder financial information helps guaranty funds to maintain consistency in their approach to determining the net worth of the policyholder. Additionally, policyholders, not guaranty funds, should bear the consequences of non-cooperation in the provision of information about their own financial condition. The NCIGF has provided model legislation to assist all guaranty funds in addressing these issues.

E. Independent Guaranty Fund Claim Bar Dates

When property and casualty insurance guaranty funds were originally enacted, the legislative initiative was primarily focused upon solving the problem of failures of relatively small personal lines insurers. The "claims tail" for the policies of such insurers was relatively short. In the interests of simplicity and administrative ease, it made sense to incorporate for the guaranty funds the claims bar date being used by receivers in the liquidation process itself. With a rash of insolvencies of commercial lines insurers in the 1980s as described above, suddenly policies with much longer "claims tails" were introduced to the insolvency process and under guaranty fund protection. Some receivers and liquidation courts, with equality of treatment of all claimants being their primary consideration, provided longer and longer periods for the filing of claims. Some receivers and

liquidation courts also permitted the filing and allowance of contingent and unliquidated claims, and even incurred but not reported claims, which became known as “policyholder protection claims.” Many of these claims are asserted by commercial lines insureds who have complex regulatory, environmental, or mass tort liability, but who are not in the core group intended to be the beneficiaries of the original guaranty fund safety net. Such filings are not true “claims” in their own right at all, but are devices to keep the right of recovery under the insolvent policy (and thus, directly or as an unintended consequence, the right of recovery from many guaranty funds) alive as long as possible.

While this fervor to avoid cutting off claims may be a rational part of a liquidation process, it is not rational as part of the guaranty fund safety net, where other and countervailing considerations come to play with equal or greater weight. Through this evolution of the insolvency process, the continued use of liquidation bar dates as the limit of guaranty fund protections introduced new complexities and uncertainties into the administration of the guaranty fund safety net. With these uncertainties came the increased financial and administrative burden and difficulties of planning for these uncertain situations, without clear limits on guaranty fund financial responsibilities. A better system would be one that was able to avoid unnecessary delay, pay creditors more quickly and run off the business more effectively.

To resolve these problems, some states have already enacted provisions for independent bar dates in their guaranty funds statutes. (See Appendix D). Such provisions have proven to be effective solutions as an alternative to the use of the liquidation claims bar date. Other state guaranty funds, however, do not currently have any independent bar date. In extreme cases, receivers have attempted to use early closure methods to close the estate before the guaranty funds complete their claims handling, with the result being the transfer of the remaining “tail” of the claims payment obligations to the guaranty funds after the estate itself is closed and all assets dissipated. To avoid becoming solely responsible for claims payment, the guaranty funds must stay actively involved with receivers on early closure methods and approaches. While the guaranty funds’ independent bar date, by terminating payment rights that claimants would otherwise retain, may be opposed by some as potentially inequitable, most policyholders with long tail liabilities tend to be large commercial policyholders. As discussed above, this type of insured is in the class of insureds that is most likely to be able to absorb the losses arising from insurance insolvency. Accordingly, every guaranty fund should have its own independent bar dates in its own statute to limit its “tail” liability. Of course, claimants who cannot recover from the guaranty fund are likely to still have an allowable claim against the insolvent insurer, providing for some limited recovery for such claimants and insureds.

F. Guaranty Funds’ Authority to Obtain Custody of Claims Records from Insurance Company Representatives

As is still the case with personal lines coverage, commercial lines coverage was traditionally sold as one integrated package by large commercial lines insurers. Each insurer maintained and required policyholders to use its own capacity to provide the full array of services related to insurance -- policy issuance and other operations, claim reporting and adjusting, loss control and engineering, etc. With this business model, when the receiver took over an integrated company upon its insolvency, the receiver gained possession of all the claims files and information necessary to administer the estate. Perhaps most importantly for our purposes, given the control of all the files and information in one integrated organization, the liquidator was able to promptly transfer the

necessary information to the appropriate guaranty funds to allow them to commence doing their jobs promptly.

This business model of an integrated company providing all services itself no longer holds true for many if not most commercial lines insurers -- the “unbundling” of services has become the norm for the reasons described earlier in this Paper, and is demanded by many if not most larger commercial lines policyholders. One important manifestation of this “unbundling” trend is the wide-spread use of TPAs in the handling of claims. Some recent commercial lines insolvencies have involved hundreds of TPAs with claims files scattered in thousands of locations. In some instances, the TPA claims records and information systems were more important than, or had fully supplanted, the insolvent insurer’s own systems and records, especially with respect to claims and related information.

Having an absolute and unimpeded right to obtain the claims files quickly and efficiently is vital for the guaranty funds to do their important job. Some recent insolvencies have revealed that receivers are not particularly well equipped to require independent representatives of the insolvent insurer, especially TPAs, to relinquish control of the claims files so that they may be transferred to the appropriate guaranty fund. The receivers, who would almost universally agree that it is their job to deliver the claims files to the appropriate guaranty funds, have often struggled to implement that transfer due to the condition or location of the claims files. Receivers often cannot cause TPAs, either because of practical reasons (lack of cooperation and sheer numbers) or legal considerations (due to a variety of defenses or remote venues), to transfer claims files to guaranty funds quickly, or perhaps at all. In the insolvency of Reliance Insurance Company, for example, there were several hundred TPAs who had claims files at over 1000 different locations. Many of these TPAs had been paid “cradle to grave,” and thus had very little incentive to be cooperative with guaranty funds or to effect an orderly transition. Many TPAs were outside the domiciliary state and not regulated by the domiciliary insurance regulator, and thus were effectively beyond the reach of the process of the liquidation court and beyond effective regulatory influence. Most TPA locations had possession of claims files that would have been needed by their local guaranty fund.

It is crucial that the receiver and guaranty funds cooperate with each other to facilitate the quick and accurate transfer of claims files to the appropriate guaranty funds, along with the required data needed to process outstanding claims in guaranty fund systems. Also, only as a last resort, guaranty funds should be authorized to have the absolute statutory power to sue for possession of the claims files, subject to no defense against the guaranty fund right to possession and control of the files for their purposes. Costs of litigation should be shifted to the losing party, thus the independent representatives of the insolvent insurer, such as TPAs or attorneys with common law liens, have the incentive to cooperate with a guaranty fund’s or the receiver’s reasonable request to turn over claims files. *Such statutory power is to be used only as a back up to the receiver’s power and is not intended to supplant or supercede the receiver’s responsibility to have claims files transferred to the appropriate guaranty fund.* It is contemplated that where litigation is required to obtain claims files that the receiver should have provided, the unreimbursed expenses and fees should be afforded administrative priority against the insolvent insurer’s estate. The NCIGF has produced model legislation that will provide guaranty funds with sufficient powers to obtain files directly from TPAs where that step is a necessity.

G. Minimize the Effect of Delayed Reinsurance Payment, Where Not Justified

It is widely understood that after an insurer goes into liquidation, the regular flow of reinsurance payments from the insolvent company's reinsurer slows down, often dramatically. It is difficult, and often takes a long time, for a regular flow of reinsurance payments to recommence, if it does at all. In Reliance, for example, reinsurance payments dropped from approximately \$68 million per month before liquidation to only approximately \$27 million a month after liquidation. In a recent NCIGF survey of receivers, almost all reported substantial drop-offs and unreasonable delay in reinsurance payments post-liquidation.⁴⁹ Such a precipitous decline in post-liquidation reinsurance payments is problematic because the obligation of guaranty funds to pay claims in a timely fashion does not abate with liquidation. Accordingly, immediate reinsurance collections for an insolvent insurer are vital to allow significant early access distributions to guaranty funds, who have already fronted the cost of the reinsured claims. Moreover, large scale litigation and arbitration to resolve reinsurance collection disputes are too slow and too expensive for both the reinsurer and the receiver.

Meanwhile, the guaranty funds either hope to or may be required to pay the insolvent companies obligations on a timely, or near timely, basis. Timely reinsurance payments would provide some relief to the financial burden of funding such claims. Without readily available estate assets in the form of reinsurance recoverables to distribute to guaranty funds under early access provisions to help offset the cost of additional claims payments, the guaranty funds have no choice but to make increased assessments against their member companies.

While the delay in reinsurance payment is widely known, it is less understood why the dramatic slow down in payments occurs. There certainly are reasons that reinsurers might become slower to pay. One possible reason is the rather obvious one: an insurer in liquidation is not going to write more business to be reinsured. Without a fresh stream of ceding premium coming from new business, the reinsurer has less incentive to perform its treaty obligations promptly. Without the ceding premium continuing, the reinsurer also understandably becomes concerned about making prompt payments before the reinsurer's rights to set off from amounts that may be due the reinsurer is resolved. Many times, there is uncertainty about set off rights under the applicable agreements and law, and about the ultimate amount of ceding premium due.

It is the view of many in the receivership community that, even allowing for all these uncertainties, the additional slow-down in post-liquidation reinsurance payments exceeds any delay that can be reasonably justified by all legitimate considerations. The guaranty funds, as one of the major beneficiaries of reinsurance payments, believe that this situation merits careful study and demands creative solutions. To the extent that unwarranted reinsurance payment delay reduces estate assets available to guaranty funds, the guaranty funds' member insurers must provide (in the short run) liquidity to allow the guaranty funds to perform in a timely fashion. Given the volume of monthly claims payments made by large commercial insurers, this financing cost is substantial and is a cost that could be minimized, if not eliminated, if the delay in post liquidation reinsurance payments could be effectively addressed and resolved.

⁴⁹ National Conference of Insurance Guaranty Funds Unpublished Survey of Certain Insurance Receivers, June-July, 2004.

H. Solvent Run-Offs

As an alternative to liquidation, a solvent run-off may effectively address problems faced by financially-troubled insurers. A solvent run-off is an attempt to systematically satisfy and wind-up all obligations of an on-going insurer with the company's existing assets. Through negotiations, insurers in a troubled or perilous financial condition can voluntarily decide not to write any new or renewal business, and instead focus on payment of all outstanding claims with the existing assets of the insurer. To be viable, of course, a solvent run-off requires that the entity being wound-up have both a sound strategy to enable it to satisfy substantially all claims obligations and sufficient and sustainable liquidity for the anticipated course of the run-off. Of course, making projections about the requisite liquidity demands in carrying out such a strategy can be extremely difficult. In some cases, the attempt to run-off the company is conducted with the protection of "rehabilitation" proceedings under state insurance laws. It is also important that a company in runoff be regulated in the same vigorous fashion as a financially healthy, viable insurer. The same rules, for example, concerning the prompt adjudication and payment of claims, must be followed by an insurer in runoff.

There is no consensus that any past solvent run-off attempt on the property and casualty side should be considered successful. One of the most serious concerns to the guaranty funds is the risk that they will wind up with responsibility for the most difficult claims left over from the run-off. Further, if projections of liquidity and available assets prove flawed, the guaranty funds may find that the total cost to the guaranty funds collectively is more, rather than less, when the cost of a failed run-off is compared to the cost of a prompt liquidation under the same circumstances. At the same time, many participants in the insurance insolvency system recognize that a carefully managed solvent run-off may nevertheless be an effective and attractive alternative to liquidation, and can mitigate the impact of a liquidation on many interested parties. A careful study of the run-off of the Home Insurance Company, which is now in liquidation after approximately seven years in run-off, will provide valuable insights into the best use of this alternative.

I. Guaranty Fund's Right to Intervene

As has been extensively discussed in this Report, many aspects of the insurance liquidation process have a profound impact on the triggered insurance guaranty funds. As a corollary matter, it follows that many of the myriad decisions made by a liquidation court, both with respect to adjudicated matters and general supervision of the estate, can also have a profound impact upon the triggered guaranty funds. Unlike the liquidator, however, the guaranty funds do not have under existing liquidation laws in most states a natural channel of communication to the liquidation court, through which they can articulate their point of view and have it considered. To remedy this unbalanced situation, the Task Force has proposed a two part solution. First, with respect to adjudicated matters and justiciable controversies, the interested guaranty funds should have a statutory right to intervene in litigation in the liquidation court. For administrative convenience, the proposed statute allows (but does not compel) this intervention right to be exercised by NCIGF (or any other designated party) in a representative capacity. Further, to prevent fomentation of satellite litigation and to prevent forum shopping, the proposed intervention statute expressly provides that general jurisdiction over the intervening guaranty fund does not attach merely by such intervention.

To provide a less formal voice with respect to more routine estate administration, the Task Force proposes that the legislators enact a provision allowing the interested guaranty funds to

request that an estate management conference be convened with the liquidator and the presiding judge. This vehicle would allow the judicial supervision of the estate to be informed of the concerns and points of view of both the liquidator and the guaranty funds in a more balanced fashion. The Task Force believes this mechanism could materially contribute to the fair and efficient administration of insolvent insurer's estate, especially where complex commercial coverages represent a major part of the insolvent insurer's business.

J. Loss Portfolio Transfers and Assumption Reinsurance

Guaranty funds covering life, accident and health insurance insolvencies have in the past successfully protected the policyholders and claimants of the insolvent insurer through loss portfolio transfers and/or assumption reinsurance transactions. Some reinsurers have been willing to consider estate closure plans that involve substantially similar transactions. Guaranty funds covering property and casualty insurance, in cooperation with liquidators, should consider such arrangements as an alternative to the traditional methods of claims payments by the guaranty funds.

K. Special Deposits

Special deposits are posted with an insurance regulator by an insurer as a condition to transacting insurance business in a given state. In the event of insolvency, these deposits are sometimes used to fund the state's guaranty fund activities, either directly or indirectly through alternative claims payment mechanisms as part of an ancillary liquidation estate. Typically, the liquidator in the domiciliary state wants to recover these deposits into the domiciliary state's own liquidation proceedings. Non-domiciliary regulators sometimes seek to keep the deposits under their own control, leading to conflicts between regulators. This conflict may spill over to lead to tension between the liquidator and the non-domiciliary guaranty fund, which often does not control the deposit. Because the attempt to marshal, track and appropriately account for special deposits creates an additional burden for liquidators, creation of additional special deposit requirements should not be encouraged.

Some states such as California, however, view such special deposits as an additional safety-net mechanism vital to protect their own citizen policyholders and claimants, and to provide an additional source of funding such protections. Without special deposits for the Reliance insolvency, for example, the capacity problems of the California Insurance Guaranty Association would have been worse. Some other states' regulators and their guaranty funds view special deposits as an outdated attempt to protect and favor an individual state's policyholders at the expense of the estate overall. Other critics view these deposits as a mechanism to tie up the assets of the insurer unnecessarily and to prevent a domiciliary receiver from using run-off procedures which may benefit the estate's creditors as a whole. In addition, special deposits may promote inefficiency in liquidations because they are sometimes used by an ancillary receiver to fund its ongoing receivership operation, though there may be no valid justification for the creation of the particular ancillary proceeding, other than the existence of the deposit itself. These funds can remain dormant or, worse, be depleted while claimants go unpaid.

The Task Force urges that all stakeholders take a new and fresh look at the role of special deposits and evaluate such deposits based on the particular regulatory system and circumstances of individual state because no one solution fits all situations. Regardless of how one views the various points of view regarding special deposits, the Task Force believes that all participants in the system

should agree on one proposition -- where special deposits exist, they should be administered to promptly benefit the claimants whom they were intended to protect. Accordingly, they should promptly be used to pay claimants or ease the guaranty fund burden by reimbursement of guaranty funds' paid claims.

L. Insurance Producers' Role in Insolvency

Insurance producers that placed insurance with a financially troubled insurer should share the burden caused by the insolvency. Insurance producers do not currently pay the cost of insolvency, other than in the narrow circumstances where the producer may lose any contingent deferred commissions that are based on the underwriting results for the business placed. (Claims for such commissions would be a general creditor claim, subordinate to all policy claims.) Thus, except in the most egregious cases where malpractice exposure looms, insurance producers may not have any direct economic disincentives to place insurance with a financially troubled insurer. For public policy purposes, insurance producers, as active participants and significantly influencing factor in the placement of insurance with a near-insolvent insurer, should become active partners in our efforts to reduce the cost and increase the efficiency of the guaranty fund system and insurance insolvencies generally. The Task Force asks that the producer community lend its significant political and financial resources to assist in this effort.

CONCLUSION

Insurance insolvency challenges are an inherent part of a thriving, competitive property and casualty marketplace, which unquestionably provides the greatest good for the greatest number of insurance consumers. An effective insurance insolvency system, with a viable, cost-effective guaranty fund safety net, helps enable such a market to exist. The safety net must evolve in order to effectively address the challenges posed by such a dynamic marketplace.

For insurance consumers, the proposed reforms are guided by the principle that the protection provided by guaranty fund must be focused on those who truly need protection from insurance insolvency losses. Targeted, effective protection of those who cannot protect themselves is the goal.

For regulators, these reforms promise to advance a regulatory agenda by providing cost-effective protection to insurance consumers, while eliminating or reducing costly and burdensome aspects of the present system that can delay and hinder essential protection for consumers and policyholders.

For insurance companies, our goal is to provide a guaranty fund system that works, but limits the financial burdens imposed upon insurance companies to a reasonable and manageable level. This can best be achieved if insurance companies lend their talent and resources to management of the guaranty fund system.

For commercial insureds, our goal is to disrupt your viable risk management arrangements as little as possible. If your insurance program provides that you retain the ultimate financial burden for all or a substantial part of your losses, we believe the guaranty fund system should not disrupt your program and we should not be asked to pick up your losses (unless you cannot pay yourself). Honoring the original intention and substance of your insurance programs gives you the flexibility

you want and need, and allowing you to fund your own claims allows us to focus our resources where they are most needed.

The dramatic increase in the cost of the guaranty fund system, in a climate of myriad challenges to public finance generally, is a clarion call to action. The insolvency burden for insurance consumers, taxpayers and solvent insurers is unacceptably high, particularly when the system is facing a potentially continuing string of large commercial line insolvencies where sophisticated policyholders with complex programs are involved. It is critical to the long term viability of the guaranty fund system that its finite resources be focused on its core mission: to protect those claimants who can least afford to absorb an insurance insolvency loss.

APPENDIX A

Guaranty Fund Coverage of Commercial Line Insolvencies in the Past Summaries of Significant Case law Developments

Mass Tort Cases On several occasions the guaranty funds have been faced with multi million dollar claims for liabilities on mass tort and asbestos exposures. The Most notable example among these cases is likely the case involving Union Carbide. On December 3, 1984, a release of toxic gas from a Union Carbide facility in Bhopal, India resulted in 2300 deaths, another 200,000 injuries and extensive damage to livestock and crops. The government of India assumed the right to prosecute all of the claims, and the matter was consolidated into a single action against Union Carbide. The matter was settled for a total of \$465,000,000. \$170,000,000 million was paid by solvent carriers. Claims against three insolvent carriers affording total policy coverages of \$32,500,000 were presented to the Connecticut Insurance Guaranty Association (“CIGA”).⁵⁰

CIGA asserted that Union Carbide had no more than six covered claims against the CIGA - one covered claim under each of the six polices of the insolvent carriers.⁵¹ CIGA argued that only one covered claim could result from each occurrence and, since the Bhopal incident constituted a single occurrence, Union Carbide could have only one covered claim for the occurrence.⁵² The Connecticut Supreme Court disagreed holding that the \$300,000 per claim limit applied to each of the underlying claims for the Bhopal incident.⁵³ Interestingly, the Court noted that “The recovery of \$300,000 by a single victim of an automobile accident is not extraordinary, and when there are multiple victims the total liability of the insured can readily exceed that amount.”⁵⁴

The Connecticut Supreme Court also rejected CIGA’s attempt to “set-off” its liability by the amounts paid by Union Carbide’s solvent carriers. Union Carbide’s recoveries from solvent carriers of \$170,000,000 were exceeded by the settlement amount of \$465,000,000. The Court held that the guaranty fund set off rights were designed “to prevent a person from twice receiving benefits for the same loss or otherwise obtaining a windfall, not to reduce the amount of a claim for a loss that remains partially unsatisfied.”⁵⁵

More recent case law has served to limit the guaranty fund liability under similar, though not identical, fact patterns. T & N, an English corporation, sought coverage for multi-millions of dollars in asbestos personal injury damage and made claims against the Pennsylvania Insurance Guaranty Association (“PIGA”-the entity is now known as the Pennsylvania Property and Liability Insurance Guaranty Association) for over \$5 million under the terms of a pre-insolvency settlement entered

⁵⁰ Connecticut Ins. Guar. Ass’n v. Union Carbide, 585 A. 2d 1216, 1219 (Conn. 1991).

⁵¹ Id. at 1220.

⁵² Id. at 1222.

⁵³ Id. at 1223.

⁵⁴ Id. at 1222-1223.

⁵⁵ Id. at 1225.

into with American Mutual.⁵⁶ The Third Circuit concluded that the claimant had only one potential covered claim against PIGA as the settlement agreement encompassed all of T & N's claims against the insolvent company.⁵⁷ The Court also rejected T & N's attempt to assert that it had covered claims against PIGA based on the fact that underlying claimants in the matter were Pennsylvania residents.⁵⁸ The Court did indicate, however, that T & N could recover under the guaranty fund statutes for damage to any of its property permanently located in Pennsylvania.⁵⁹

Residency and Jurisdiction Issues Insureds were often challenged in their efforts to recover against the guaranty funds by difficulties in establishing that they should be considered "residents" of a particular state for the purpose of coverage under the guaranty fund statutes. A typical covered claim definition in guaranty fund statutes would require that: (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 or insured is the state in which its principal place of business is located at the time of the insured event; or (b) the property from which the claim arises is permanently located in this state.

In Clark Equipment Co. v. Massachusetts Insurers Insolvency Fund,⁶⁰ Clark was declined coverage by both the Indiana and Michigan guaranty funds. Clark was a Delaware insured with a principal place of business in Indiana. Prior to February 1985, Clark's principal place of business was in Michigan. The Indiana Guaranty Association refused obligations on claims for incidents occurring prior to February 1985 when Clark moved its principal place of business to Indiana. The Michigan Property and Casualty Guaranty Association declined Clark's claims as Clark's net worth exceeded the limit embodied in the Michigan guaranty fund statutes.⁶¹

Clark attempted to obtain coverage from the Massachusetts Insurers Insolvency Fund (the "Massachusetts Fund") based on the Massachusetts residence of some of the tort claimants who had asserted claims against it. The Massachusetts Supreme Judicial Court pointed out that because the underlying tort claimants in the matter were not asserting claims against the Massachusetts Fund, they were not "claimants" within the meaning of the Massachusetts guaranty fund statutes. Clark, although it was asserting claims, was not a resident. Therefore, Clark's claims were not "covered claims" within the meaning of the Massachusetts guaranty fund statute.⁶² A similar result was reached in T & N.⁶³

T & N also tried to argue that it was a resident under the Pennsylvania guaranty fund statutes as it was subject to the jurisdiction of the Pennsylvania courts. The Third Circuit applying Pennsylvania law held that "the exercise of jurisdiction is not limited to those who are residents of the state which is attempting to assert jurisdiction....[I]f residence were connected to jurisdiction, it

⁵⁶ T & N, plc v. Pennsylvania Ins. Guar. Ass'n, 44 F. 3d 174, 176 (3^d Cir. 1994).

⁵⁷ Id.

⁵⁸ Id. at 180.

⁵⁹ Id. at 183.

⁶⁰ Clark Equipment v. Massachusetts Insurers Insolvency Fund, 666 N.E. 2d 1304 (Mass. 1996).

⁶¹ Id. at 166.

⁶² Id. at 169.

⁶³ T & N, supra at 180.

would increase the number of guaranty associations which could be liable, and lead to disputes regarding which association should be liable for payments. This would defeat one of the purposes of the Act which is to avoid delays in payment.”⁶⁴

In an interesting twist on jurisdiction issues, insureds have on occasion attempted to bring a guaranty fund into a foreign jurisdiction, presumably with the hope of being afforded a favorable judgment from a court thought to be “plaintiff friendly.” For example, General Electric brought actions against the California Insurance Guarantee Association, the Delaware Guaranty Association the Illinois Insurance Guaranty Association and the Tennessee Insurance Guaranty Association in Beaumont, Texas. The insured sought defense and indemnity on third-party asbestos claims based on policies of insolvent insurance companies. In the General Electric case, there was no evidence that any of the actions of the subject guaranty associations were directed to Texas. None of such funds did any business in Texas, nor did they have any offices or property in Texas.⁶⁵ The gist of General Electric’s argument was that since the guaranty funds “stand in the shoes of the insolvent insurer,” personal jurisdiction could be found based on the activities of the insolvent insurer.⁶⁶ The General Electric Court found that the guaranty funds stood in the shoes of the insolvent insurer only for limited purpose and did not consent to the personal jurisdiction of Texas. Further, the Texas Court had little interest in the subject litigation and that its jurisdiction would not comport with fair play and substantial justice.⁶⁷

Scope of Guaranty Fund’s Duty to Defend. While guaranty fund claim obligations are in most cases limited by a covered claim cap, whether its duty to defend extends to the scope of the obligation the insolvent insurer would have had is a different matter. In Saylin v. California Ins. Guar. Ass’n, the Court held that the duty to defend does not necessarily relate back to insurers original obligation under the policy.⁶⁸ In other cases, the guaranty fund obligation to defend has been extended well beyond covered claim limits. In one pollution case where multiple insurers had coverage, the Texas fund was required to contribute pro-rata to defense costs.⁶⁹

⁶⁴ T & N at 181.

⁶⁵ General Electric v. California Ins. Guar. Ass’n, 997 S.W. 2d 923, 927 (Tex. App. 1999).

⁶⁶ Id. at 928.

⁶⁷ Id. at 929.

⁶⁸ Saylin v. California Ins. Guar. Ass’n, 179 Cal. App. 3d 256, 224 (Cal. Ct. App. 1986.)

⁶⁹ Texas P & C v. RSR, Mealey’s Litigation Reports - Insurance Insolvency 1/24/96 (Travis County Ct. 1996).

APPENDIX B

State Net Worth Provisions

STATE

APPLICABLE PROVISIONS

- AL** Covered claim shall not include any first party claim by an insured whose net worth exceeds twenty-five million dollars (\$25,000,000) on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

The association shall have the right to recover from the following persons the amount of any covered claim paid on behalf of the person: (1) An insured whose net worth on December 1 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars (\$25,000,000) and whose liability obligations, including obligations under workers' compensation insurance coverages, to other persons are satisfied in whole or in part by the payments. (2) Any person who is an affiliate of the insolvent insurer and whose liability obligations, including obligations under workers' compensation insurance coverages, to other persons are satisfied in whole or in part by the payments. Ala. Code §§ 27-42-5, 27-42-11 (2005).

- AR** Covered claim shall not include an unpaid claim of an insured or third party liability claimant whose net worth as of December 31 of the year preceding the date the insurer becomes an "insolvent insurer" exceeds fifty million dollars. provided that an insured's or third party liability claimant's net worth on such date shall be deemed to include the aggregate net worth of the insured or third party liability claimant and all of its affiliates as calculated on a consolidated basis. Ark. Code Ann. § 23-90-103 (2005)

- CO** "Covered claim" does not include any first-party claim by an insured whose net worth exceeds ten million dollars on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer. An insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

The association shall have the right to recover from the following persons the amount of any covered claim paid on behalf of such person: (1) Any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part 5; (2) 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 part 5. Colo. Rev. Stat. §§ 10-4-503, 10-4-511 (2005).

- CT** ...the term "covered claim" shall not include any claim... against an insured whose net worth at the time the policy was issued or at any time thereafter exceeded twenty-five million dollars, provided that an insured's net worth for purposes of this section and section 38a-844 shall be deemed to include the aggregate net worth of the insured and

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all of its subsidiaries as calculated on a consolidated basis;

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 sections 38a-836 to 38a-853, inclusive: ... any insured whose net worth on December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer exceeds fifty million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under said sections. Conn. Gen. Stat. § 38a-838, 38a-844 (2005).

- DE** Covered claim shall not include any first-party claim by an insured whose net worth exceeds \$10 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer or a first-party claim by an affiliate of the insolvent insurer, provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis; or

Association shall have right to recover from following persons the amount of any covered claim paid on behalf of such person: (1) any insured whose net worth on December 31 of the year preceding the date of insolvency exceeds \$25,000,000 and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter; and (2) any person who is an affiliate of an insolvent insurer and whose liability obligations to any other person are satisfied in whole or in part by payment under this chapter. Third party net worth provision applies only to insolvencies which occur on or after June 30, 1991. Del. Code Ann. tit. 18, §§ 4205, 4211 (2005).

- DC** The association shall have the right to recover from any insured whose net worth on December 31st of the year 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 from any person who is an affiliate of the insolvent insurer and whose obligations to other persons are satisfied in whole or in part by payments made under this act. D.C. Code Ann. § 31-5508 (2005).

- GA** Covered claim shall not include any obligation to any person who has a net worth greater than \$3 million at the time of the insured event. Ga. Code Ann. 33-36-3 (2005).

- HI** Covered Claim shall not include any first party claim by an insured whose net worth exceeds \$25,000,000 on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

The association shall have the right to recover from the following persons the amount of any covered liability claim paid on behalf of such person: (1) any insured whose net worth on December 31st of the year preceding the date of insolvency

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exceeds \$50,000,000, and (2) any person who is an affiliate of the insolvent insurer. Haw. Rev. Stat. §§ 431:16-105, 431:16-111 (2005).

- IL** Covered claim does not include any first or third party claim by or against an insured whose consolidated net worth on December 31 of the year preceding the year of insolvency exceeds \$25 million. Provision does not apply to 3rd party claims when insured has applied for bankruptcy or other insolvent status or has been adjudicated as such.

The Fund has the right to recover from the following persons the amount of any covered claims and allocated claims expenses which the Fund paid or incurred on behalf of such a person in satisfaction of liability obligation of such person to any other person: (1) any insured whose net worth on December 31 of the year preceding the insolvency exceeds \$25 million; (2) any insured who is an affiliate of the insolvent company. 215 Ill. Comp. Stat. 5/534.3, 5/545 (2005).

- IN** Covered claim excludes any claim brought by a person whose net worth at the time of the insured event exceeded five million dollars (\$5,000,000); or claim brought against an insured whose net worth at the time of the insured event exceeded fifty million dollars (\$50,000,000). Ind. Code § 27-6-8-4 (2005).

- KY** Covered claims excludes any first-party claim by an insured whose net worth exceeds twenty-five million dollars (\$25,000,000) on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer, provided that an insurer's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out, except as follows: any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars (\$25,000,000) and whose liability obligations to other persons are satisfied in whole or in part by payments made under this subtitle; any person who is an affiliate of the insolvent insurer.

No limitation is placed on the ability of the association to recover from the principal all claim payments and expenses arising from a surety contract that is a covered claim to the association. Ky. Rev. Stat. Ann. §§ 304.36-050, 304.36-110 (2005).

- LA** "Covered claim" shall not include any claim by any insured whose net worth exceeds twenty-five million dollars on December thirty-first of the year immediately preceding the date of the determination of insolvency. However, an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis. An insured for the purposes of this provision shall not include any state or local governmental agency or subdivision thereof

The association shall have the right to recover from an insured any covered claim paid on behalf of the insured whose net worth exceeds twenty-five million dollars

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on December thirty-first of the year immediately preceding the date of the determination of the insolvency. La. Rev. Stat. Ann. §§ 22:1379, 22:1382 (2005).

ME “Covered claim” does not include any first-party claims by an insured whose net worth exceeds \$25,000,000 on December 31st of the year prior to the year in which the member insurer becomes an insolvent insurer. An insured’s net worth on that date is deemed to include the aggregate net worth of the insured and all its subsidiaries as calculated on a consolidated basis. Me. Rev. Stat. Ann. 24-A § 4435 (2005).

MD Covered claim does not include a first party claim by an insured whose net worth exceeds \$50 million on December 31 of the year before the year in which the insurer became an insolvent insurer. Net worth of insured is deemed to include aggregate net worth of insured and all of its subsidiaries calculated on consolidated basis. Md. Code Ann. Insurance § 9-301 (2005).

MI Covered claims shall not include obligations to a person who has a net worth greater than .1% of the aggregate premiums written by member insurers in the preceding calendar year. Provision applies to first party claims only. Mich. Comp. Laws § 500.7925 (2005).

MN A covered claim does not include any claims, resulting from insolvencies which occur after July 31, 1996, by an insured whose net worth exceeds \$25,000,000 on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

The association may recover the amount of any covered claim including claim handling expenses paid, resulting from insolvencies which occur after July 31, 1996, on behalf of an insured who has a net worth of \$25,000,000 as provided in section 60C.09, subdivision 2, clause (3), on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter. Minn. Stat. §§ 60C.09, 60C.11 (2005).

MO Covered claim shall not include a claim by or against an insured of an insolvent insurer, if such insured has a net worth of more than \$25,000,000 on the date of insolvency. Mo. Rev. Stat. § 375.772 (2005).

MT The association has the right to recover from the following persons amounts paid as covered claims : 1) any insured whose net worth on December 31 of the year 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 part and from 2) 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 part. Mont. Code Ann. § 33-10-114

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(2005).

NV Covered claim does not include a first party or third party claim brought by or against an insured, if the aggregate net worth of the insured and any affiliate of the insured, as determined on a consolidated basis, is more than \$25,000,000 on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer. The provisions of this paragraph do not apply to a claim for workers' compensation. As used in this paragraph, "affiliate" means a person who directly or indirectly owns or controls, is owned or controlled by, or is under common ownership or control with another person. For the purpose of this definition, the terms "owns," "is owned" and "ownership" mean ownership of an equity interest, or the equivalent thereof, of 10 percent or more.

The Association may recover the amount of money paid to or on behalf of an insured of an insolvent insurer.

If the aggregate net worth of the insured and any affiliate of the insured, as determined on a consolidated basis, is more than \$25,000,000 on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer. Nev. Rev. Stat. §§ 687A.033, 687A.090 (2005).

NH "Covered claim" shall also not include an unpaid claim of an insured or third party liability claimant whose net worth as of December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds \$25,000,000; provided, that an insured's or third party claimant's net worth on such date shall be deemed to include the aggregate net worth of the insured or third party liability claimant and all of its affiliates as calculated on a consolidated basis. N.H. Rev. Stat. Ann. § 404-B:5 (2005).

NC "Covered claim" also shall not include ...claims of any claimant whose net worth exceeds fifty million dollars (\$50,000,000) on December 31 of the year preceding the date the insurer becomes insolvent.

The Association shall have the right to recover from the following persons the amount of any "covered claim" paid and any and all expenses incurred, including attorneys' fees and costs of defense, in connection with any claim against the person or the person's affiliate pursuant to this Article.

Any insured whose net worth on December 31 of the year next preceding the date the insurer becomes insolvent exceeds fifty million dollars (\$50,000,000) and whose liability obligations to other persons are satisfied in whole or in part by payments under this Article; or, 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 Article. N.C. Gen. Stat. §§ 58-48-20, 58-48-50 (2005).

ND Covered claim does not include any first-party claim by an insured whose net worth exceeds ten million dollars on December thirty-first of the year immediately following the date the insurer becomes an insolvent insurer. provided that an insured's net worth on that date is deemed to include the aggregate net worth of the

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insured and all of the insured's subsidiaries as calculated on a consolidated basis; and
The association may recover from the following persons the amount of any covered claim paid on behalf of that person pursuant to this chapter: Any insured whose net worth on December thirty-first of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter. N.D. Cent. Code §§ 26.1-42.1-02, 26.1-42.1-08 (2005).

- OH** The association has the right to recover: 1) from any insured whose net worth exceeds \$50 million on the last day of the insured's fiscal year next preceding the date the insurer becomes an insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this act; 2) from any person who is an affiliate of the insolvent insurer; 3) from any insured who is not a resident of the state at the time of the insured event, except for first-party claims for property damage to an insured's property that is permanently located in the state. Ohio Rev. Code Ann. § 3955.12 (2005).
- OK** The Association shall have the right to recover from the following persons the amount of any "covered claim" paid on behalf of such person: 1. Any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds \$50,000,000 and whose liability obligations to other persons are satisfied in whole or in part by payments made hereunder; and 2. 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 hereunder. Okla. Stat. tit. 36, § 2010 (2005).
- OR** Covered Claim does not include: Any first party claim by an insured whose net worth exceeds \$25 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer, provided that an insurer's net worth on such date is deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis. The Oregon Insurance Guaranty Association may recover from the following persons the amount of any covered claim paid on behalf of (a) Any insured whose net worth exceeds \$25 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under ORS 734.510 to 734.710; and (b) Any person who is an affiliate of the insolvent insurer. Or. Rev. Stat. §§ 734.510, 734.695 (2005).
- PA** Covered claim shall not include any first-party claim by an insured whose net worth exceeds twenty-five million dollars on the year prior to the year in which the insurer becomes an insolvent insurer provided that an insured's net worth shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries. The association shall have the right to recover from the following person the amount of any covered claim paid on behalf of such a person : (1) any insured whose net worth exceeds \$50,000,000 and whose liability obligations to other persons are satisfied in whole or in part by payments made under the Act; and (2) any person who is an

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affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under the Act. 40 Pa. Cons. Stat. §§ 991.1802, 991.1816 (2005).

RI The fund shall have the right to recover from the following persons the amount of any "covered claim" paid on behalf of such person hereunder: (a) Any insured whose net worth on December 31 of the year next preceding the date the insurer became an insolvent insurer exceeded \$50,000,000 and whose liability obligations to other persons are satisfied in whole or in part by payments made hereunder; and (b) 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 hereunder. R.I. Gen. Laws § 27-34-11 (2005).

SC Covered claim does not include any first party claim by an insured whose net worth exceeds ten million dollars on December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date must be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

The association has the right to recover from the following persons the amount of any "covered claim" paid on behalf of such person pursuant to this chapter...an insured whose net worth on December thirty-one of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter. S.C. Code Ann. §§ 38-31-20, 38-31-90 (2005).

SD Covered claim does not include any first party claims by an insured whose net worth exceeds fifty million dollars on December thirty-first of the year immediately preceding the year in which the insurer becomes an insolvent insurer. However, an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and any of its subsidiaries as calculated on a consolidated basis.

The association may recover from the following persons the amount of any covered claim paid on behalf of such person pursuant to this chapter: (1) Any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds \$50,000,000 and whose liability obligations to other persons, including obligations under workers' compensation insurance coverages, are satisfied in whole or in part by payments made under this chapter; and (2) 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 chapter. The term, affiliate, does not include any insurance producer of the insolvent insurer. S.D. Codified Law §§ 58-29A-55, 58-29A-71 (2005).

TN Covered claim does not include any first party claim by an insured whose net worth exceeds ten million dollars (\$10,000,000 on December 31 of the year next preceding the date the insurer becomes an insolvent insurer. An insured's net worth on such date is deemed to include the aggregate net worth of the insured and all of its

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subsidiaries as calculated on a consolidated basis.

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 this part... any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars (\$25,000,000) and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part. Tenn. Code Ann. §§ 56-12-104, 56-12-110 (2005).

- TX** The association is entitled to recover from the following persons the amount of any covered claim paid on behalf of that person under this Act: (1) any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an impaired 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 (2) any person who is an affiliate of the impaired insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act.

The association is not liable to pay a first-party claim of an insured whose net worth on December 31 of the year next preceding the date the insurer becomes an impaired insurer exceeds \$50 million.

The net worth of an insured for purposes of this section includes the aggregate net worth of the insured and all the insured’s parent, subsidiary, and affiliated companies computed on a consolidated basis.

This section does not exclude the payment of a covered claim for workers’ compensation benefits otherwise payable under this Act.

Tex. Ins. Code Ann. Art. 21.28-C (2005).

- UT** Covered claim does not include any first-party claims by an insured if the insured’s net worth exceeds \$25,000,000 on December 31 of the year preceding the date the insurer becomes an insolvent insurer and the insured’s net worth includes the aggregate net worth of the insured and all of its subsidiaries as calculated on a calculated basis.

The association may recover from the following persons the amount of any covered claim paid on behalf of that person: (i) any insured whose net worth on December 31 of the year next preceding the date the insurer becomes insolvent, exceeds \$25,000,000; or (ii) any person who is an affiliate of the insolvent insurer. Utah Code Ann. §§ 31A-28-203, 31A-28-203 (2005).

- VA** Association shall have the right to recover from the following persons the amount of any covered liability claim paid on behalf of such persons: (a) any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds \$50,000,000; and (b) any person who is an affiliate of the insolvent insurer. Va. Code Ann. § 38.2-1609 (2005).

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- WI** (a) Payment of a first party claim to an insured whose net worth (as of end of insured's fiscal year immediately preceding date of liquidation order) exceeds \$10,000,000 is limited to the amount by which the aggregate of the insured's claims plus the amount, if any, recovered from the insured pursuant to the following provisions exceeds ten per cent of the insured's net worth. (b) Except as provided in (c) below, the association may recover from a person the amount of any liability claim paid on behalf of that person to a third party, if the person is either an insured whose net worth exceeds \$10,000,000, or an affiliate of the insurer. (c) The total amount recovered from the insured under (b) above, plus the amount of the insured's ineligible claims under (a) above may not exceed ten per cent of the insured's net worth. Wis. Stat. § 646.325 (2005).

APPENDIX C

Factors Potentially Indicating Financial Trouble of an Insurer

Relevant financial factors,⁷⁰ according to the NAIC:

- ✓ Significant adverse findings are reported in financial condition and market conduct examination reports.
- ✓ Ratios of commissions, general insurance expenses, policy benefits, or reserve increases in relation to annual premiums, net income, or other bases indicate unprofitable operations, which, if not corrected, could lead to an impairment of capital and surplus.
- ✓ Ratios of financial leverage indicate an undercapitalized insurance company.
- ✓ Reported financial results are considerably better than the norm for a particular line of business, possibly indicating that unreliable financial information is being reported.
- ✓ An insurance company's asset portfolio, when viewed in light of current economic conditions, is not of sufficient value, liquidity, or diversity, raising potential questions as to the insurance company's ability to meet its outstanding obligations as they become payable.
- ✓ The maturities of the insurance company's assets and liabilities appear to be mismatched, which might indicate a forthcoming liquidity problem.
- ✓ Questions arise as to the ability or willingness of an insurance company's assuming reinsurers to meet their obligations under reinsurance contracts.
- ✓ Questions arise as to whether the insurance company's reinsurance program provides sufficient protection for the insurance company's remaining surplus.
- ✓ An affiliate, subsidiary, or significant reinsurer of an insurance company is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations.
- ✓ An insurance company has contingent liabilities, pledges, or outstanding guarantees that, either individually or collectively, may affect the solvency of the insurance company.
- ✓ An insurance company's operating loss in the most recent reporting period (including but not limited to net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders) is a significant portion of the company's remaining surplus.
- ✓ A "controlling person" of an insurance company, its agents, or some other parties are delinquent in transmitting or paying the net premiums due to the insurance company.
- ✓ The insurance company's receivables show an unusual increase in age.
- ✓ The insurance company has been identified as having accounting and/or EDP internal control weaknesses, or other deficiencies that do not allow the company to accurately capture financial and nonfinancial data.

⁷⁰ Troubled Insurance Company Handbook, pp. 17-18. (National Association of Insurance Commissioners, 2001).

- ✓ The company's parent has incurred a high level of debt and must rely on dividends from the company to meet debt servicing.
- ✓ The insurance company has a history of adverse loss reserve development indicating deliberate or chronic under reserving.
- ✓ The NAIC Financial Analysis Solvency Tools (FAST) show significant financial ratio results that indicate a need for further attention.

Relevant operational factors,⁷¹ according to the NAIC:

- ✓ Premium volume increases could indicate expansion into new products or new lines of business, a lowering of underwriting standards, or exposures exceeding guidelines for an existing capital structure. Premium volume decreases could indicate operating problems such as application processing delays.
- ✓ New policy form filings or expanding lines of business, in particular, high-risk products or continuing-payment policies, might imply planned rapid expansion to obtain premiums to cover prior losses.
- ✓ There may be indications that an insurance company does not have the required expertise in-house to successfully operate the insurance company. For example, the use of managing general agents or third-party administrators may suggest such a lack of in-house expertise. The uncontrolled use of managing general agents and third-party administrators frequently has been a factor in causing Troubled Insurance Company situations.
- ✓ There may be indications that the information technology systems of an insurance company are inappropriate for its current business plan.
- ✓ Significant deviations from rate filings might indicate insufficient revenues to cover losses and expenses.
- ✓ Changes in reinsurance practices, including increased surplus relief arrangements, or changes in reinsurers, might be used to offset losses or surplus decreases.
- ✓ Changes in claim reserving practices might be used to conceal an erosion of surplus.
- ✓ An increase in the number of complaints filed with insurance departments by policyholders, claimants, employees, agents, or third parties could indicate liquidity or internal control problems.
- ✓ An increase in the licensing of agents, including managing general agents or third-party administrators might indicate relaxed underwriting standards.
- ✓ The existence of interest crediting rates in excess of the earnings rate could represent an attempt to obtain premiums to offset cash flow problems in other areas.
- ✓ A sale of agents' balances, furniture, equipment, or other operating nonadmitted assets could indicate cash flow or collectibility problems or an insufficient level of surplus.

⁷¹ Id. at pp. 21-22.

- ✓ A change to new investment strategies to increase the potential rate of return may substantially increase the investment risk.
- ✓ A gain realized on the termination of an employee benefit plan might be used to offset adverse operating results.
- ✓ A need for new debt or capital infusions might indicate a need to fund adverse operating results.
- ✓ A significant change in the volume of business or product mix of an insurance company may indicate the introduction of underwriting practices that emphasize cash inflows, rather than traditional underwriting practices that emphasize pricing and control of loss ratios.
- ✓ The management of an insurance company has failed to respond to inquiries about the condition of the insurance company or has furnished false or misleading information concerning an inquiry.
- ✓ The management of an insurance company has filed a false or misleading sworn financial statement, has released a false or misleading financial statement to regulatory authorities, lending institutions, or to the general public, has made a false or misleading financial accounting entry, or has omitted an entry of a material amount from the financial records of the insurance company.
- ✓ The management personnel of an insurance company, including officers, directors, or any other persons who directly or indirectly control the operations of the insurance company, fail to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurance company in such position.
- ✓ The unexpected resignation of an insurance company's officers, directors, or other management personnel might indicate internal turmoil or dissatisfaction with the company's goals or operating practices.
- ✓ Significant acquisition activity.
- ✓ Insurers continually explaining questionable transactions are "tax driven" without providing precise details of benefits to be gained.
- ✓ Frequent or sudden changes in actuarial or auditing firms.
- ✓ Change of domicile without a clear-cut business reason.
- ✓ Parental guarantees for subsidiaries which outweigh the parent's financial ability to perform.

APPENDIX D

State Independent Bar Date Provisions

(Please see statutes and case law for exact language and interpretation.)

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SUMMARY OF BAR DATE PROVISIONS

- AL** Notwithstanding any other provisions of this chapter, 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.
- AK** The association is not obligated to pay a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- AZ** With respect to the handling of claims, the fund may by resolution bar known claims, whether liquidated or unliquidated, not filed within four months from the date of notice to creditors.
- AR** Notwithstanding any other provisions of this chapter, 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.
- CA** Covered claim are a claim to the liquidator in this state or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings.
- CO** Notwithstanding any other provision of this part 5, 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.
- CT** In no event shall the association be obligated for any claim filed with the association after the expiration of two years from the date of the declaration of insolvency unless such claim arose out of a workers' compensation policy and was timely filed in accordance with section 31-294c.
- DE** Notwithstanding any other provisions of this chapter, a covered claim shall not include any claim filed with the Association after the later of: (i) 24 months after the date of the order of liquidation or (ii) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- DC** A covered claim shall not include any claim filed with the Guaranty Fund after the earlier of the final date for the filing of claims against the liquidator or receiver of an insolvent insurer or 18 months after the order of liquidation.
- FL** A covered claim as defined herein with respect to which settlement is not effected and suit is not instituted against the insured of an insolvent insurer or the association within 1 year after the deadline for filing claims, or any extension thereof, with the receiver of the insolvent insurer shall thenceforth be barred as a claim against the association and the insured.

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SUMMARY OF BAR DATE PROVISIONS

- GA** In no case shall a covered claim include any claim filed with the pool, ancillary receiver, or liquidator after the final date set by a court for the filing of claims against the liquidator or ancillary receiver of an insolvent insurer.
- HI** Notwithstanding any other provisions of this part, a covered claim shall not include a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- ID** Notwithstanding any other provisions of this chapter, a covered claim shall not include any claim filed with the association after the earlier of (i) eighteen (18) months after the date of the order of liquidation, or (ii) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- IL** A covered claim, for other than unearned premium, is a claim which appears on the books and records of the insolvent company as of the date of the Order of Liquidation or a claim for which notice is given in writing to the liquidator of the insolvent company's domiciliary state or to an ancillary receiver in this State, if any, or to the Fund or its agents prior to the earlier of the last date fixed for the timely filing of proofs of claim in the domiciliary liquidation proceedings or 18 months after the entry of the order of liquidation.
- IN** Covered claims shall not include any unpaid claim that is not both filed within one (1) year after an order of liquidation and permitted to share in liquidation distributions under IC 27-9-3-33 if the insolvent insurer is a domestic insurer or in accordance with the applicable provisions of the law of the state of domicile if the insolvent insurer is not a domestic insurer.
- IA** Notwithstanding any other provision of this chapter, a covered claim shall not include any claim filed with the association after the final date set by the court for the filing of claims against the insolvent insurer or its receiver.
- KY** A covered claim shall not include a claim filed with the association after the earlier of twelve (12) months after the date of the order of liquidation, or the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- LA** Notwithstanding any other provision of this Part, a “covered claim” shall not include a claim filed with the association after the earlier of five years after the date of the order of liquidation of the insolvent insurer or the final date set by the domiciliary court for the filing of claims against the liquidator or receiver of an insolvent insurer. A “covered claim” shall also not include any claim filed with the association or a liquidator for incurred-but-not-reported losses or unspecified potential losses.

- ME** Notwithstanding any other provisions of this subchapter, a covered claim does not include any claim filed with the association after the earlier of 24 months after the date of the order of liquidation or the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. The association, in its discretion, may accept a late filed claim as a covered claim when the claimant demonstrates good cause. The demonstration of good cause by a claimant includes showing that the existence of the claim was not known to the claimant within 60 days of learning the claim.
- MD** A covered claim is presented on or before the last date fixed for the filing of claims in the domiciliary delinquency proceeding as a claim to the corporation or to the receiver in the State...
- MI** Covered claims are presented as a claim to the receiver in this state or the association on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings...
- MN** A covered claim does not include claims filed with the guaranty fund after the final date set by the court for the filing of claims except for workers' compensation claims that have met the time limitations and other requirements of chapter 176 and excused late filings permitted under section 60B.37.
- MO** All covered claims shall be filed with the association on the claim information form required by this paragraph no later than the final date first set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer, except that if the time first set by the court for filing claims is one year or less from the date of insolvency, and an extension of the time to file claims is granted by the court, claims may be filed with the association no later than the new date set by the court or within one year of the date of insolvency, whichever first occurs.
- NE** Covered claim shall mean an unpaid claim which has been timely filed with the liquidator as provided for in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act...
- NV** Except as otherwise provided in this paragraph, any claim filed with the association after:
- (1) Eighteen months after the date of the order of liquidation; or
 - (2) The final date set by the court for the filing of claims against the liquidator or receiver of the insolvent insurer, whichever is earlier, is not a covered claim. The provisions of this paragraph do not apply to a claim for workers' compensation that is reopened pursuant to the provisions of NRS 616C.390.
- NJ** A "covered claim" shall not include a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer unless the claimant demonstrates unusual hardship and the commissioner approves of treatment of the claim as a "covered claim." "Unusual hardship" shall be defined in regulations promulgated by the commissioner. With respect to insurer insolvencies pending as of the effective date of this 1996 amendatory act, a "covered claim" shall not include a claim filed with the association: (1) more than one year after the effective date of this 1996 amendatory act or (2) the date set by the court for the filing of claims against the liquidator or receiver of the insolvent insurer, whichever date occurs later.

- NC** Notwithstanding any other provision of this Article, a covered claim shall not include any claim filed with the Association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- ND** Notwithstanding any other provision of this chapter, a covered claim does not include a claim filed with the association after the earlier of eighteen months after the date of the order of liquidation or the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer...
- OH** Notwithstanding any other provision of the Revised Code, the association shall not be liable to pay any claim filed with the association after the earlier of the final date set by a court for filing claims in the liquidation proceedings of the insolvent insurer or eighteen months after the order of liquidation.
- OK** A covered claim shall not include any claim filed with the Association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- OR** Except for claims arising out of workers' compensation policies subject to ORS chapter 656, a covered claim does not include a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer
- PA** Notwithstanding any other provisions of this article, a covered claim shall not include any claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- RI** Notwithstanding any other provision of this chapter, a covered claim shall not include any claim filed with the fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- SC** A covered claim does not include any claim filed with the Association after the final date set by a court for the filing of claims against the liquidator or receiver of an insolvent insurer, or any claim filed with the association more than eighteen months after the declaration of insolvency, whichever date occurs first; provided, however, that this provision shall be without prejudice to the filing of a claim with the liquidator or receiver of an insolvent insurer or the filing of a claim with any other Guaranty Association or similar organization in another state.
- SD** Notwithstanding any other provisions of this chapter, a covered claim does not include a claim filed with the association after the earlier of eighteen months after the date of the order of liquidation, or the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- TN** In no case shall a covered claim include any claim filed with the association, domiciliary receiver, ancillary receiver or liquidator, after the earlier of:
- (1) Eighteen (18) months after the date of the order of liquidation; or
 - (2) The final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

- TX** Notwithstanding any other provision of this Act, a covered claim shall not include any claim filed with the guaranty association on a date that is later than eighteen months after the date of the order of liquidation, except that a claim for workers' compensation benefits is governed by Title 5, Labor Code, and the applicable rules of the Texas Workers' Compensation Commission.
- UT** The association need not pay any claim filed after the final date under Sections 31A-27-315 and 31A-27-328, or similar statutes of other states, for filing the same type of claim with the liquidator of the insolvent insurer.
- VT** In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises, nor for any claim filed with the association after the final date set for the filing of claims against the liquidator or receiver of the insolvent insurer, nor in any event after the expiration of three years from the date of determination of the insolvency of such insurer.
- VA** Notwithstanding any other provision of this chapter, a covered claim shall not include any claim filed with the Guaranty Association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- WA** In addition, "covered claim" shall not include any claim filed with the association subsequent to the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.
- WV** Notwithstanding any other provision of this article, 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.
- WI** The board has no duty or liability with respect to any claim filed as follows: Except for claims under life insurance policies, annuities and noncancelable or guaranteed renewable disability insurance policies and except for claims determined to be excused late filings as provided in pars. (a) and (b), with a liquidator or court after the earlier of the following:
1. Eighteen months after the order of liquidation is entered.
 2. The final date for filing specified by the liquidator or court.
- WY** Notwithstanding any provision in this chapter, a covered claim shall not include any claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

APPENDIX E

Overview of the Property and Casualty Guaranty Association System

Purpose: The purpose of state guaranty associations is to provide a mechanism for the prompt payment of covered claims of an insolvent insurer, as those terms are defined and limited by guaranty association statutes, so that catastrophic financial loss to certain claimants and policyholders may be avoided.

Creation: The property and casualty guaranty association system was created by state laws of the various states in the late 1960s and early 1970s. Each state has at least one property casualty guaranty association system. A few states have established separate funds to handle workers compensation liabilities and one state has a separate surplus lines fund.

Triggering Mechanism: Most guaranty associations become obligated when an insurance company is found to be insolvent and ordered liquidated. A minority of funds are triggered by some other means such as a finding of insolvency only.

Coverage: Specific coverage parameters of the various guaranty associations are included in their enabling statutes. In general, the funds pay certain claims of *licensed* insurers who have been found insolvent and placed in to liquidation. The funds, with one exception, do not pay claims on surplus lines companies and other unregulated market insurance arrangements. The funds pay certain claims on *direct* business. They do not cover claims on reinsurance contracts. Claims against the funds are capped by their state laws. For the most part the covered claim limit is \$300,000 but there is no limit for workers compensation claims.

Funding: Insurance companies writing property and casualty lines of business covered by a guaranty association are required to be a member of a guaranty association of a particular state as a condition of their authority to transact business in that state. To fund their claims obligations, guaranty associations assess member insurers based upon their proportionate share of premiums written on covered lines of business in that state. Most often assessments to members are limited to two percent of net direct written premium per year. In a few states the assessment cap is one percent.

The acts of all states and territories, except the act of the state of New York, create post-assessment guaranty associations. These guaranty associations make assessments to obtain funds to pay claims after an insolvency occurs. The New York Security Fund and certain funds which cover only workers' compensation are pre-assessment guaranty funds meaning that assessments are made prior to an insolvency occurring.

Member insurers of the guaranty funds are permitted to recoup assessments paid. In some state this is done by factoring the cost of assessment in to rates, in others insurers may take a premium tax offset, and in some states assessments are recouped by means of a surcharge to policyholders.

More Information: More information on the guaranty associations, including their enabling statutes and state-specific summary information on the various guaranty fund act provisions is available on the NCIGF website at <http://www.ncigf.org/>.