

Restructuring Mechanisms

An NAIC White Paper

May 2024

Created by the
Restructuring Mechanisms (E) Working Group

of the
Financial Condition (E) Committee

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ISBN: 978-1-64179-180-9

Printed in the United States of America

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A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period resulting in obligations for insurers that need to be reserved for to ensure payment of claims when they come due. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer's business model and left to pay its claims as they come due over time. For some insurance companies, runoff business remains embedded with the core business without the ability to segregate the runoff business. Please note that the NAIC has yet to finalize a definition on this matter and is only included within this paper to provide some basis for comprehension; however note that some business continues to have premium being collected but is referred to in run-off (e.g., LTC insurance). There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers or policy novation. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remains with the original insurer. The only way to transfer a block of business with finality is an individual policy novation or a policy commutation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled "Liability-Based Restructuring White Paper." (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off "material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities" from current insurer operations. The white paper achieves this focus by inclusion of various sections on related topics as well as multiple appendices. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled "Alternative Mechanisms for Troubled Companies." (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States ("US") at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendices.

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD"). Several states, including Arkansas, Illinois, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes while other states such as Arizona, Arkansas, Colorado, Connecticut, Illinois, Iowa,

Michigan, and Pennsylvania, have enacted CD statutes. The stated intent of these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will begin with some historical background from the United Kingdom (“UK”) to provide historical context and explain some of the inspiration for the US laws. Then this white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the UK are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Company efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, although it should be noted that if not done properly, it can reduce policyholder protection, at least from the perspective of some regulators. Restructuring transactions also create other company efficiencies, such as better allocation of specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsurers and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as redirect regulatory focus away from the insurer’s ongoing business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.

Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and

better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such as mass tort, asbestos, environmental, general liability risks and life insurance. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer and ideally still retain value for the policyholders. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business.¹ With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities.² One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; 2) finality of economic transfer and 3) operational efficiencies.³

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulatory Concerns with Restructuring Plans

While restructuring may provide value to the insurer, some regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that could provide less capital than is needed to satisfy the insurer's obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to approve the restructuring plan. Regulators have utilized procedures to ensure the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

¹ Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

² Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee, Liability-Based Restructuring White Paper 3 (1997) at pages 4-5.

³ David Scasbrook (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.

Section 2: History of Restructuring in the United Kingdom

A. Part VII Transfers and Solvent Schemes of Arrangement in the United Kingdom

Restructuring laws and regulations are relatively new in the US, but the legal mechanism for the transfer of insurance business has been implemented and operational in the UK for over twenty years. Part VII of the Financial Services and Markets Act of 2000.⁴ (“Part VII” and “FSMA”) enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 300.⁵ successful Part VII transfers have taken place in the UK without any failures⁶ providing guidance to American insurers on how this process could continue to unfold in the US.

A Part VII transfer is a regulatory mechanism, governed by sections 104–116 within Part VII of the FSMA. This act allows an insurer or reinsurer to transfer both long-term (life and annuity business) and general insurance (property and casualty) business from one legal entity to another, subject to approval of a court and an independent expert review. Many insurers use the procedure to give effect to group reorganizations and consolidations. Part VII transfers have also been used extensively in response to Brexit.

In accordance with the FSMA, the Prudential Regulatory Authority (“PRA”) and the Financial Conduct Authority (“FCA”) maintain a Memorandum of Understanding which describes each regulator’s role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. In general, the PRA is focused on solvency regulation while the FCA is focused on market conduct regulation. Under the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

Section 110 of the FSMA allows both the PRA and the FCA to be heard in the proceedings. The Memorandum of Understanding confirms that both the PRA and the FCA may provide the court with written representations setting out their views on the proposed scheme, and the PRA may prepare a report regarding the IBT.

As set out in the Memorandum of Understanding, before nominating or approving an independent expert under section 109(2)(b) of FSMA . . . the PRA will first consult the FCA. Further, the PRA will consult appropriately with the FCA before approving the notices required under the Business Transfers Regulations.

Part VII transfers require a “scheme report.” A similar report is required under US IBTs laws, but the word “scheme” is not used and has negative connotations in American English. Under section 109(2) of FSMA, the scheme report may only be made by an independent expert who:

⁴ Financial Services and Markets Act of 2000, 48 Eliz. 2, part 7 (Eng.). FOR CITATION TO ONLINE SOURCE USE:

Financial Services and Markets Act of 2000, part 7 (Eng.), <https://www.legislation.gov.uk/ukpga/2000/8/contents>.

⁵ Comment letter from the IBT Coalition Interested Parties to the Restructuring Mechanisms (E) Subgroup dated July 22, 2019.

⁶ The Working Group has heard comments about the Lack of Failures of Part VII transfers but requests a commentor provide a reliable source for this proposition.

- (a) appears to the PRA to have the skills necessary to make a proper report; and (b) is nominated or approved by the PRA.

The regulators expect the independent expert making the report to be a neutral person, who:

- (a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and
- (b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group's discussion of the Part VII transfers, consumer representatives raised the UK court's decision in *In re Prudential and Rothesay*.⁷ which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals.⁸ found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to

⁷ As noted by Birny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. The decision denying the Part VII Transfer is available online here: <https://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Ch/2019/2245.html>. Note this decision was overturned by *The Prudential Assurance Company Limited v. Rothesay Life PLC* [2020] EWCA Civ 1626.

⁸ *Prudential Assurance Company Ltd and Rothesay Life Plc, Re*, England and Wales Court of Appeal (Civil Division)(Dec. 2, 2020). That appeals court decision is available online here: <https://www.judiciary.uk/wp-content/uploads/2020/12/Prudential-Judgment.pdf>.

give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

- (1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.
- (2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries' capital.
- (3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.⁹

Ultimately, the UK High Court of Justice approved the Part VII transfer between Prudential and Rothsay in a judgment dated November 24, 2021,¹⁰ Despite this series of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of being transferred. While such an arrangement may provide some of the same features as a Part VII transfer, solvent schemes do not continue the coverage with a new insurer the way a Part VII transfer does. Instead, the coverage is typically terminated in exchange for a sum of money being paid by the insurer to the insured. Other differences exist in law but this is the most significant for purposes of this white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. One type of restructuring law generally follows the UK structure, Rhode Island was the first state to take this approach adopting a statute in 2002 titled Voluntary Restructuring of Solvent Insurers¹¹ patterned after Solvent Schemes of Arrangements (“Solvent Schemes”). Rhode Island refers to this process as a “Commutation Plan.” Another type of restructuring modeled after UK law is an Insurance Business Transfer or IBT, which is modeled after a Part VII transfer in the UK. A third type of restructuring we will discuss is called a Corporate Division (“CD”) generally follows longstanding corporate law and is akin to a reverse merger.

Commutation Plans differ from a Solvent Scheme in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process

⁹ *Id.* at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15.

¹⁰ [2021] EWHC 3152 (Ch). Available online at <https://www.bailii.org/ew/cases/EWHC/Ch/2021/3152.html>

to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.¹¹

Although Commutation Plans continue to be available in Rhode Island, the Department updated its regulation in 2015 to provide an additional option: Insurance Business Transfer Plans.¹³ Similar to the Part VII transfers, but again, in contrast to the UK, the Rhode Island regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments received continues to believe that it meets the statutory requirement, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act (“LIMA”).¹² LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act.¹³ modeled after UK’s Part VII regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed three IBTs in October 2020, September 2021, and September 2023 involving a Rhode Island, Wisconsin, and Missouri insurer respectively which are described below. Neither of the plans were challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act.¹⁴ which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is made for an extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report.

¹¹ [In re GTE Reinsurance Co., No. PB 10-3777, 2011 WL 7144917, at *5–6 \(R.I. Super. Ct. Apr. 25, 2011\)](#) ¹³ 230 RICR 20-45-6.

¹² See Legacy Insurance Management Act, 2014 Vt. Acts & Resolves 93 (codified as amended at VT. STAT. ANN. tit. 8, §§ 7111–7121 (West 2017)).

¹³ Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 *et seq.*

¹⁴ As announced by the Arkansas Department of Insurance July 8, 2021, ACA §§ 23-69-501, *et seq.* (See Arkansas statute at <https://www.arkleg.state.ar.us/Bills/Detail?id=SB203&ddBienniumSession=2021%2F2021R>)

One of the earlier CD statutes was adopted in Pennsylvania.¹⁵ That statute is not within the Pennsylvania insurance statutory title, but rather is part of their general corporate law title. That law creates a CD and allows that the CD be transacted with or without the approval of all “interest holders.” And as discussed later, having a mechanism not requiring all “interest holders” approving is important from a commercial point of view.

In 2017, Connecticut adopted a statute titled “An Act Authorizing Domestic Insurers to Divide,”¹⁶ that authorized the Connecticut Division of Insurance to approve CD plans. This statute creates a lane for insurers to file CD plans with the Connecticut DOI to divide itself into two or more companies, with the resulting insurers segregating the assets and liabilities, including insurance policies, of the initial insurer as detailed in their plan of division. While the Connecticut CD law may allow interested parties to offer their opinion of the transaction as part of a public hearing, the Commissioner of Insurance makes the ultimate decision on the plan.

In 2018, Illinois adopted a statute titled “the Domestic Stock Company Division Law (SB1737)”¹⁷ that allowed the Director of the Illinois Department of Insurance to approve a CD for Illinois domestic insurers once specific requirements are satisfied.

The National Council of Insurance Legislators has promulgated a model IBT law.¹⁸ modeled after the Oklahoma IBT statutes, as well as a model CD law.¹⁹ A number of states have adopted CD statutes, whether specific to insurance or based on the state’s general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania.²⁰ All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

A. Similarities and Differences between Statutes

Rhode Island’s IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer’s domestic insurance regulator is also required. All states require an independent expert report that contains an opinion on the likely effects of the transfer plan on policyholders considering whether the security position of policyholders is materially adversely affected by the transfer. All states also require notification to all affected policyholders as well as the opportunity to be heard at a public hearing.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a

¹⁵ 15 PA. CONS. STAT. §§ 361–368 (2017).

¹⁶ Connecticut Public Act No. 17-2, available at: <https://www.cga.ct.gov/2017/act/pa/2017PA-00002-R00HB-07025-PA.htm> [cga.ct.gov].

¹⁷ Illinois Public Act 100-1118. Available at <https://www.ilga.gov/legislation/publicacts/100/100-1118.htm>.

¹⁸ Insurance Business Transfer Model Act (Nat’l Council of Ins. Legislators 2020).

¹⁹ Insurer Division Model Act (Nat’l Council of Ins. Legislators 2021).

²⁰ See A.R.S. §§ 29-2601, *et seq.*; C.G.S.A §§ 38a-146, *et seq.*; 215 ILCS 5/35B-1 *et seq.*; M.C.L.A. §§ 500.5500 *et seq.*; A.C.A. §§ 23-69-501, *et seq.*; 15 Pa.C.S. §§ 361 *et seq.*

regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate certain books of business from an insurer.

The Illinois' Domestic Stock Company Division Law.²¹ requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless at least one of the following disqualifying factors is found:

- (1) policyholder/shareholder interest are not protected;
- (2) the resulting insurer would not be eligible to receive a license in the same state as the dividing insurer;
- (3) division violates the Uniform Fraudulent Transfer Act;
- (4) division is made for the purpose of hindering, delaying, or defrauding other creditors;
- (5) any of the companies is insolvent after the division is complete.

The Connecticut CD statute.²² creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the dividing insurer; (2) the names of the resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing. The Connecticut Division's Law only applies to Connecticut domestics (i.e., both the dividing insurers and ultimate resulting insurer must be Connecticut domestics). In addition, all insurance lines, whether active or closed block, may submit a plan of division under the statute.

There are three ways to affect an insurance division in Connecticut:

²¹ 215 ILL. COMP. STAT. 5 as found at <https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1249&ChapterID=22>.

²² C.G.S.A §§ 38a-146, *et seq.*, Public Act No. 17-2.

- **Division and Simultaneous Merger into an affiliated CT insurer.** (Company stays within the same insurance group but in a separate legal entity. May be used to set a company up for future sale);
- **Division and Simultaneous Merger into an affiliated CT insurer followed by a 3rd party's acquisition of the CT insurer.** (This would be a 2-step process. A division (de-merger) followed by a Change in Control Application (Form A)); and
- **Division and Simultaneous Merger into an Unaffiliated CT insurer.** (Similar to above but all part of the same filing and proceeding. It creates a CT domestic for a split second as a pass through to an unaffiliated CT insurer).

The Pennsylvania CD statute.²³ was enacted in 1990 and is discussed in the NAIC 1997 white paper on Liability-Based Restructuring, attached to this paper as an appendix. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the state's equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because with the exception of Colorado and Iowa, the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal expertise. The processes set forth in the CD laws are not modeled after UK Part VII Transfers, but are instead modeled after existing US laws dealing with corporate restructuring and insurance laws dealing with change of control, mergers, and demutualizations.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in 1995, when the Pennsylvania Insurance Department approved a division of the Cigna Corporation, which is commonly referred to as the “Brandywine transaction,” after the name of one of the resulting insurers. This transaction is discussed in more detail within Appendix 1 of the 1997 Liability-Based Restructuring White Paper, but having been approved, ultimately resulted in the proposed business within the transaction to be transferred to another insurance group.

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that

²³ 15 PA. CONS. STAT. §§ 361 *et seq.*

had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and therefore had less direct impact on individual policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re.²⁴ completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision.²⁵ on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company's ("PWIC") IBT plan.²⁶ The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company ("Sentry"), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for approval.²⁷ This IBT transferred a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2021. The dividing companies were eight Illinois-domiciled insurance subsidiaries of a corporation that transacted, among other business, automobile insurance in Michigan. The dividing companies allocated certain portions of the automobile insurance business written by the dividing companies in Michigan – namely their inactive policies with outstanding claim reserve – to eight new insurance companies created in the divisions. The eight new insurance companies were then simultaneously merged into three previously established Illinois-domiciled insurance companies that became the surviving companies of the mergers. The surviving companies of the mergers are Illinois-domiciled insurance companies licensed to conduct business in Illinois and Michigan. The Illinois Department utilized a website to make their process transparent,²⁸ and it includes a report from their Hearing Officer,²⁹ as well as an Order approving the CD in March 2021.³⁰

²⁴ C.A. No. PB 10-3777 (R.I. Super. Apr. 25, 2011).

²⁵ State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777 available at <https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/decisions/10-3777.pdf>.

²⁶ Judgment & Order of Approval & Implementation of the IBT Plan, In re Transfer and Novation of Insurance Policies from Province Wash. Ins. Co., et al., CJ-2019-6689 (D.Ct. Okla. Cnty Oct. 15, 2020), available at <https://www.oscn.net/dockets/GetCaseInformation.aspx?db=oklahoma&number=CJ-2019-6689&cmid=3831864>.

²⁷ Approval Order in Case No. 20-0582-IBT from Oklahoma Insurance Commissioner, filed on November 23, 2020, at <https://www.oid.ok.gov/wp-content/uploads/2020/11/20-0582-IBT-SAW-Order-11-23-20.pdf>.

²⁸ <https://doi.illinois.gov/consumers/company-divisions.html>.

²⁹ The Hearing Officer's report is available online at: <https://doi.illinois.gov/content/dam/soi/en/web/insurance/consumers/documents/allstate-division-doiho-report-only3-29-21.pdf>.

³⁰ For more on the Illinois transaction, FORC has published an article on the topic, available at: <https://www.forc.org/Public/Journals/2021/Articles/Summer/Vol32Ed2Article5.aspx>.

A. **Guaranty Association Issues**

In order to prevent restructuring from materially adversely affecting consumers, it is essential to ensure that guaranty association coverage is not reduced or eliminated or otherwise changed by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine Guaranty association coverage. It is possible that a corporate restructuring could result in the reduction, elimination or change in guaranty association coverage provided to a policyholder in the event of the restructured insurer's insolvency if steps are not taken to prevent that result. The potential coverage issues are different for life and health guaranty association coverage and property and casualty guaranty fund coverage. We address them separately below:

Transactions Involving Life or Health Insurance

The Working Group received input from the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA") about the concerns for insurance consumers of personal lines life and health insurance business.

NOLHGA indicated that for there to be guaranty association coverage in the event of a life or health insurer insolvency, there are three conditions that must be present. Those conditions are:

- (1) The consumer seeking protection must be an eligible person under the guaranty association statute; typically, this is achieved by being a resident of the guaranty association's state at the time of the insurer's liquidation;
- (2) The product must be a covered policy; and
- (3) The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state or have been licensed in the state to write the lines of business covered by the guaranty association.

In most states, coverage can also be provided for an "orphan" policyholder of the insurer by the guaranty association in the insolvent insurer's domestic state. Orphan policyholders are policyholders who are residents of states where the guaranty association cannot provide coverage because the insolvent insurer not a member insurer due to not being licensed at the time required by the guaranty association act. The orphan policyholder situation can arise when a policyholder purchases a policy in a state where the issuing company is licensed (i.e., is a member of the guaranty association) but subsequently moves to a state where the issuing insurance company was never licensed (i.e., is not a member of the guaranty association). The provision in the NAIC Life and Health Insurance Guaranty Association Model Act, and the laws of most states, that provides that orphan policies are covered by the guaranty association in the insolvent insurer's domestic state is designed to plug the gap in these rare situations.

A key factor when considering a life or health IBT or CD transaction is whether the resulting insurer is or will be a member insurer of the same guaranty associations where the transferring insurer was a member insurer. If the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer, guaranty association coverage will be preserved and not changed for all policyholders. (Of course, specific guaranty association coverage will be determined if/when the resulting insurer is placed under an order of liquidation with a finding of insolvency.) If the resulting insurer is not a member insurer of the same guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or be covered as orphans by the guaranty association in the insurer's domestic state. Orphan coverage was not designed to plug the gap in this situation. Shifting the coverage obligation to the domestic state guaranty association could result in guaranty association coverage being concentrated in that state.

To address these concerns with respect to IBT and CD transactions involving life or health insurance, NOLHGA recommends restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred. However, it is not clear the state approving the transaction does not have the power to require other states to license the resulting insurer(s) and making it a mandatory condition of approval would have the unintended consequences of giving other states (perhaps every other state) and absolute veto power over any IBT or CD transaction. In a CD, the state regulator would have the authority to require the merger of the divided line(s) of business, whether into an affiliated company of the dividing insurer or unaffiliated company, be made into an entity that is so adequately licensed. This can either be done under an adopted specific standard of approval (see Colorado and Illinois) or the general standard of policyholder protection.

Transactions Involving Property and Casualty Insurance

The Working Group received input from the National Conference of Insurance Guaranty Funds ("NCIGF") about the concerns for insurance consumers of personal lines property and casualty insurance business.

One interpretation of the NAIC Property and Casualty Insurance Guarantee Association Model Act (Model # 540).³¹ is that based on the definitions of "Covered Claim," "Member Insurer," "Insolvent Insurer," and "Assumed Claim Transaction" an orphan policyholder could not be covered by the state guarantee association.³² Consequently, there is a concern that no guaranty association coverage would be provided if policies are transferred to a nonmember insurer. Many property and casualty guaranty fund statutes require that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred. These limitations, however, are designed to avoid coverage being provided when the policy at issue did not "contribute" to the association, which would not exist in the case of an assessable policy later transferred to an insurer that was not a member at the time the policy was issued. Moreover, the restrictions exist to prevent claims resulting from a company regulated as a surplus lines or a similar structure to benefit from the protections afforded licensed business when a licensed company is liquidated.

³¹ Available at <https://content.naic.org/sites/default/files/inline-files/MDL-540.pdf> .

³² See NOHLGA and NCIGF joint submission to NCOIL dated February 24, 2020 for more information. Available at <http://ncoil.org/wp-content/uploads/2020/02/2020-02-24-Comment-on-NCOIL-IBT-Model.pdf>.

NCIGF's position is that where there was guaranty fund coverage before the IBT or CD, state regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate or in any way impact guaranty fund coverage. An CD or IBT should not create, expand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states that have adopted the NAIC Property & Casualty Insurance Guaranty Association Model Act.³³ These gaps could include the definitions of Covered Claim, Member Insurer, Insolvent Insurer, and the Assumed Claims Transaction found in Section 5 of the model law.

Fulfilling this intent will likely require property and casualty guaranty fund statutes to be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee's work is discussed in the Recommendations section below. It should be noted that the same membership and timing issues that are raised by IBTs could also be raised in the case of any other policy novation including the assumption reinsurance transactions discussed below.

B. Assumption Reinsurance Model Act and Other Affirmative Consent Requirements

Assumption Reinsurance Model Act

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholder with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, in situations where the solvency of the insurer might be at risk. There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.³⁴ Under the Model Act, individual policyholders are notified of a proposed transfer of their policy and "have the right to reject the transfer and novation of their contracts of insurance."

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be effectuated. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act implicitly prohibit an IBT or a CD approved by a different state court or department of insurance. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholder's express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the

³³ Property and Casualty Guaranty Association Model Act (Nat'l Ass'n of Ins. Comm'r's 2009).

³⁴ Available at <https://content.naic.org/sites/default/files/inline-files/MDL-803.pdf>.

restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper, and may ultimately be decided by a court after an IBT or CD is approved over a state or policyholder's objection. But the issue has not yet been addressed by any court nor raised in the proceedings on restructurings.

Virginia Law Requiring Affirmative Consent Requirements

A state may also require such consent through independent anti-novation statutes or the application of common law principles. For example, in one state, the principle of policyholder consent is codified in the insurance code.³⁵ This state's code prohibits the assumption of policy obligations on risks located in the state as direct obligations unless (1) the policyholder consents and (2) the assuming insurer is properly licensed in the state. Absent policyholder consent, such a transaction requires an order from the state corporation commission (hereafter referred to as the Commission) approving the transaction. The Commission may enter such an order whenever (i) the Commission finds a licensed insurer to be impaired or in hazardous financial condition, (ii) a delinquency proceeding has been instituted against the licensed insurer for the purpose of conserving, rehabilitating, or liquidating the insurer, or (iii) the Commission finds, after giving the insurer notice and an opportunity to be heard, that the transfer of the contracts is in the best interests of the policyholders. Additionally, if granting an approval order, the Commission is required to ensure that policyholders do not lose any rights or claims afforded under their original policies by the state Property and Casualty Insurance Guaranty Association or the state Life, Accident and Sickness Insurance Guaranty Association.

The Virginia State Corporation Commission, which acts as a court of record, applied Virginia's anti-novation statute to the previously mentioned PWIC/Yosemite IBT. In that particular case, the transferred business, included a number of Virginia workers' compensation policies. As such, the Bureau informed PWIC and Yosemite that the IBT—as to the Virginia policies—required policyholder consent under § 38.2-136 (B) of the Code because it involved the cessation or assumption of policy obligations on risks located in Virginia. In response, PWIC and Yosemite requested that the Commission waive the policyholder consent requirement by finding that the transfer of the Virginia policies was in the best interests of the policyholders pursuant to § 38.2-136 (C)(iii) of the Code. The Commission found that the transfer of Virginia policies was subject to the requirements of § 38.2-136 (B) of the Code (i.e. policyholder consent and proper licensure), but approved the transfer pursuant to § 38.2-136 (C)(iii) of the Code (i.e. best interests of the policyholders).

Therefore, it should be clear to all states, that when considering an IBT or CD involving Virginia policyholders, absent policyholder consent, The Virginia Commission must find the transfer of the Virginia policies to be “in the best interests of the policyholders” in accordance with § 38.2-136 (C)(iii) of the Virginia Code. If this is not found, the transfer will not apply to Virginia policyholders.

C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the regulator's willingness to consider the restructuring of certain lines of business. During the Working Group's discussion, it was noted by a number of regulators that restructuring of certain lines of business,

³⁵ See Virginia Commonwealth Code at § 38.2-136.

such as long-term care insurance, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care insurance, is likely to be subject to a great deal of opposition. Even where permitted, it could be subject to higher capital requirements for the insurers involved.

The circumstances of long-term care insurance policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. Furthermore, if the block of business has been in runoff for a substantial period of time, the policyholders will be aging and many will be disabled. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders. That being said, there should be increased scrutiny for any block transfers, not just those relating to long-term care insurance, that are currently in a projected deficit situation.

It is important to note that all of these concerns exist whenever there is an entity involved in the restructuring plan that has potentially troubled policies, including (but not limited to) long-term care insurance. It does not matter whether the potentially troubled policies are to be transferred to a new entity or are to remain in the current entity that will no longer contain the transferred policies (and corresponding assets that may have provided additional financial protection to the troubled block). Creating monoline LTC entities through restructuring mechanisms may result in significant long term solvency risk.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others,³⁶ a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. Article IV of the US Constitution included both the Full Faith and Credit Clause and the Privileges and Immunities Clause, and separately courts have been known to honor decisions from other courts through a doctrine of Comity. These represent three methods that insurers might rely on to extend the legal and practical effect of a restructuring mechanism beyond the state that issued the initial decision or judgment, and can make the restructuring transaction effective in all other states in which the insurer does business.³²

As the highest court in the land, the US Supreme Court has addressed the Full Faith and Credit clause in the US Constitution. The Court wrote “a final judgment in one State, if rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, qualifies for recognition throughout the land. For claim and issue preclusion (res judicata) purposes, in other words, the judgment of the rendering State gains nationwide force.”³⁷ However, that mandate is not absolute, as the Court also write “[t]he Full Faith and Credit Clause does not compel “a state to substitute the statutes of

³⁶ Gendron, Matthew Esq. (2018) "Rhode Island's Voluntary Restructuring of Solvent Insurers Law and Similar Efforts in Other States," *Roger Williams University Law Review*: Vol. 23: Iss. 3, Article 3, available at: https://docs.rwu.edu/rwu_LR/vol23/iss3/3. That article briefly raises questions about whether full faith and credit or comity would apply to help insulate an IBT transaction from collateral challenge in a court outside the approving state.

³⁷ Baker by Thomas v. Gen. Motors Corp., 522 U.S. 222, 232–33 (1998)

other states for its own statutes dealing with a subject matter concerning which it is competent to legislate.”³⁸ The determination of whether a court will provide full faith and credit will likely rely upon the issues raised and considered by the Court or the regulator issuing a decision approving a restructuring plan. If a policyholder wished to challenge a restructuring plan based on the full faith and credit clause, they must first identify the property or right of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to a new insurer in a restructuring plan without alleging additional harm may have difficulty identifying the property interest of which they have been deprived.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

While full faith and credit is used to apply the judgment of one state’s action in another state, the Privileges and Immunities Clause guarantees “that in any State every citizen of any other State is to have the same privileges and immunities which the citizens of that State enjoy.”³⁹ This means that the Clause imposes a direct restraint on state action in the interests of interstate harmony.⁴⁰ This protection provides that citizens of one state should not be discriminated against by another state, such as through the approval of a restructuring plan. However, in applying those protections, the US Supreme Court has first applied a threshold test of whether the out-of-state application of the Privileges and Immunities Clause to a particular instance of discrimination against out-of-state residents entails a two-step inquiry. As an initial matter, the court must decide whether the ordinance burdens one of those privileges and immunities protected by the Clause. *Baldwin v. Montana Fish and Game Comm’n*, 436 U.S. 371, 383, 98 S.Ct. 1852, 1860, 56 L.Ed.2d 354 (1978). Not all forms of discrimination against citizens of other States are constitutionally suspect. *United Bldg. & Const. Trades Council of Camden Cty. & Vicinity v. Mayor & Council of City of Camden*, 465 U.S. 208, 218, 104 S. Ct. 1020, 1027, 79 L. Ed. 2d 249 (1984)

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK.⁴¹ This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-

³⁸ *Id.* at 232-3

³⁹ *Baldwin v. Fish & Game Comm’n of Mont.*, 436 U.S. 371, 382 (1978)

⁴⁰ *United Bldg. & Const. Trades Council of Camden Cty. & Vicinity v. Mayor & Council of City of Camden*, 465 U.S. 208, 220 (1984).

⁴¹ See SIDLEY AUSTIN LLP, PART VII TRANSFERS EFFECTUATED PURSUANT TO THE UK FINANCIAL SERVICES AND MARKETS ACT 2000 (2017), <https://www.sidley.com/-/media/publications/part-vii-transfers.pdf>.

based insurers on a regular basis,⁴² while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. *Narragansett Electric Co. v. American Home Assurance Co.* is one such case.⁴³ In *Narragansett Electric Co.*, the court reviewed claims by a London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier.³⁶ Equitas had assumed a block of business from Lloyd's of London in a Part VII transfer, but argued that it had not assumed the obligations at issue. As the court summarized, "Equitas's motion to dismiss raises the question whether this transfer of insurance obligations from Lloyd's to Equitas is effective and enforceable under U.S. law." First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent to US policyholders raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a UK's independent expert's report.⁴⁴ Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. *Allianz* is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. *Allianz* also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

Allianz involved a dispute over liabilities incurred by General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the

⁴² See Jennifer D. Morton, Note, *Recognition of Cross-Border Insolvency Proceedings: An Evaluation of Solvent Schemes of Arrangement and Part VII Transfers under U.S. Chapter 15*, 29 FORDHAM INT'L L.J. 1312, 1314–15 (2006).

⁴³ See *Narragansett Elec. Co. v. Am. Home Assur. Co.*, No. 11 Civ. 8299(PKC), 2012 WL 4075171 (S.D.N.Y. Sept. 12, 2012). There, a claim originating in Pawtucket, Rhode Island, but with waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co.*, 57 N.E.3d 18, 24 (Mass. App. Ct. 2016).

⁴⁴ There, a claim originating in Pawtucket, Rhode Island, but with waste disposed near Attleboro, Massachusetts (the next town over, but across the state line). In subsequent related matters, the Massachusetts Appeals Court found that Massachusetts law would govern whether the pollution was discharged in sudden and accidental ways. *OneBeacon America Ins. Co. v. Narragansett Elec. Co.*, 57 N.E.3d 18, 24 (Mass. App. Ct. 2016). See Steven E. Sigalow & Richard E. Stewart, *How Lloyd's Saved Itself*, 37 THE INS. FORUM (2010), reprinted in JONES DAY, <http://www.jonesday.com/files/Publication/dae28676-d6c8-4de6-9cbb-c05aee419d4b/Presentation/PublicationAttachment/533860ba-d4f1-4056-85d9-78b84dc71af5/How%20Lloyd's%20Saved%20Itself.pdf> (last visited June 9, 2021). *Air & Liquid Sys. Corp. v. Allianz Ins. Co.*, No. 2:11-CV-00247-JFC, 2012 U.S. Dist. LEXIS 121553 (W.D.P.A. 2012). *Id.* at *12. This interrelated nature is not unusual and is referred to as an intra-company transaction.

policies shared an ultimate parent company—Berkshire Hathaway. At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in *Allianz* seemed to be that the transferee insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden’s potential asbestos claim

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law.⁴⁵ The court determined that, given the location of the petitioner’s assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action.⁴⁶ The court in *Hopewell* also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.⁴¹

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The insurance regulators of virtually all states have recognized the effectiveness in the US of Part VII transfers for insurance regulatory purposes on numerous occasions⁴⁷. Additionally, there are insurers on the NAICs International Insurers Department quarterly listing for surplus lines carriers after having completed a Part VII transfer. The Working Group believes there should be a standard set of financial principles under which to judge these transactions. Accordingly, the Working Group created a subgroup to specifically address these financial issues.

⁴⁵ Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)

⁴⁶ Gendron, Matthew Esq. (2018) "Rhode Island's Voluntary Restructuring of Solvent Insurers Law and Similar Efforts in Other States," *Roger Williams University Law Review*: Vol. 23: Iss. 3, Article 3, available at: https://docs.rwu.edu/rwu_LR/vol23/iss3/3. That article briefly raises questions about whether full faith and credit or comity would apply to help insulate an IBT transaction from collateral challenge in a court outside the approving state

⁴⁷ As cited by Gregory Overton FIA, Price Waterhouse Coopers, <http://www.project-river-transfers.com/ProjectRiver-IESupplementalReport.PDF> [project-river-transfers.com] “In respect of Unionamerica’s US Reinsurance Trust Fund, 30 US State regulators are needed to approve River Thames as an accredited reinsurer in place of Unionamerica. I understand that approval has been received from 11 US state regulators to date, with a further 18 awaiting the approval of the New York Department of Financial Services (“NY DFS”) to complete its review. Enstar has confirmed to me that all additional information requests and pre-conditions in connection with the application of all 30 US States have been addressed save that the NY DFS have stipulated that the new trust fund must be established by River Thames and funded to the minimum required level prior to the transfer of the protected policyholders. Enstar are in the process of meeting this final condition. Once it is met US regulatory counsel remain confident that the remaining approvals will be received shortly thereafter.”

The Restructuring Mechanism Subgroup (“Subgroup”) has been charged with the following initial work related to this White Paper:

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long- term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration as a basis for accreditation standards.⁴⁸

Members of the Subgroup have studied the UK Part VII procedures, and have concluded that they set forth robust processes and that similar guidelines should be established for IBTs and CDs. Those best practices will be appended to this paper as an Appendix.

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. In some states, such as Colorado and Illinois, and to a certain degree, Arkansas, require an assuming or resulting insurer to be licensed in the same state(s) as the transferring or dividing insurer. As previously noted, one state has higher standards for those transactions under which policyholder consent has not been provided. In that state, policyholders cannot lose any rights or claims under the original policies by the state guaranty associations. Therefore, unless and until guaranty association coverage can be ensured, transactions involving policies in states with anti-novation statutes will not be possible.

On the life and health side, as noted above, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for life and health guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

On the property and casualty side, amendments to the guaranty fund statutes likely will be necessary. A number of states—California, Illinois, and Oklahoma—have enacted statutory solutions to the property and casualty guaranty association issues similar to what NCIGF has suggested to the working group. In addition, NCIGF has provided proposed statutory language for other states to consider. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership and Insolvency Task Force for consideration. Specifically, the Working Group recommends that the language proposed by NCIGF be included in the NAIC Property and Casualty Insurance Guaranty Association Model Act. Regulators, guaranty funds and other appropriate industry stakeholders should work cooperatively to implement this statutory remedy with all deliberate speed.

⁴⁸ Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the property and casualty guaranty association issues to assure that consumers are not harmed by the transaction.

C. Proposals for Minimum Requirements

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

- (1) Requirement of court approval for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.
- (2) Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.
- (3) Requirement of a notice to stakeholders, a public hearing, a robust public and transparent regulatory process, and an opportunity to submit written comments are necessary for all stakeholders, including policyholders, reinsurers, and guaranty associations.

For most of the submitted which could prevent furtherance of the transactions included in this white paper.

None of the restructuring mechanisms are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes, while generally comparable to each other, are different and drafted by the legislatures of the respective states. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transaction. Other transactions, however, may not need all of these provisions.

While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Some stakeholders, however, believe that the expert should not be an employee of the department that is reviewing the proposed IBT or CD transaction and should be independent of the insurer or sponsor who is proposing the transaction. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies may have difficulty getting licensed in the various states either because of

“seasoning” issues or because a state may be hesitant to grant a license to a company that is not writing ongoing business.

There are two possible outcomes, neither of them desirable. Either the restructuring fails to go forward, even though it is in the public interest, or the resulting or transferee company operates without a license, creating gaps in guaranty association coverage and a lack of regulatory control over the company’s ongoing operations, which can open the door to actions that harm consumers. The Working Group, therefore, recommends that the appropriate working group (National Treatment and Coordination (E) Working Group) consider whether any changes should be made to the licensure process for companies resulting from restructuring transactions of runoff blocks. A streamlined process that still ensures appropriate regulatory oversight (and any licensure necessary to preserve guaranty association coverage) may be appropriate in limited circumstances. However, care needs to be taken to ensure that the licensing process is robust and rigorous enough for new entities emerging from a restructuring transaction so that the policyholders of the new entities retain a comparable level of regulatory and solvency protection as under the original entities.

E. Impact on Other NAIC Models & Other NAIC Groups

The Working Group has tentatively decided to pursue the development of changes to the NAIC Protected Cell Model Act (#290). Before doing so, it may be appropriate for the Statutory Accounting Principles (E) Working Group to first determine the appropriate accounting for an IBT or CD that utilizes a protected cell. In recent years, regulators have generally concluded that while protected cells or segregated accounts can provide a means of segregation from one policyholder or group of policyholders to another, the financial reporting and RBC should be calculated for each protected cell/segregated account, for the legal entity on a stand-alone basis, and for the legal entity on a consolidated basis. This should be confirmed and codified before the NAIC updates #290.

F. Extra Procedures for Long-Term Care Insurance IBT or CDs

As previously noted, increased scrutiny for any block transfers that are currently in projected deficit situations should occur, in particular long-term care insurance. However, to be more clear, the Working Group strongly discourages states from entertaining the use of an IBT or CD involving long-term care insurance, but if a state does consider, they should bring such a proposed transaction to all of the licensed states first and generally such transactions should only be utilized to the extent the NAIC develops a national solution for such transactions, which could occur in the future if such a national solution was proposed to a particular NAIC group that could document and develop such a solution.

ATTACHMENT 1 – 1997 NAIC White Paper

Liability-Based Restructuring White Paper

**Liability-Based Restructuring Working Group of the
NAIC Financial Condition (EX4) Subcommittee
June 1997**

**Adopted by Liability-Based Restructuring Working Group & EX4 in June 1997 Adopted by
Executive Committee in September 1997 Adopted by Plenary in December 1997**

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- I. SCOPE**

In general, restructurings can be effected through various forms and occur for different reasons: a parent company may divest itself of insurance operations by walling off and trying to sell certain operations, or making material changes to pooling arrangements in a way that, in effect, results in a corporate restructuring. Similarly, an insurance organization may spin-off some of its operations, possibly taking a private company public, may separate commercial and personal lines operations, or may create an off-shore entity to which problematic liabilities and/or assets are transferred due to favorable regulatory and tax

environments. The most common specific examples of restructuring during the past several years have been liability-based restructurings (LBRs) of insurance operations into discontinued and on-going operations, primarily because of material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities. Policyholders, insurers, regulators and guaranty funds have expressed concerns about these transactions. Descriptions of some recent restructurings are summarized in Appendix 1.

Conceptually, an LBR is an extraordinary transaction, or series of transactions, in which one or more affiliated insurance companies wholly or partially, isolate their existing insurance obligations from their on-going insurance operations. The notion of isolation is one of substantive change that creates a legal separation, such that policyholders and other creditors holding the isolated existing insurance obligations have limited or no financial recourse for their direct satisfaction against the on-going insurance operations. The concept of an LBR does not, in the absence of such isolation, include restructurings to achieve capital allocation or business-mix decisions, such as changes in pooling percentages, changes of the primary insurance writer or the separation of on-going insurance operations from other on-going insurance operations.

The purpose of this paper is to identify and discuss regulatory, legal and public policy issues surrounding such LBRs of multistate property/casualty companies and their affiliates. Single-state insurers and their affiliates may undertake similar LBRs and many of the issues contained herein may apply; individual states may choose to utilize this paper as a resource in those transactions. While restructurings of life and health companies are known to have occurred, such transactions may present different issues and considerations and therefore are excluded from discussion in this paper.

This paper is not intended to establish a position either for or against LBRs since each case must be evaluated on its own merits by the regulatory authority. Furthermore, this paper is not intended to address every insurance company merger, acquisition, divestiture, withdrawal from one or more lines of business or states, or other corporate transaction which impacts a company's obligation to its policyholders or its ability to meet those obligations. These are typically addressed under other applicable statutes or regulations.

II. BUSINESS REASONS

A. Rating Considerations

One of the major considerations in recent LBRs has been the insurer's desire to maintain or obtain favorable financial and other rating designations from the private rating agencies. Ratings play a major role in determining whether an insurer can remain competitive in its target market and may affect its ability to attract new capital. Insurers that have been subject to earnings drag due to the adverse development of APH or other liabilities may be faced with rating downgrades. By separating problem liabilities from on-going operations, the insurer may improve or maintain its rating. In turn, this may allow the insurer to more effectively take advantage of business opportunities, potentially achieve higher returns on its capital, and become more attractive to the financial markets.

B. Solvency Issues

Through an assessment of its APH or other liability exposures, an insurer may realize that recognition of probable ultimate liabilities in these areas will have a material impact on its financial condition. By separating these liabilities from the on-going operations, the insurer can dedicate surplus to support the restructured operations and eliminate the drag on earnings in its on-going operations and avoid further commitment of capital for pre-existing liabilities.

It should be recognized that an LBR, by itself, does not create resources from which claims can be paid. Accurately establishing adequate reserves to meet probable ultimate liabilities may eliminate the drag on earnings. If the establishment of such reserves materially weakens the insurer's financial condition, it is unlikely that it will be able to dedicate appropriate surplus to support both the restructured and on-going operations without additional capital. In these circumstances, if additional capital is not forthcoming, the regulatory authority should take appropriate action.

C. Other

Other reasons an insurer may consider restructuring include, but are not limited to, the need to raise capital or a desire to exit a line of business. In some cases, restructuring may be considered as a method to exit the insurance business or to camouflage financial and other problems.

III. ADVANTAGES AND DISADVANTAGES

LBRs may result in a more effective use of existing capital, a more competitive on-going insurance operation, more effective claims management, better management of ultimate liabilities related to problematic lines of business, and improvement of the availability and affordability of insurance coverage. In addition, an LBR may result in the attraction of additional capital and the enhancement of shareholder value.

On the other hand, underfunded LBRs may reduce the likelihood certain policyholder claims will be paid by the insurer. In addition, LBRs may be difficult to structure equitably due to the uncertainty associated with estimating APH liabilities, may pose questions related to policyholder participation and guaranty fund coverage in the event a restructured entity fails, and may have a negative impact on the public trust in the property and casualty insurance industry and the effectiveness of insurance regulation.

Each LBR will present certain advantages and disadvantages. An advantage to future policyholders (availability and affordability) may arise from a disadvantage to existing and prior policyholders (reduced likelihood of having their claims paid). The regulatory process requires that these advantages and disadvantages be assessed in light of applicable law and the impact upon policyholders. A pre-approval checklist is attached at Appendix 2.

IV. FINANCIAL SOLVENCY ISSUES

A. General Solvency Considerations

Regardless of the nature of an LBR, a key responsibility of the regulatory authority in assessing whether to approve the transaction will be to analyze financial solvency issues. The regulatory authority must determine whether the resulting structure will have sufficient assets, both as to

quality and duration, to meet policyholder and other creditor obligations. To make this determination, the regulatory authority will need to assess reserve adequacy, collectibility of reinsurance balances, and the value and liquidity of assets. Before formulating a conclusion based on these assessments, the regulatory authority should also consider the adequacy of capital and surplus levels and whether financial support is available from the parent company or other affiliates.

The restructuring insurer should provide the regulatory authority a detailed analysis of business and operational aspects of the LBR, including a detailed business plan, historical, current and pro-forma financial statements, and a description of the transaction's tax consequences. The financial information provided should include a balance sheet of the insurer as if the restructuring plan were approved, and schedules detailing assets and liabilities to be reallocated as a part of the restructuring plan. Any special charges or write-downs that will be made as a result of the LBR should also be specifically identified. The detailed business plan should also include a discussion of how the LBR will impact obligations to policyholders and other creditors. In addition, a statement should be provided describing the consequences if the LBR is not approved.

The regulatory authority should consider the engagement of experts to provide opinions about the impact on obligations to policyholders and other creditors, solvency, and the financial condition of the companies affected by the LBR, both immediately before and after restructuring.

B. Reserve Adequacy

Determining a reasonable estimate for liabilities will be a key part of the regulatory review process. Long-tail liabilities, especially those related to APH exposure, are most difficult to estimate. Although it is acknowledged that there is a high degree of uncertainty related to estimation of APH reserves, some regulatory authorities have concluded that sufficient information and actuarial methodologies exist to assess and estimate these exposures. The regulatory authority should consider taking the following actions to thoroughly review the adequacy of reserve estimates:

First, the regulatory authority should engage a qualified actuarial firm to: a) review methodologies used by the insurer to estimate reserves; b) review the insurer's economic approach to funding the run-off liabilities, including reserve discounting, if any; c) determine whether the claims unit is adequately staffed with qualified professionals and that its approach to settling claims is consistent with industry "best practices"; d) opine on the adequacy of reserves on a gross and net of reinsurance basis, by accident year and line of business; and e) review the funding of the discount and the adequacy of reserves net of the discount, if reserve discounting will be permitted. Second, if liabilities include material exposures to APH liabilities, consideration should be given to performing a "ground-up" review of reserves to estimate known and incurred but not reported (IBNR) reserves. This review should include the evaluation of all known liabilities on a case-by-case, policy-by-policy basis, including IBNR reserves.

Third, the regulatory authority should consider requiring the development of a cash flow model stress test to evaluate the adequacy of assets, including reinsurance, to fund the liabilities. The ultimate liabilities, payment patterns and cash flow assumptions should be included in the review. The stress test should consider varying loss payment patterns and investment yields.

C. Reinsurance

1. Collectibility of Reinsurance Balances

The success of an LBR may depend, in large part, on the LBR's effect upon existing reinsurance agreements and the collectibility of reinsurance balances stemming from those agreements. Depending on the materiality of these balances, the regulatory authority should consider requiring an independent analysis of reinsurance recoverables including: a) a review of the process used to monitor, collect, and settle outstanding reinsurance recoverables; b) an analysis of existing and projected reinsurance balances, including the expected timing of cash flows; c) an analysis of the quality and financial condition of the reinsurers and prospects for recovery; d) a detailed description of write-offs or required reserves based on the independent analysis taken as a whole; e) disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes; and f) a discussion of the impact of the LBR on the collectibility of the reinsurance balances. The regulatory authority may also consider requiring a legal analysis of the effect a liquidation or rehabilitation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and the legal rights of reinsurers to claim offsets against such recoveries.

2. Reinsurance Coverage

LBRs may include reinsurance stop loss or excess of loss coverage as an integral part of the transaction. These treaties are often complex and may require the regulatory authority to retain qualified experts to ensure that coverage is adequate, and that the treaty will perform as anticipated. The treaty may be analyzed to determine how it will operate, how the reinsurance premium will be calculated and how it will be paid, and whether the quality and financial condition of the reinsurer(s) is adequate. The regulatory authority should determine whether the amount of coverage provided by the treaty, in combination with other resources, is sufficient to meet the obligations of the restructured entity.

In addition to a stop loss or excess of loss treaty, the LBR may involve new or amended quota-share or pooling agreements within the group. The regulatory authority should review the agreements and supporting documentation to understand the movement of business and to determine the financial impact of the changes on the run-off and on-going companies. The regulatory authority should also consider reviewing existing reinsurance programs to determine that provisions are consistent with other information provided and that adequate coverage exists for on-going operations.

D. Liquidity and Value of Assets

Although proper estimation of liabilities is critical to the success of an LBR, equally as important is the assessment of whether existing assets and future cash flow are sufficient to fund the liabilities.

Much of the work related to determining whether there is a proper matching can be achieved through an appropriate stress testing process. The asset assumptions used in the stress test should be evaluated by the regulatory authority, especially if assets have high volatility, liquidity uncertainties, material valuation issues or lack diversification.

Consideration should be given to obtaining current appraisals for any material real estate or mortgage holdings; and obtaining independent investment expertise to value limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other asset for which the regulatory authority has concerns about the carrying value.

The regulatory authority should also consider reviewing assumptions as to investment yield and determine how the reallocation of assets might impact historical yields. This review will be the key determination of allowable discount rates and the spreads to be required between investment yield and reserve discount.

Should the asset analysis indicate there are problems related to asset matching, the regulatory authority may consider requiring: a) reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk; b) parental guarantee of investment yields; c) collateralized parental guarantee of asset valuation; and d) disposition of assets prior to transaction approval.

E. Capital and Surplus Adequacy

One of the most difficult aspects of reviewing an LBR is determining what level of capital and surplus is adequate. In general, standard provisions of the NAIC's Risk-Based Capital (RBC) For Insurers Model Act (the Model Act) should apply.

Unlike an on-going insurance company, run-off entities do not compete for new or renewal business. There may be other differences in the risk profile of run-off entities that could indicate the need for reassessment of the applicability of the Model Act in individual circumstances. The reserve, underwriting, and investment factors generating the majority of required RBC were developed to measure risks retained by a run-off entity. The Model Act makes specific provision for exempting a property and casualty insurer from actions to be taken at the Mandatory Control Level if that insurer is writing no business and is running off its existing business. Under such circumstances the insurer may be allowed to continue its run-off operations with the regulatory authority's oversight.

Other factors to consider in determining the adequacy of capital and surplus levels include volatility and uncertainty related to reserve estimates, the quality of assets, and the degree of parental and affiliated support.

F. Support From Parents and Other Affiliates

As discussed in previous sections, support from parents or affiliates may play an integral part in the LBR and may be a significant factor in whether the transaction is approved. The

regulatory authority should consider analyzing the change in organizational structure resulting from the LBR, placing special emphasis on the extent to which the resulting corporate structures have common ownership, overlapping management, substantial reinsurance arrangements, and on-going business ties. If the financial and marketing futures of the corporate structures are materially tied together, it may be less likely that any part of the organization will be abandoned.

If one of the resulting insurer structures is perceived to be weaker than another, the parent may show its intention of continued support through issuance of “cut-through” provisions for the benefit of policyholders of the “weaker” entity. These provisions give policyholders the legal right to file a claim against the entity issuing the cut-through should the insurer liable under the insurance contract (policy) be unable to meet its obligations. (Note: Some states have enacted laws prohibiting cut-through transactions.)

Stop loss and excess of loss reinsurance transactions have been discussed earlier in this report. The importance of these transactions, especially if with affiliated entities, should not be minimized. These transactions are often used to provide a cushion for the uncertainties related to asset and liability assumptions and can often be structured to strengthen the transaction. The regulatory authority should determine whether parental or affiliated support is available should the collectibility of reinsurance balances deteriorate.

The parent or affiliates should be encouraged to provide financial and managerial support to all entities. This support lends credibility to the LBR and provides an additional layer of security to policyholders.

V. LEGAL AND PUBLIC POLICY ISSUES

A. Applicable Laws

LBRs may implicate, directly or indirectly, a number of laws in the state of domicile including both general corporate statutes and insurance code provisions. A thorough review of all potentially applicable laws is necessary to fully understand the requirements and potential ramifications of an LBR. To the extent changes to an insurer’s corporate structure affect relationships with policyholders in other states, the laws of those jurisdictions may apply. Following is an overview of the principal laws that may need to be considered by the regulatory authority with regard to an LBR.

1. General Corporation Statutes

Corporate organization is governed by each state’s corporation law. Many states have enacted the Revised Model Business Corporation Act (RMBCA)¹ or a similar law. In most states, the corporation law applies to insurers, unless stated otherwise. The state insurance codes supplement the corporate law with additional or different requirements for insurers.²

The general corporation law addresses the existence and internal governance of the corporation. Corporation laws set forth minimum requirements and procedures to be adhered to in connection with extraordinary transactions affecting corporate existence and structure such as reorganizations, mergers, exchanges, divisions,³ disposal of assets and dissolutions. Such extraordinary transactions may require the approval of shareholders in addition to that of the board of directors.

a. Mergers and Consolidations

State law governs consolidation and mergers of insurers. The procedures and requirements regarding changes to the corporate structure of an insurer are usually the same as those for other corporate entities. Insurers may be subject to more regulatory scrutiny than general business corporations. A merger occurs when one corporation absorbs the other and the identity of the absorbed corporation disappears. In consolidation, the separate corporate entities disappear and a new corporate entity emerges.

Statutes governing consolidations or mergers, for the most part, require that notice be given to all stockholders or members. Mergers or consolidations of stock insurers do not require the approval of policyholders but do require approval by the regulatory authority. Mergers or consolidations of mutual insurers must be approved by both the policyholders and the regulatory authority.

b. Divisions

Division statutes have recently been enacted by two jurisdictions. These statutes permit the division of a single corporation into two or more resulting corporations. In a division, assets and liabilities are allocated among the resulting corporations. An LBR that includes a division may also include other transactions such as changes to a pooling agreement that may require regulatory review in other jurisdictions.

2. Insurance Code Provisions

a. Insurance Holding Company Act

¹ As of 1996, 22 states have enacted the current version of the RMBCA or substantially similar laws.

² Neb.Rev.Stat. § 44-301 (Reissue 1993) states in pertinent part: "...[T]he Nebraska Business Corporation Act except as otherwise provided... shall apply to all domestic incorporated insurance companies so far as the Act is applicable or pertinent to and not in conflict with other provisions of the law relating to such companies."

³ 15 Pa.Cons.Stat. §§ 1951-1960 (1995), effective in 1989; Tex.Bus.Corp.Act § 5.01 *et seq.* (Vernon Supp. 1990), effective in 1989.

⁴ The Insurance Holding Company System Regulatory Act (Holding Company Act) adopted by the NAIC is enacted in some form in 48 states.

Certain aspects of an LBR may be subject to the Holding Company Act even though the act does not explicitly address LBRs. An LBR may be subject to review by the

regulatory authority under the Holding Company Act if the insurer is a member of an insurance holding company system. For example, if an LBR results in a change of control⁴⁹ of a domestic insurer, the transaction must be pre-approved by the regulatory authority in accordance with certain stated criteria.⁵⁰

In addition, the Holding Company Act governs transactions between the domestic insurer and other members of the insurance holding company system even if there is no change in control.⁵¹ Some of these transactions trigger advance notification to the regulatory authority depending upon the nature and extent of the transaction. All of these transactions must be on terms that are fair and reasonable. An LBR will probably be subject to these requirements of the Holding Company Act if intercompany agreements such as management agreements, reinsurance agreements or tax allocation agreements are affected.

Finally, the Holding Company Act also governs dividends or distributions by a domestic insurer. For example, if an extraordinary dividend or distribution is part of an LBR, the prior approval of the regulatory authority may be required.⁸

b. Examination Law

All states have examination statutes that provide the authority and responsibility to conduct examinations of insurers to determine their financial condition and compliance with insurance laws and regulations. This authority includes targeted examinations triggered by a wide array of events such as deteriorating financial condition, risk-based capital results, financial analysis results, financial ratios and LBRs. Generally, a periodic examination of insurers is contemplated; however: the regulatory authority may also conduct an examination as often as deemed appropriate.⁵² The regulatory authority has the discretion within statutory confines to determine the scheduling, nature and scope of an examination. The regulatory authority is also granted examination powers under the Holding Company Act.⁵³

Generally, the regulatory authority may retain attorneys, appraisers, actuaries, certified public accountants, loss-reserve specialists, investment bankers or other professionals and specialists at the cost of the insurer being examined.¹¹ Given the extraordinary nature and complexity of LBRs, it is essential that the regulatory

⁴⁹ Control is presumed to exist with the power to vote 10% or more of the voting securities of an insurer.

⁵⁰ Regulatory jurisdiction under the NAIC Insurance Holding Company System Regulatory Act is of domestic insurers, but some states assert jurisdiction over non-domestic insurers on the basis of the insurer being “commercially domiciled” in that jurisdiction due to the volume of business. *See* CAL. INS. CODE § 1215.4 (1993).

⁵¹ The NAIC Insurance Holding Company System Regulatory Act at Section 5A. Similar authority as to insurers that are not a part of an insurance holding company system can be found in the Disclosure of Material Transactions Model Act adopted by the NAIC. ⁸ *Id.* at Section 5B.

⁵² The Model Law on Examinations adopted by the NAIC has been enacted in 41 states, see Section 3A.

⁵³ The NAIC Insurance Holding Company System Regulatory Act at Section 6A. ¹¹ The NAIC Model Law on Examination at Section 4D.

authority have the ability to contract for the services of all experts and specialists deemed necessary and to assess such costs to the insurer.

The examination statutes generally provide for the confidentiality of all workpapers, recorded information and documents obtained by, or disclosed to, the regulatory authority in the course of an examination and that these materials may not be made public, subject to some limited exceptions.⁵⁴ The examination authority under the Holding Company Act contains a similar provision regarding confidentiality of examination materials. These confidentiality provisions are necessary for the regulatory authority to conduct a thorough examination. The examination statutes provide the regulatory authority an important tool to evaluate LBRs, but the examination law prevents the regulatory authority from disclosing examination documents that might be of interest to policyholders. (See § 5(B)(4)).

c. Other Laws

Other insurance regulatory laws that may need to be considered regarding an LBR relate to the orderly withdrawal from insurance business in the state,⁵⁵ demutualization, or redomestication⁵⁶ of the insurer to another state. Issues regarding guaranty fund coverage and assumption reinsurance requirements deserve special consideration and are discussed in separate sections of this paper. Other insurance laws and regulations may need to be considered in connection with an LBR. Therefore, it is important to evaluate all the ramifications of an LBR and the component steps and transactions necessary to achieve the LBR. This may involve regulatory issues not identified in this paper.

B. Due Process

What do the concepts of due process and equal protection mean in the context of the review of an LBR by the regulatory authority? The requirements of due process and equal protection are triggered by action of the state through its authorized governmental agencies. The concept of due process includes both procedural and substantive aspects. Procedural due process concerns the right of interested parties to notice and the opportunity to be heard. Substantive due process requires that government action be based on legislation that is within the scope of legislative authority and reasonably related to the purpose of the legislation. Not every proposed LBR will affect private interests to the extent that the requirements of due process and equal protection will be applicable.

The regulatory authority should consider the persons whose interests are affected by a proposed LBR and who is entitled to notice and the opportunity to be heard. The regulatory authority should consider whether a public hearing concerning the LBR is required or should be held.⁵⁷ The regulatory authority should consider whether interested parties should be allowed to present

⁵⁴ *Id.* at Section 5F (Six of the 41 states that have enacted the Model Law have not adopted the section on confidentiality).

⁵⁵ See N.J. Stat. Ann. § 17:33 8-30 (1994).

⁵⁶ The Redomestication Model Bill adopted by the NAIC is enacted in 37 states.

⁵⁷ The United States Supreme Court has held that due process of law does not require a hearing in every case of government action. See 16A Am.Jur.2d 1054, citing *Boddie v. Connecticut*, 401 U.S. 371 (1971).

evidence, call witnesses and cross-examine the witnesses of other parties. The regulatory authority should consider whether policyholder consent is necessary.

The regulatory authority should consider the information that should be disclosed and to whom disclosure should be made. The regulatory authority should consider the persons that may be aggrieved by its decision. These questions may well have their answers in general (*i.e.*, noninsurance) administrative and state and federal constitutional law. If not, local law may govern policyholder relationships and rights. Finally, the regulatory authority should consider whether the action to be taken is reasonable under all the attendant circumstances.

C. Assumption Reinsurance

Corporate restructurings may be subject to the assumption reinsurance transactions statutes. The Assumption Reinsurance Model Act was drafted by state insurance regulators and adopted by the NAIC Dec. 5, 1993. The model act establishes notice and disclosure requirements intended to protect consumers' rights in an assumption reinsurance transaction. Under these statutes, insurers must seek prior approval from the regulatory authority for a transfer of business as well as notify all policyholders affected by the transfer. Policyholders must be informed that they have the right to reject the transfer.

An assumption reinsurance agreement is any contract that both transfers insurance obligations and is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations and/or risks under the contracts are extinguished. If the laws of the domiciliary states of both the transferring and assuming insurer contain provisions substantially similar to the model act, the assumption reinsurance transaction is subject to prior approval by both states' regulatory authorities. If no substantially similar requirements exist, the transaction is subject to the prior approval of the regulatory authorities of the states in which affected policyholders reside. Policyholders receive a notice of transfer by mail and may reject or accept the transfer. If the policyholder does not respond, the policyholder will be deemed to have given implied consent and the novation of the contract will be effected.

The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. In addition, a domiciliary regulatory authority has the necessary discretion to effect a transfer and novation if an insurer is in hazardous financial condition and the transfer of its insurance contracts would be in the best interests of the policyholders. These statutes may also come into play if an insurer transfers business through bulk reinsurance or a contract of bulk reinsurance. Bulk reinsurance or a contract of bulk reinsurance is an agreement whereby one insurer cedes by an assumption reinsurance agreement a certain percentage of its business to another insurer. The transaction must be filed with and approved by the regulatory authority of the insurer's state of domicile.

D. Policyholder Consent

When a new agreement replaces an existing agreement, a novation has occurred.⁵⁸ Because the Assumption Reinsurance Model Act specifically states that it is intended to provide for the regulation of assumption reinsurance transactions as novations of contracts,¹⁷ general rules of contract law apply to any disputes arising under the assumption reinsurance agreements.

Many courts have found that the type of implied consent required by the Assumption Reinsurance Model Act is legally sufficient. For example, in *State Dept. of Public Welfare v. Central Standard Life Ins. Co.*,¹⁸ the Supreme Court of Wisconsin found implied consent to an assumption agreement where the policyholder retained the original policy, was silent after receiving a certificate of assumption and subsequently paid 15 premiums to the assuming insurer.

Furthermore, in *Sawyer v. Sunset Mutual Life Insurance Co.*,¹⁹ the Supreme Court of California held that when an insured's beneficiaries sued the insurer that had assumed the insured's life insurance policy, "the bringing of suit is sufficient evidence of assent on the part of respondents to said agreement and undertaking."

However, other courts have required express consent by the policyholder to an assumption reinsurance transaction. For example, in *Security Benefit Life Ins. Co. v. Federal Deposit Insurance Corp.*,²⁰ the U.S. District Court for the District of Kansas found that where a series of assumption reinsurance agreements was executed, the agreements were not enforceable without proof that the policyholder or at least one of its successors in interest consented to the novation. Acquiescence to the transaction did not constitute policyholder consent to the assumption reinsurance transaction.

In *Travelers Indemnity Company v. Gillespie*,²¹ the Supreme Court of California stated that even when an insurer obtained reinsurance and assumption agreements pursuant to the state's withdrawal statute, policyholder consent to the transaction was still required.

In *Prucha v. Guarantee Reserve Life Ins. Co.*,²² the policyholder wrote to his insurer and said he did not consent to the transfer of his policy to another insurer through an assumption reinsurance agreement, but he paid premiums to the new company. The Court of Appeal of Florida, Third District, found that the policyholder's payment of premiums did not constitute implied consent to the novation because the policyholder had no opportunity to consent and his premium payments were merely an effort to protect his investment.

E. Rights of Other Interested Parties

What persons have an interest in a proposed LBR in addition to policyholders and insurance regulators in non-domiciliary states? Guaranty funds have an interest in the approval of LBRs because they may be called upon to step in and pay claims if the restructured entity is subsequently

⁵⁸ See, e.g., *Black's Law Dictionary* 1064 (6th ed. 1990) which defines "novation" as, in part: "A type of substituted contract that has the effect of adding a party, either as obligor or obligee, who was not a party to the original duty. Substitution of a new contract, debt, or

obligation for an existing one, between the same or different parties.... A novation substitutes a new party and discharges one of the original parties to a contract by agreement of all parties....”¹⁷ NAIC Assumption Reinsurance Model Act § 1 (1993).

¹⁸ *State Dept. of Public Welfare v. Central Standard Life Ins. Co.*, 120 N.W.2d 687 (Wis. 1963).

¹⁹ *Sawyer v. Sunset Mutual Life Insurance Co.*, 66 P.2d 641 (Cal. 1937).

²⁰ *Security Benefit Life Ins. Co. v. Federal Deposit Insurance Corp.*, 804 F.Supp. 217 (D.Kan. 1992).

²¹ *Travelers Indemnity Company v. Gillespie*, 785 P.2d 500 (Cal. 1990).

²² *Prucha v. Guarantee Reserve Life Ins. Co.*, 358 So.2d. 1155 (Fla. App. 1978).

found to be insolvent. Third parties having pending claims against an insured of the restructuring insurer may also be interested persons. Other interested persons, depending upon the circumstances in each case, may include reinsurers, ceding insurers, general creditors, shareholders, if the restructuring insurer is a stock company, and the public.

The regulatory authority should consider the type of notice to be given to interested persons. The regulatory authority should also consider whether certain persons should be afforded the opportunity to intervene in the proceedings concerning an LBR. Finally, the regulatory authority must consider the fiscal impact of giving notice to a large number of interested persons and the participation of those persons in the approval process.

F. Disclosure of Information

In an LBR the regulatory authority should consider the extent to which financial information about the insurer involved must be disclosed to interested persons or the public. Applicable state laws may require the regulatory authority to disclose certain information. However, most of the states have enacted laws that provide for maintaining the confidentiality of sensitive information acquired by the regulatory authority during an examination of an insurer or in the course of certain other regulatory activities. Use of the examination law to evaluate an LBR may prevent the regulatory authority from disclosing materials that the regulatory authority would prefer to release to interested persons or the public.

The regulatory authority should determine whether disclosure requirements or confidentiality provisions are applicable to the review of an LBR. In the absence of explicit statutory guidance, the regulatory authority should balance due process considerations and the public’s right to know with the need to protect sensitive or proprietary information.

G. Guaranty Fund Coverage

An important issue for the regulatory authority with regard to an LBR is the availability of guaranty fund coverage in the event of the insolvency of the restructured insurer. From the viewpoint of the insurance consumer, absent express consent, guaranty fund coverage should not be reduced or eliminated by an LBR.

1. Overview of Guaranty Fund System

Each state has a guaranty fund, created by statute, to provide a safety net for policyholders and third party liability claimants in the event of the insolvency of an insurer writing property and liability lines of insurance. Although the majority of state guaranty fund statutes are based upon the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act, there are variations from state to state that should be taken into account by the regulatory authority when reviewing a proposed LBR. First, the lines of business covered may differ. Also, the amount of coverage provided per claim varies. Although the Model Act and many state statutes provide for payment of covered claims of up to \$300,000, some state laws provide more or less coverage. Several states have enacted net worth provisions that exclude from coverage the claims of persons whose net worth exceeds a certain benchmark, the rationale being that such persons are sophisticated purchasers and can afford to absorb some loss.⁵⁹

Since each state guaranty fund is a separate entity, each fund makes its own determination with respect to coverage. Therefore, potentially, the guaranty funds in some states may determine that claims arising from the policies of the restructured insurer are covered, while other guaranty funds may reach a different conclusion.

Finally, although the regulatory authority reviewing an LBR should consider the potential availability of guaranty fund coverage as one of many factors in deciding whether to approve the LBR, it is important to note that the existence of guaranty fund coverage can only be conclusively determined if and when the insurer becomes insolvent.

2. The Availability of Guaranty Fund Coverage May Depend Upon the Form of Restructuring

Whether guaranty fund coverage is available to policyholders, claimants, and creditors of an insurer involved in an LBR may depend upon the form of the restructuring. The regulatory authority should determine the effect of an LBR on the availability of guaranty fund coverage in the event the restructured insurer subsequently becomes insolvent. Issues to be considered include:

- a.** Whether an unlicensed insurer is involved in the LBR;
- b.** Whether the restructured insurer that could become insolvent is the insurer that issued the policy;
- c.** Whether the restructured insurer that could become insolvent was the insurer at the time the insured event occurred;

⁵⁹ It might be questioned whether such exclusions are appropriate if policies are transferred to a restructured entity without the insured's consent.

- d. Whether the guaranty fund coverage in other states varies from the coverage available in the regulatory authority's jurisdiction.

3. Conclusion

Guaranty fund coverage and the provisions for triggering the guaranty fund vary by state. Regulators involved in the approval of an LBR should determine the effect of the LBR on the availability of guaranty fund coverage for policyholders in the event the restructured insurer subsequently becomes insolvent. If it is concluded that an LBR places the availability of guaranty fund coverage in serious question, the structure of the proposed transaction or questionable component should be modified before approval.

VI. ON-GOING REGULATORY OVERSIGHT

A. General

The responsibility of the regulatory authority does not end with the approval of an LBR. Subsequent to the completion of the transaction there will be one or more insurers with obligations to policyholders and other creditors. These insurers will continue to require regulatory oversight. Because of the existence of obligations to policyholders and other creditors, the insurance laws of the state of domicile should continue to apply to the restructured insurer. However, the LBR may also result in the need for additional regulatory oversight. As an LBR can take many forms, the exact nature of the oversight is dependent on the risks created by an individual restructuring. To the extent that these risks can be identified prior to the approval of the LBR, the regulatory authority should consider incorporating any additional regulatory requirements in the order approving the transaction.

This section assumes that the restructured insurer remains domiciled in the United States. If this is not the case, most of this section will not apply, as the regulatory authorities approving the transaction will no longer have jurisdiction over the restructured insurer. This should be considered prior to approving the LBR.

In the end, any LBR will be judged on the reorganized insurer's ability to meet its obligations to policyholders and other creditors. If approved, the regulatory authority has the responsibility to identify new risks created by the LBR, and institute appropriate regulatory safe-guards to help ensure that all obligations to policyholders and other creditors will be met. An outline of a program for on-going regulatory oversight is attached at Appendix 3.

B. Oversight

One of the primary areas of concern regarding a restructured insurer is the availability of sufficient resources to meet all of its obligations to policyholders and other creditors. Although the restructured insurer would still be subject to the domiciliary state's examination law, additional

oversight may be required to help mitigate additional risks created by the LBR. For instance, if a dedicated pool of assets is created to meet obligations to policyholders the regulatory authority should consider additional oversight measures designed to ensure the assets will be available to pay policyholder claims. See Appendix 3 for examples of conditions and requirements for on-going regulatory oversight of an LBR.

One of the factors that will be analyzed prior to approving an LBR is future corporate affiliations. In cases where there are continuing affiliations, the regulatory authority's oversight would most likely include monitoring compliance with agreements between the resulting insurers. For example, the regulatory authority should consider on-going evaluations of statutory compliance with any capital maintenance agreement, and review of management or administrative agreements or other inter-company agreements or transactions. In addition, the regulatory authority should review compliance with the requirements set forth in the order approving the LBR.

Where there is common management and/or ownership of on-going and run-off operations of a restructured insurer, the regulatory authority needs to be aware of any potential conflicts of interest between the two entities. This may lead to inappropriate influence by the on-going entity of the run-off entity's operations. For example, it might be in the interest of the on-going entity for the run-off entity to settle claims of current on-going entity customers on a preferential basis. This could have the effect of jeopardizing whether the run-off entity will have sufficient assets to settle other policyholders claims. A similar conflict exists if there is a block of policies whose obligations revert to the on-going entity upon the insolvency of the run-off entity. If such conflicts exist the regulatory authority should consider an examination of the claim settlement patterns of the run-off entity as part of its regular examination process.

If an LBR results in one or more insurers that have no on-going operations, the regulatory authority should consider requiring regulatory approval before the run-off entity can begin or resume ongoing operations. Prior to approving the reactivation of operations, the regulatory authority should consider the financial and operational resources available to the restructured insurer, and be able to determine that such a reactivation will not place existing policyholders at any additional risk.

The regulatory authority should evaluate residual market obligations before approval of an LBR. Consideration should be given to requiring that these types of obligations be assumed by the ongoing entity.

VII. CONCLUSIONS AND RECOMMENDATIONS

The Liability-Based Restructuring Working Group concludes and recommends as follows:

- LBRs present both advantages and disadvantages, and therefore, LBRs should not be prohibited per se, but each should be evaluated on its own merits by the regulatory authority.
- LBRs are extraordinary transactions that vary widely in form, method and circumstances, and therefore, a "one size fits all" stand alone model law approach is not recommended at this time. Insurance

regulatory authorities must have adequate statutory authority with sufficient flexibility and discretion to respond to the situation presented. The Working Group believes that existing regulatory authority is generally adequate, but recommends that the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, the Assumption Reinsurance Model Act, and the Insurance Holding Company System Regulatory Act be revisited to consider whether amendments may be appropriate in light of LBRs.⁶⁰

- An LBR should be subject to approval or disapproval by the domestic regulatory authority(ies) on the basis of a comprehensive and thorough review. The regulatory authority should have the ability to engage all experts necessary to assist in the review at the expense of the LBR applicant.
- The LBR applicant has the burden of justifying the LBR to the regulatory authority. The regulatory authority should not approve a proposed LBR if the transaction is likely to jeopardize the financial stability of the insurers, prejudice the interests of policyholders or be unfair or unreasonable to policyholders. An LBR is not an acceptable alternative to appropriate regulatory action, such as the rehabilitation or

liquidation of insurers in hazardous financial condition, unless the hazardous financial condition is corrected in association with the LBR.

- If the effect of the LBR is intended to extinguish an insurer's obligation to its policyholders, consent of the policyholders should be required. Such transactions result in a novation or have the same effect on policyholders as a novation and therefore should satisfy the procedural and legal requirements of a novation. States should consider adopting the Assumption Reinsurance Model Act or other legislation that will safeguard the interests of policyholders.⁶¹
- Public confidence in insurance and the integrity of the regulatory process requires that regulatory authorities strive to respond to LBRs as consistently as possible. Consideration should be given to developing a standardized regulatory review process through filing requirements, guidelines, protocols and best practices. The Pre-approval Checklist, Appendix 2, and On-going Regulation Oversight, Appendix 3, are examples of such regulatory guidelines.
- Interstate cooperation and communication are especially important. LBRs are likely to trigger the regulatory jurisdiction of more than one state and will be of interest to all states where affected policyholders reside. The domiciliary state of the parent or largest insurer involved in the LBR should coordinate activities among the states having jurisdiction over some aspect of the LBR, make basic

⁶⁰ More specifically: the working group recommends that; (1) the NAIC review its Post-Assessment Property and Liability Insurance Guaranty Association Model Act to consider whether the definitions of "covered claim" and "insolvent insurer" should be amended to make it clear that coverage continues when there has been a division; (2) that the Assumption Reinsurance Model Act be reviewed to consider whether to clarify that a division transaction is subject to all the requirements of that Act; and (3) that the Insurance Holding Company System Regulatory Act be reviewed to consider whether any of the filing requirements should be amended in order to more fully address LBR transactions.

⁶¹ Arizona recently enacted Title 20, chapter 4, article 1, section 20-736 which requires policyholder consent or approval by the Director of Insurance of transfer or assignment of an insurer's direct obligations under insurance contracts covering Arizona residents.

information available to nondomiciliary states and respond to specific inquiries from non-domiciliary states as necessary.

- Policyholders should have an opportunity for direct participation in the LBR approval process. At a minimum, this should include notice to policyholders of the proposed LBR with an explanation of the LBR and its effect on policyholders, meaningful access to information about the LBR, and a public hearing that affords policyholders an opportunity to be heard. Meaningful access to information necessarily requires that policyholders be given access to information that may be sensitive and proprietary. The competing interests of the policyholders and the insurer in this regard should be balanced with appropriate measures such as protective orders or confidentiality agreements to allow policyholders access to such information while protecting the insurer's interests, in accordance with applicable public information laws.
- The review of all financial aspects of a proposed LBR culminate in a determination of the adequacy of capital and surplus. It should be demonstrated that each insurer in the group will have adequate capital and surplus to support its own liabilities and plan of operation. The capital facilities at the holding company level also should be reviewed for adequacy should a member of the group require additional capital infusions, guarantees or other support measures.
- A key regulatory consideration in evaluating an LBR is whether there will be an on-going parental or affiliate involvement with the restructured insurer after the completion of the LBR. This involvement may take many forms, including, but not limited to, overlapping management, capital and surplus guarantees, reinsurance agreements, cut-through provisions and investment yield guarantees. The form and extent of the involvement or support will depend on the structure of the LBR and the entities involved.
- Material exposures to asbestos, pollution and health hazard claims (APH) have been the motivating factor in recent noteworthy LBRs. The Working Group recommends that the NAIC request that the

Casualty Actuarial (Technical) Task Force consider documenting and evaluating the analytical techniques in use to estimate such long-tail exposures.

- The major LBRs that have generated concern and raised issues are a fairly recent development. The nature of future LBRs and their frequency remains to be seen. The NAIC should consider monitoring the evolution of these transactions in order to determine whether additional regulatory responses are necessary.

APPENDIX 1

Case Studies

Cigna Corporation Property and Casualty Division

An intercompany reinsurance pooling arrangement existed between a substantial portion of the property and casualty insurance companies of Cigna Corporation. The lead company in the pool was the Insurance Company of North America (INA), a Pennsylvania-domiciled insurer.

For some years the pool's loss reserves experienced adverse development mainly from its 1986 and prior general liability policies which included APH and other long-tail liabilities. During 1994, A.M. Best downgraded the rating of the companies within the pool to B++. After a mini-restructuring in 1994 that created two separate intercompany reinsurance pooling arrangements, A.M. Best gave the pools two separate ratings, one being A- with developing implications, the other a B+ with negative implications.

To alleviate A.M. Best's and market concerns over the operations of Cigna, a second restructuring proposal was submitted to the Pennsylvania Insurance Department in October 1995. The restructuring plan called for the use of the Pennsylvania Business Corporation Law's division statute to divide INA into two companies. The two companies resulting from the division would be controlled by two separate holding companies. Simultaneously with the division, Cigna would amend its two pooling arrangements. The effect would be that the one resulting insurer, CCI (which would then be merged into Century Indemnity), would receive the 1986 and prior liabilities along with certain assets and be placed in run-off. The other resulting insurer, INA, would receive the remaining liabilities and assets, continue to write business and enter into a new intercompany reinsurance pooling arrangement with a substantial portion of the Cigna companies (active companies). As part of the restructuring, a capital infusion of \$500 million was contributed by Cigna Corporation to Century Indemnity. In addition, the active companies supported Century Indemnity through an \$800 million excess of loss reinsurance agreement and a \$50 million dividend retention fund.

The Pennsylvania Insurance Commissioner approved the division and changes to the intercompany reinsurance pooling arrangements. Seven other states, Texas, Ohio, Indiana, Illinois, California, New Jersey and Connecticut, approved changes in the intercompany reinsurance pooling arrangements and a change of control of certain insurers. The reorganization became effective on Dec. 31, 1995.

Restructuring of the Crum and Forster Group

Prior to the 1993 restructuring, the Crum and Forster Group, ultimately owned by Xerox Corporation, included 21 property and casualty insurance companies, five of which directly participated in an interaffiliate pool. The lead company of the pool was United States Fire, which, along with affiliates Westchester Fire and Constitution Reinsurance, was domiciled in New York. International Insurance Company was the sole Illinois domestic participant in the inter-affiliate pool. International Surplus Lines, an Illinois domestic, ceded 100% of its business to International Insurance Company, so it was an indirect participant in the pool.

Following a preliminary restructuring in 1990 which included exiting from the standard personal lines market and other market-related action to improve on-going operational results, Xerox announced plans to exit the financial services business. During the latter part of 1992, in preparation for the LBR, the group greatly strengthened loss reserves, after having suffered significant losses from Hurricanes Andrew and Iniki. Although the LBR was intended to enhance the salability of the insurance operations, an immediate goal was to realign the business into stand-alone company groups. Each group was to be dedicated to a particular purpose with greater management accountability and better focus.

The initial step of the LBR was to de-pool the group's operations. Seven separate operating groups were created: (1) Constitution Reinsurance – treaty and facultative reinsurance; (2) Coregis – professional liability, public entity and other property and casualty programs; (3) Crum & Forster Insurance – commercial property and casualty insurance through a select network of independent agents; (4) Industrial Indemnity – workers' compensation coverage and services; (5) The Resolution Group – reinsurance collection services and management of run-off businesses; (6) Viking – non-standard personal auto; and (7) Westchester Specialty Group – umbrella, excess casualty and specialty property business. To this end, various assumptive and indemnity reinsurance contracts were executed among the affiliates, and a stop loss contract was entered with Ridge Re, an affiliated reinsurer funded by the group's direct parent, Xerox Financial Services. Additional capital constituting \$235 million in cash and \$100 million in notes was contributed to the group.

The LBR received approval in the 15 states in which the 21 property and casualty insurance companies were domiciled. The primary states were New York, Illinois, California, and New Jersey. Initial discussions with the states began during the first part of 1993, and approval from all states was received by September 7 of that year. Regulators granted approvals to Form A exemptions, restatement of unassigned funds/quasi reorganization, various reinsurance agreements, the merger of International Surplus Lines into International Insurance Company, various service agreements, and assumption certificates.

ITT Corporation

In 1992, the Connecticut Insurance Department approved a series of transactions through which ITT Corporation restructured its insurance business into discontinued and on-going operations. Effective Sept. 30, 1992, First State Insurance Company (FSIC) redomesticated from Delaware to Connecticut. Ownership of FSIC and its Connecticut domiciled subsidiaries, New England Insurance Company and New England Reinsurance Company, collectively referred to as the First State Companies, was transferred from Hartford Fire Insurance Company (HFIC) to ITT Corporation through an extraordinary dividend. Since Connecticut was domicile to FSIC and its subsidiaries, no other state was required to approve the transaction. All approvals were made pursuant to Connecticut's holding company act and notification was made to all states requiring notice regarding the discontinuation of writing new and renewal business.

The Home Insurance Group

Prior to mid-1995, the Home Insurance Company and five of its seven property/casualty insurance subsidiaries operated under a pooling agreement for the writing of commercial business. Following several years of losses, the Home's upstream parents, Home Holdings, Inc. and Trygg Hansa AB, entered into an

agreement in principle in December 1994 with the Zurich Insurance Group to sell the Home Companies. The agreement virtually put the Home and its subsidiaries into run-off. The issues surrounding the acquisition and related transactions involved adequacy and funding of reserves, including asbestos and environmental, reinsurance, mergers and redomestications, and placement of renewal business. In addition, Home Holdings, Inc. had outstanding public shareholders and public bondholders.

New Hampshire, the domiciliary regulatory authority for the Home Insurance Company, coordinated a multistate review. Provisions of the modified agreement included a guaranteed investment rate of 7.5%, excess of loss reinsurance coverage of up to \$1.3 billion, deferral of servicing fees over cost, policyholder access to a Zurich company for new and renewal business, renewal fees paid by Zurich to fund interest on public debt, and the buyout of Home Holdings' publicly held capital stock. The states of New Hampshire, New York, New Jersey, Illinois, Indiana, California and Texas participated in approving all or part of the transaction, and all insurance subsidiaries except U.S. International Reinsurance Company were eventually merged into the Home Insurance Company in run-off. New Hampshire has maintained continual regulatory oversight since the transaction was approved in June 1995.

APPENDIX 2**Pre-Approval Checklist**

Following is a list of information and data that, if not included in the original filing, should be requested by the regulatory authority and considered in the review of an insurer's proposed LBR. This list should be used as general guidance and is not intended to be all inclusive. An LBR may be effected through various forms. The regulatory authority may find it necessary to request additional information, dependent upon the complexity of the proposal, the level of regulatory oversight warranted and other circumstances specific to the proposal or the insurer.

1. Narrative

A general written summary of the proposed LBR, explaining:

- a. Reasons for undertaking the LBR;
- b. All steps necessary to accomplish the LBR, including legal and regulatory requirements and the timetable for completing such requirements;
- c. The effect of the LBR on the insurer's financial condition;
- d. The effect of the LBR on the insurer's policyholders;
- e. The consequences if the LBR is not approved.

2. Business Plan

- a. On-going Operations
 - i. A listing of the insurer's major markets/products.
 - ii. A description of the insurer's strategy covering major markets/products and customers and the critical success factors for achieving these strategies.
 - iii. A description of the insurer's competitive positioning for each of its major markets/products and a discussion of growth potential, profit potential and trends for each.
 - iv. Identification and a discussion of the significant trends in the insurer's major markets/products, *e.g.*, demographic changes, alternative markets, distribution methods, *etc.*
 - v. Identification of the largest risk exposures of the insurer, *e.g.*, financial market volatility, environmental exposures, geographic distribution, *etc.*
 - vi. A description of the major business risks of the insurer, *e.g.*, sales practices, data integrity, service delivery, technology, customer satisfaction, *etc.*

b. Run-off Operations

- i. A description of all plans regarding any run-off operations.

3. Financial Information

- a. Historical financial statements, including the most recently filed annual and quarterly statutory statements.

- b. Financial statements (in a spreadsheet format) detailing the accounting of the proposed LBR including:

- i. Schedules detailing assets and liabilities to be reallocated as part of the LBR.
 ii. An accounting of any special charges, reevaluations, or write-downs to be made as part of the LBR.

- c. Pro-forma financial statements of the insurer(s) as if the LBR were approved including an explanation of the underlying assumptions.

- d. Financial projections for three years (assuming the LBR is approved) for both the run-off and on-going entities and an explanation of the assumptions upon which the projections are based.

- e. A description of any tax consequences of the LBR.

4. Analysis of Reserves

Retain qualified independent actuarial experts.

- a. The actuarial expert should perform a “ground-up” actuarial review of case and incurred but not reported reserves for asbestos, pollution, health hazard and other long-tail claims.

- b. The actuarial expert should also opine on:

- i. Methodologies used by the insurer to estimate reserves.
 ii. The adequacy of reserves on a gross and net of reinsurance basis. iii. The adequacy of the expertise of the insurer’s claims unit.
 iv. The insurer’s economic approach to funding the run-off liabilities, including cash flow model stress tests.
 v. If reserve discounting is permitted, funding of the discount and the adequacy of reserves net of discount.

5. Analysis of Reinsurance

- a. An analysis of reinsurance recoverables by a qualified expert including:
 - i. A review of the process used to monitor, collect and settle outstanding reinsurance recoverables.
 - ii. An analysis of existing and projected reinsurance balances including the expected timing of cash flows.
 - iii. An analysis of the quality and financial condition of the reinsurers and prospects for recovery.
 - iv. A detailed description of write-offs or required reserves based on the independent analysis taken as a whole.
 - v. Disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes.
 - vi. A discussion of the impact of the LBR on the collectibility of reinsurance balances.
- b. A legal analysis of the effect that a rehabilitation or liquidation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and on the legal rights of the reinsurers to claim setoffs against such recoveries.
- c. If reinsurance stop loss or excess of loss coverage is an integral part of the transaction, a copy of such agreement and a written opinion from a qualified expert as to:
 - i. The adequacy of coverage;
 - ii. The ability of the treaty to perform as anticipated and be unaffected by delinquency proceedings;
 - iii. The practical operation of the treaty;
 - iv. The timing and method of payment of reinsurance premium;
 - v. The financial condition of reinsurers;
 - vi. The sufficiency of coverage and other resources.
- d. A discussion of existing or proposed reinsurance programs, whether with affiliates or other reinsurers, to assist the regulatory authority in determining that provisions are consistent with other information provided and that adequate coverage exists for both on-going and run-off operations.
- e. Any proposed amended, cancelled, or new pooling agreements, including explanations of significant differences before and after the restructuring, flowcharts to demonstrate the proposed movement of business, and the anticipated financial impact upon the affected companies.

6. Analysis of Liabilities Other Than Reserves

An analysis of material liabilities other than reserves, including a discussion about any reallocations or dispositions as part of the LBR, especially as they relate to reinsurance agreements and inter-company cost and tax-sharing agreements. The analysis should include all non-reserve related accruals and outstanding debt line items found on the Property/Casualty Annual Statement (page 3) for liabilities, including writeins.

7. Analysis of Assets

An analysis should be performed to determine if existing assets and future cash flows are sufficient to fund liabilities. This analysis should include:

- a. Disclosure of assumptions regarding the assets of the insurer(s) involved in the LBR, especially those assets with high volatility, liquidity uncertainties, material valuation issues, or representing a material percentage of the invested asset portfolio.
- b. Current appraisals of any material real estate or mortgage holdings, independent valuation of limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other assets of concern.
- c. A list of assumptions used by the insurer(s) as to investment yield, and disclosure of the effect that the reallocation of assets will have on historical investment yields.
- d. If the asset analysis performed by the insurer indicates a potential asset/liability matching problem, documentation that the insurer plans to take action such as:
 - i. Reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk.
 - ii. Securing a parental guarantee of investment yield.
 - iii. Securing a parental guarantee of asset valuation or a parental agreement to substitute the insurer's assets.
 - iv. Disposing of assets prior to approval of the LBR.

8. Parental Support

- a. The plan should provide for the provision of financial and managerial support by the parent company to all entities.
- b. The plan should provide for a commitment of parental support to run-off operations in the event of:
 - i. Inadequacy of reserves; ii. Asset deterioration; iii. Deterioration in the collectibility of reinsurance recoverables.

9. Organizational Impact

- a. The plan should affirm that the restructured entity was either licensed or an approved surplus lines carrier in all jurisdictions in which it wrote business, and will be licensed in all jurisdictions where it takes on business as a result of the restructuring.

- b. Analysis of the change in organizational structure resulting from the transaction. Areas to emphasize include:
 - i. Ownership of the resulting corporate structures; ii. relation between management of the resulting entities; iii. Substantial reinsurance arrangements between resulting entities; iv. Other on-going business ties between the resulting entities.

10. Analysis of Issues Affecting Policyholders

- a. Consider whether to require that “cut-through” provisions be put in place for policyholders of the weaker entity.
- b. Obtain a legal opinion that policyholders of restructured entities will not lose guaranty fund coverage as a result of the LBR.
- c. Hold discussions with affected guaranty funds and National Conference of Insurance Guaranty Funds (NCIGF) regarding any coverage issues.
- d. Consider whether to require that a mechanism be put in place to obtain policyholder consent regarding any novations.

APPENDIX 3 ON-GOING REGULATORY OVERSIGHT

The following are examples of conditions and requirements for on-going regulatory oversight of an LBR.

- Reporting
- Require periodic operating reports.
- Require financial statements and management reports more frequently than required by statute.
- Require periodic reports on certain losses, including payments.
- Require financial projections annually.
- Require reports on actual results compared to plans.
- Balance Sheet Discipline
- Require recurring actuarial reviews of reserves. This requirement could include departmental approval of the actuarial firm selected and the scope of the review.
- Require periodic independent reviews of reinsurance recoverables.
- Establish guidelines for future investments of inactive operations.
- Limit discounting of reserves as allowed by law, so long as investment earnings continue to support the rate of discount.
- Specific Transactions
- Prohibit dividends by inactive operations without prior approval.
- Prohibit dividends by active operations for a set period of time.
- Require creation of a dividend “sinking fund,” with contributions from inactive operations requiring regulatory approval and payments to be made from the principal amount. The fund would be maintained in a separate account and could not be terminated without prior written approval from the regulatory authority.

- Require intercompany balances with the inactive operations be settled within 90 days of each quarter.
- Require prior approval of affiliated transactions between inactive and active operations.
- Require prior approval for inactive operations to establish security deposits with any

Attachment One

other jurisdictions except to the extent required by law.

- Communications
- Require notice to all known policyholders and claimants affected by the transaction.
- Require a written response to any inquiry regarding the LBR.
- General Monitoring
- Require on-site monitoring facilities.
- Require right to notice of and right to attend all Board of Directors meetings.

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Alternative Mechanisms for Troubled Companies

An NAIC White Paper

February 2010

Created by the

**NAIC Restructuring Mechanisms for Troubled Companies Subgroup of
the Financial Condition (E) Committee**

Drafting Note: This white paper is limited to situations where the legal entity is in a financially troubled condition that could potentially lead to an insolvency in the foreseeable future. It will not consider situations where the insurer is merely inconvenienced by a particular book of business.

Attachment Two

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I. INTRODUCTION

A. BACKGROUND/PURPOSE

State insurance regulators have well-developed receivership statutes, practices, and procedures to handle impaired and insolvent insurers. These statutes, practices, and procedures serve, first and foremost, the goal of consumer protection. They are a critical and essential part of the Regulatory Solvency Framework. However, given improvements in regard to the early detection of financially troubled insurers and insureds' requirements for A-rated coverage, a new landscape has emerged with a growing number of troubled insurers seeking to engage in mechanisms of run-off or restructuring as an alternative to being placed in traditional receivership proceedings. For example, as of mid-year 2008 alone, there were approximately 129 active insurers in voluntary run-off domiciled in the United States with over \$36 billion in claims in progress. As a result of a changing landscape and the fact that the NAIC has little formal documentation available to regulators dealing with alternative mechanisms for winding-down troubled companies, the Receivership and Insolvency (E) Task Force during 2007 began drafting charges to undertake a study of alternative mechanisms and relative best practices. These charges were presented to the Financial Condition (E) Committee during the 2007 NAIC Winter National Meeting. The Committee members supported the charges, but felt the topic of active troubled insurers required the expertise and perspective of regulators involved in the active solvency monitoring process, as well as receivership process. Thus, a Restructuring Mechanisms for Troubled Insurers Subgroup was formed directly under the Committee with regulators representing both perspectives. The Subgroup's 2008 adopted charges were as follows:

Undertake a study of alternative mechanisms, such as solvent schemes of arrangement, solvent run-offs, and Part VII portfolio transfers (a transfer leaving no recourse to original contractual obligor/insurer) and any other similar mechanisms to gain an understanding of:

- i. How these mechanisms are utilized and implemented.
- ii. The potential effect on claims of domestic companies, including the consideration of preferential treatment within current laws.
- iii. How alien insurers (including off-shore reinsurers) who have utilized these mechanisms might affect the solvency of domestic companies.
- iv. Best practices for state insurance departments to consider if utilizing similar mechanisms in the United States and/or interacting with aliens who have implemented these mechanisms.

The study is documented in the form of this NAIC white paper. Additionally, the study was limited to situations where the legal entity was in a financially troubled condition that could have potentially led to an insolvency in the foreseeable future. The Subgroup did not consider situations where the insurer was merely inconvenienced by a particular book of business or wished to exit the insurance business for reasons unrelated to solvency.

B. AUTHORITY & APPLICABILITY

The information in this white paper is meant to provide guidance to state insurance regulators and be an advisory resource. It discusses approaches and concepts that are available within and outside the United States in order to assist regulators with assessing possible alternatives for handling troubled insurers. Mechanisms discussed in this white paper may not be available or applicable in all

jurisdictions due to differences in statutes, regulations, and implementing tools and resources, as well as changing market conditions. In fact, statutes and regulations that define the authority and duties of regulators may require, or provide for, specific procedures to be implemented in certain circumstances. In addition, although this white paper was intended to generally apply to all risk assuming entities that are subject to the authority of the insurance department, the majority of the Subgroup's discussion was focused on property/casualty insurance companies. Due to their unique characteristics, the mechanisms mentioned in this white paper, may not be appropriate in the context of life, health, or other personal lines of insurance for which guaranty association protections are available, or for certain types of specialized risk-assuming entities (e.g., health maintenance organizations, syndicates, risk retention groups, chartered purchasing groups, chartered self-insured groups or pools, captives, insurance exchanges, etc.). Lastly, an appropriate mechanism for a particular troubled insurer will also depend on the specific circumstances of the situation.

C. OTHER CONSIDERATIONS

As state insurance regulators consider the relative advantages and disadvantages of these alternative mechanisms, they should do so in the context of the overall policy objectives behind each alternative. Different policy objectives will inevitably lead to very different results. The current system that utilizes liquidation and provides for guaranty fund protection for certain policyholder claims reflects a legislative policy that places the rights of policyholders and claimants above the interests of other creditors of the insolvent company. While these laws may vary somewhat from state to state, they share several key features. The interests of policyholders and claimants are granted priority over claims brought by other insurers, the government, and general creditors. The laws seek to preserve, to the greatest possible extent, the insurance protection that the policyholder believed he/she was getting when he/she purchased his/her policy from the now-insolvent insurer. The law treats all similarly situated claimants in the same manner, thereby prohibiting preferential treatment for certain favored individuals or entities. Finally, they preserve, in some meaningful form, the right of judicial review. These elements form the foundation of the existing system that exhibits a clear legislative choice to place the interests of consumers above the interests of investors and large institutions that are better equipped to withstand the losses resulting from insurer insolvency.

II. GENERAL ADVANTAGES AND DISADVANTAGES FOR UTILIZING ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

A. ADVANTAGES

- Alternative mechanisms can be useful tools for a troubled insurer's management and regulators, potentially leading to a quicker resolution than a traditional receivership.
- Alternative mechanisms typically allow for continuous claims payments, or at least orderly claims processing and partial claims payments without interruption.
- Alternative mechanisms can cost less than receiverships, thus resulting with maximum dollars paid out to policyholders/claimants.

- Alternative mechanisms may allow greater flexibility to achieve commercially acceptable results, such as freeing up capital.

B. DISADVANTAGES

- The inherent risk for consumer and claimant issues increases, requiring stronger regulatory monitoring and controls for protection. For some alternative mechanisms, there is no guarantee that appropriate fairness will take place.
- Alternative mechanisms for troubled insurers might become a tool for solvent carriers to transfer value away from policyholders.
- As to reinsurance, restructuring might affect the value of the future reinsurance claim or offset rights, arbitration rights, and reinsurance collateral.
- The cost of efficiency or company enticements may come at the expense of policyholders or insureds.
- Difficult decisions arise with a troubled insurer that is not clearly solvent or insolvent, and significant ramifications could follow with certain choices.
- Companies may seek to continue run-off or restructuring activities even after it becomes clear that the company is hopelessly insolvent, resulting in preferential payments made at the expense of outstanding claims.
- Compensation incentives may restrict future claims-paying ability.
- Voluntary restructuring schemes may deny policyholders and consumers the substantive and procedural safeguards otherwise available for their protection in court-supervised receivership proceedings.
- Run-off and restructuring schemes may be used to circumvent state priority and preference rules in order to discount claims at the expense of policyholders and other claimants. They may also be used to circumvent other consumer protection laws, including state receivership and guaranty association laws as well as commutation and assumption transfer laws.
- May allow the company to terminate coverage and extinguish liabilities over the objections of policyholders and other creditors by majority cram-down vote.
- Run-offs and restructuring schemes may result in substantially reduced payments to policyholders. State receivership laws typically require a showing that a rehabilitation plan is fair and equitable, complies with priority rules, and provides no less favorable treatment of claims than would occur in liquidation. Run-offs and alternative mechanisms, such as those addressed herein, may have the ability to sidestep these equitable standards and permit broad discretion in discounting claim values. In fact, the success of a plan may be dependent on the ability to impose deep discounts on claims, and there may be no rules or mandatory standards in place to protect policyholders or claimants.
- There is a risk that similarly situated creditors will be treated differently or that they will receive payments that are less than they would receive in an insolvency proceeding.
- Alternative mechanisms adopted in any given state may not be enforceable across state lines, leaving the company at risk of further exposure, litigation, and ongoing collection activity that may disrupt efforts to implement a restructuring plan.
- Alternative mechanisms are not appropriate for compromising the claims of consumer policyholders due to lack of sophistication and the existence of extensive consumer protections built into insolvency laws.

- In the absence of strong regulatory involvement, there is a risk that policyholders and creditors will not receive adequate or accurate information on which to base their decisions.
- The interests of management may not be the same as the interests of policyholders and creditors.

III. TYPES OF ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

MECHANISMS AVAILABLE TO INSURERS WITHIN THE UNITED STATES AND RELATED TERRITORIES

A. RUN-OFF OF TROUBLED INSURER

1. DESCRIPTION

A troubled company run-off is usually a voluntary course of action where the insurer ceases writing new business on all lines of business, but continues collecting premiums and paying claims as they come due on existing business. Due to state cancellation laws, the insurer may be required to renew business, which can be particularly challenging for insurers running-off personal lines risks. The insurer may seek to runoff business in the traditional sense—paying claims in full in the ordinary course of business—or management of the insurer might seek to end or limit their exposure on insurance business before policy terms expire by utilizing reinsurance, assumption transfers, negotiated settlements, and/or voluntary policy commutations. These transactions should not have a negative impact on policyholders, as close regulatory monitoring is normally maintained throughout the process. The goal is to completely close operations while remaining solvent.

In order to succeed in run-off, assets and income must be maintained at sufficient levels to cover the remaining claims and administrative costs of handling those claims. However, solvent run-offs may have little revenue other than investment income, and run-offs may develop into insolvencies that could require receivership proceedings—for example, if the insurer is unable to collect reinsurance, makes errors in estimating recoverable assets, experiences a decline in asset values and investment income, and/or encounters other cash flow issues at any point in the process.

Although run-off mechanisms can generally be applied to property/casualty, life, health, title, or fraternal insurers, it is of general consensus that personal lines should not be included in any commutation plan incorporated as a component of any run-off plan.

a. STATUTORY BASIS FOR SUPERVISED RUN-OFF PLANS

Run-off of a troubled company may be subject to regulatory supervision under applicable state law. (See, e.g., NAIC Risk-Based Capital (RBC) For Insurers Model Act, Section 6.B(2).) Regulatory supervision of a troubled company run-off may be triggered in order to enhance the regulatory oversight and monitoring of the financial performance, consumer protections, and market conduct related to implementation of the run-off plan. Enhanced regulatory oversight may include increased financial and regulatory reporting requirements, regulatory approval of transactions and claim settlement practices, and on-site regulatory supervision. Supervision of the run-off plan is conducted in order to ensure that policyholders, consumers, and other creditors fare no worse under the run-off plan than in receivership.

For example, the Illinois Insurance Code, based on the NAIC Model Act, provides the Illinois Director of Insurance with a discretionary alternative mechanism for handling troubled property and casualty companies and health organizations whose RBC Reports indicate a mandatory control level event. Section 35A-30(c) of the Illinois Insurance Code, 215 ILCS 5/35A-30(c), provides:

In the case of a mandatory control level event with respect to a property and casualty insurer, the Director shall take the actions necessary to place the insurer in receivership under Article XIII or, **in the case of an insurer that is writing no business and that is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Director.** (Emphasis added)

A mandatory control level event is defined under the statute as an RBC Report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC. Under this statutory mechanism, if there is a mandatory control level event at a company that has ceased writing new business and the company is engaged in a voluntary run-off, the Director has the discretion to either seek a receivership order or to allow the company to continue its run-off under the Director's supervision.⁶² In order to persuade the Director to exercise the supervised run-off option, the company must prepare and present a comprehensive run-off plan, including financial projections, that establishes that the plan is viable, that there is a high probability that the run-off can be conducted without putting policyholders at greater risk, and that all claim obligations will be satisfied.

The specific content of the run-off plan may vary depending upon the nature of the business being run-off and the financial circumstances of the troubled company. (See a sample outline for a run-off plan at VII. *Appendix C.*) However, the primary goals of the plan should include and achieve consumer protection, satisfaction of all policyholder obligations, and the maintenance of positive surplus and sufficient liquidity. Typically, the components of such a plan would include substantial cost-cutting measures, commutations of reinsurance agreements, collection of outstanding premium, recovery of statutory deposits, policy buy-backs, novations, and claim settlements.⁶³ A key element of such a plan would be a discussion of the benefits to the policyholders of a run-off rather than a receivership, including the impact of any state guaranty fund or guaranty association coverage.

The nature and scope of the Director's supervision may be delineated in a comprehensive corrective order, which would include and reference such things as the run-off plan, periodic reporting requirements, onsite monitoring, procedures relating to the approval of transactions, claim settlement practices, and other related matters. The corrective order, which may be amended from time to time, would likely be confidential under state law. Because the company is involved in a supervised run-off, it may be appropriate to negotiate certain adjustments (e.g., discount reserves, allow prepaid expenses, remove schedule F penalty) to its statutory financial statements, but, as adjusted, the financial statements should

⁶² Section 35A-30(d), 215 ILCS 5/35A-30(d), of the Illinois Insurance Code provides the Director with a similar supervised run-off option with respect to troubled health organizations.

⁶³ In 2005, the Illinois voidable preference statute was amended to provide that in the case of a company involved in a supervised run-off, a transaction involving transfer of cash or other assets by the company (buy-back, settlements, etc.) that was approved by the Director in writing cannot later be found to constitute a voidable transfer, 215 ILCS 5/204 (m)(C). This provision provides policyholders and other parties to buy-back, novation, commutation and other approved transactions with protection from the voidable preference statute in the event that the company ultimately goes into liquidation. In the absence of this protection, policyholders and others may be reluctant to enter into such transactions.

still comply with Generally Accepted Accounting Principles. Any such adjustments should be based upon credible forecasts and other available information.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Voluntary run-offs may enable commercial parties to achieve commercially acceptable results in arm's-length transactions that reflect customary market practice.
- Timely defense and payment of policyholder claims in full not otherwise always covered by guaranty funds or associations.
- Potentially more favorable environment for the negotiation of disengagement transactions and commutations with reinsurers.
- Continuity of management information systems.
- Some business entities may be willing to acquire insurance companies in run-off and inject additional capital or reduce overhead expense. This consolidation and management expertise could provide some efficiency for regulators in regard to their monitoring processes.
- Typically involve commutations and other solutions reflective of the consent of the contracting parties.
- There is evidence that it appears to be a robust method, given that there are accumulators of seasoned run-off companies.
- Strategic decisions can be made quickly and efficiently working with appropriate state regulators.

DISADVANTAGES

- Preferential treatment issues might arise when dealing with business-to-business structures, if both large and small policyholders exist, as deals tend to focus on settling with large carriers first. In addition, more complicated commutations may be structured in the run-off plan to be handled last.
- Preferential payments may arise with respect to creditors whose priority of payment in the event of liquidation would be classified below that of policyholder and consumer claims.
- Policyholders and consumers may be compelled to accept less than the fair value of their claims.
- Potential negative impact of adverse claim development.
- Attempts to commute or settle with policyholders (complete policy buy-backs) can result in reinsurers resisting payment.
- To the extent the estate assets are reduced by paying claims earlier, the estate assets remaining to pay remaining policyholder and guaranty association claims will be reduced, costing the industry more.
- Larger insureds may have better leverage to negotiate better settlements.
- Absent regulatory oversight—there is no guarantee that settlements will be at consistent or even fair levels.
- The absence of court oversight and mandatory rules and standards (such as priority rules and rehabilitation plan standards) increases the likelihood that policyholder claims will be sharply discounted and that bargained-for benefits and protections will be lost.

- Guaranty funds may be disadvantaged in a subsequent receivership if non-guaranteed creditors were paid more than the ultimate distribution from the receivership.

B. NEW YORK REGULATION 141

1. DESCRIPTION

In 1989, at the request of the New York Superintendent of Insurance, the New York Legislature enacted New York Insurance Law § 1321. Section 1321 authorized the Superintendent to permit an impaired or insolvent New York domestic insurer (or an impaired or insolvent United States branch of an alien insurer entered through New York) to commute reinsurance agreements to eliminate the company's impairment or insolvency.

Until the Legislature enacted NYIL § 1321, commutation agreements with troubled New York domestic insurers were subject to challenge as potential preferences pursuant to the Insurance Law's voidable transfer provisions. When the Legislature enacted Section 1321, it extended the voidable transfer period from four to 12 months (NYIL § 7425(a)). The Legislature also amended the insurance law to provide that commutation agreements executed pursuant to NYIL § 1321 "shall not be voidable as a preference" (NYIL §7425(d)).

Section 1321 required that any commutation proposed under the new statute be approved by the Superintendent "in accordance with standards prescribed by regulation." In 1990, the acting New York Superintendent promulgated Regulation 141 (Regulation No. 141, Commutation of Reinsurance Agreements, N.Y. Compo Codes R. & Regs. tit. 11, Section 128 (1989) (11 NYCRR Section 128)). Regulation 141 sets out the "applicable standards that the superintendent will use in determining whether such commutations entered ... will be approved."

Regulation 141 applies to all New York-domiciled insurers (and U.S. branches) "other than a life insurance company" as defined in NYIL § 107(a)(2). However, the regulation excludes impaired or insolvent life insurers and solvent insurers. The Regulation sets out how a troubled insurer may propose and implement a Regulation 141 plan. Among other things, the Regulation's procedures add the requirement that any company seeking the benefits of Regulation 141 must stipulate that the troubled insurer will consent to an order of rehabilitation or liquidation if its proposed commutation plan does not restore policyholder surplus to the required minimum amounts (or such surplus as the Superintendent deems adequate).

The troubled insurer must provide the New York Department with a draft commutation agreement and a proposed commutation offer that will be extended to "each and every ceding insurer to which the impaired or insolvent insurer has obligations." The reinsurer must also provide a balance sheet showing both the insurer's impairment or insolvency as determined by the Superintendent and a pro forma balance sheet reflecting the troubled company's financial condition subsequent to the plan's implementations.

The proposed commutation offer must include an offer to pay a percentage of the cedent's losses. The impaired insurer must advise its cedents that the commutation offer remains subject to the Superintendent's determination that the total of all accepted commutation offers has restored policyholder surplus either to a statutory minimum or an amount that the Superintendent deems adequate.

Regulation 141 requires that offers to commute assumed reinsurance obligations be made to “each and every ceding insurer to which the impaired insurer or insolvent insurer has obligations.” The Regulation broadly defines the term “obligations” to include paid losses, loss reserves, incurred but not reported (IBNR), all loss adjusting expenses (paid, case, and IBNR), reserves for unearned premiums, and “any other balances due under the reinsurance agreements.” The terms of all proposed commutation agreements must be the same.

For example, the same discount must be offered to each cedent—e.g., 90% of paid losses, 60% of case reserves, and 30% of IBNR. No cedent may be favored with different discounts. Discounts for different lines of business may be proposed, but these discounts must be “reasonable, actuarially sound, and supported by documents justifying such a variance.” To date, none of the Regulation 141 plans approved by New York Superintendents of Insurance has incorporated different discounts by line of business.

Any proposed Regulation 141 plan submitted to the Superintendent must include an exhibit setting forth the obligations due each cedent to which the troubled company has obligations and the consideration (commutation offer) to be paid each cedent. Within 10 days of the plan’s approval, the troubled company must deliver its proposed commutation agreements to its cedents. No cedent may be compelled to commute its “obligations.” The terms of the proposed commutations and the amount offered “shall not be subject to negotiation.” Each cedent makes its own determination with respect to whether the cedent wishes to accept the proposed commutation or refuse to commute and run the risk that the Regulation 141 plan will not succeed.

The results of an approved plan must be returned to the Superintendent within a period specified by the Superintendent. The plan results must include: copies of all executed commutation agreements; copies of all rejected commutation agreements; “correspondence pertaining to all ... offers made to the ceding insurers”; a pro forma balance sheet showing the effect of the accepted/rejected offers; any other components of the plan to restore surplus to policyholders; and copies of any agreements that modify, commute, or assign any retrocession agreements.

If the Superintendent determines that the proposed commutation agreements and any other plan components sufficiently restore policyholder surplus, the commutation agreements take effect. The Superintendent may specify, when he or she approves the Regulation 141 plan, that cedents that agree to commute be paid within so many business days.

If the Superintendent determines that surplus has been restored, the Superintendent may proceed against the troubled company armed with the company’s stipulation consenting to entry of any order of rehabilitation or liquidation.

The primary procedural safeguards for an approved Regulation 141 plan include: the state regulator’s full discretion to accept, reject, or modify any proposed plan; explicit requirements that the same commutation terms be offered to every ceding company whose obligations appear on the troubled company’s books and records; the absence of any “cram down” provisions that would allow the Superintendent to approve the commutation of a cedent’s contracts over a cedent’s objections; time- frames for the submission of a plan and payment of agreed commutation amounts within days after the plan’s results have been approved; and

provisions calling for the preservation and production of all communications between the troubled company and its cedents.

In addition, and as previously noted, the commutation agreements executed pursuant to an approved Regulation 141 plan will not take effect “unless ... the plan shall eliminate the insurer’s impairment or insolvency” and restore surplus to policyholders to levels required under the insurance law or an amount that the Superintendent deems “is adequate in relation to the insurer’s outstanding liabilities or financial needs.”

Although the troubled company’s directors must consent to an order of rehabilitation or liquidation if the company’s surplus has not been restored to the required minimum, the Superintendent need not consider any plan proposed pursuant to Regulation 141 “in lieu of taking any other action” against the company. This gives the Superintendent full discretion to decide whether to allow the troubled company to propose a plan or to take other action against the company, including supervision, rehabilitation, or liquidation.

Thus far, three professional reinsurers have successfully implemented New York Superintendent-approved commutation plans pursuant to Regulation 141: 1) Rochdale Insurance Company; 2) Paladin Reinsurance Company; and 3) Constellation Reinsurance Company. In addition, the Insurance Company of the State of New York (INSCORP) obtained the Superintendent’s approval for a Regulation 141 plan and submitted its commutation plan results to the Superintendent. However, as a result of the continued adverse development, INSCORP’s policyholder surplus could not be improved to an acceptable level, and INSCORP was placed in rehabilitation.

See VII. Appendix D – Reference List of NAIC Model Laws and State Selected Related Statutes for review of the Regulation.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- No cedent can be outvoted and compelled to accept a commutation offer.
- All communications to and from the ceding insurer must be preserved and provided to the regulator.
- Although the regulation was designed for professional reinsurers, the plan also works if the troubled insurer is engaged in assumed reinsurance and also wrote direct business.
- No court approval is required.
- The plan must show how the proposed commutations will affect its retrocessional program, thus reducing the risk that the commutation plan will bind or negatively affect retrocessionaires.
- The Superintendent has ultimate oversight, flexibility, and control, to the extent that the Superintendent may approve, disapprove, or modify a plan, and the Superintendent may also review all the communications exchanged relating to the offer to ensure that no unfair offsets were arranged or that offers to commute did not otherwise favor or disfavor particular cedents.
- Regulation 141 also allows for other components to be added to the plan to restore policyholder surplus, including surplus notes and capital contributions.

DISADVANTAGES

- As an offer under this regulation is based on the assuming reinsurer’s books at a given date, discrepancies between the ceding and assuming insurers’ books are likely to occur.

- Timing could become problematic if the regulator does not enforce strict deadlines regarding the consideration and execution of offers.
- Regulation 141 does not require an audited balance sheet to confirm the extent of the troubled insurer's financial condition.
- Many subjective considerations must be used by the troubled insurer to determine in advance what percentage of approval is needed for the plan to work.

C. RHODE ISLAND STATUTE AND REGULATION FOR VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS

1. DESCRIPTION

Rhode Island's Title 27, Chapter 14.5⁶⁴ provides for voluntary restructuring of solvent insurers. The statute was intended to provide an alternative to a traditional run-off by bringing "solvent schemes of arrangement" (which are discussed further in the next section) to the United States. It allows solvent companies that are in run-off to reach a court-ordered (and department of insurance supervised) agreement with all of its creditors in order to accelerate completion of the run-off, bringing certainty of payment to creditors and reducing administrative costs often associated with lengthy run-offs.

The statute sets forth a structure for court-ordered review, approval and implementation of what the statute refers to as a "commutation plan." The process may only be utilized by reinsurers and commercial property and casualty insurers domiciled in Rhode Island and in run-off (R.I. Gen. Laws § 27-14.5-1(6)). In addition, the insurer must be solvent and adequately reserved in accordance with all applicable Rhode Island statutes and regulations, as well as in compliance with all other department solvency standards.

A company considering the process must first prepare and submit their proposed commutation plan to the insurance department for review⁶⁵ (Insurance Regulation 68(4)(a)(i)). A commutation plan is very broadly defined as a plan for extinguishing the outstanding liabilities of a commercial run-off insurer. After the plan is reviewed by the department and all issues are resolved, the company may apply to the court for an order agreeing to classes of creditors and calling for a meeting of creditors (Insurance Regulation 68(4)(a)(iii)). At this point, the company is required to give notice of the application and proposed commutation plan to all parties pursuant to fairly broad requirements set forth in the statute (R.I. Gen. Laws §§ 27-14.5-3 and 27-14.5-4(b)(1)).

All creditors and interested parties (such as Guaranty Funds) are granted full access to the plan and all information related to the plan. Both creditors and interested parties are given an opportunity to file comments or objections to the plan with the court (R.I. Gen. Laws § 27-14.5-4(b)(3)). Ultimately, all creditors must be given an opportunity to vote on the commutation plan, and approval of the plan

⁶⁴ The Rhode Island statute was adopted in 2002 and amended in 2007. See R.I. Gen. Laws § 27-14.5-1 *et seq.*, "Voluntary Restructuring of Solvent Insurers," and R.I. Insurance Regulation 68 (Commutation Plan regulations).

⁶⁵ Plan approval is done by the court; however, the department has the statutory authority to intervene in any proceeding brought under this statute. According to the Rhode Island Division of Insurance Regulation, it is highly unlikely that the court would approve a plan over the Division's objection.

requires consent of at least i) 50% of each class of creditors, and ii) the holders of 75% in value of the liabilities owed to each class of creditors (R.I. Gen. Laws § 27-14.5-4(b)(4)). However, it is important to note that only the claims of creditors present or voting through proxy at the meeting of the creditors are counted toward determining whether the requisite majorities have been achieved. (See Insurance Regulation 684(e)(i).)

Upon approval of the commutation plan by the creditors, the company must petition the court to enter an order confirming the approval and allowing implementation of the plan (R.I. Gen. Laws § 27-14.5-4(c)(1)). The implementation order must enjoin all litigation in all jurisdictions between the applicant and creditors, as well as release the applicant of all obligations to its creditors upon payment

of the amounts specified in the plan (R.I. Gen. Laws § 27-14.5-4(c)(2)). The court may only issue an implementation order if it determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders (R.I. Gen. Laws § 27-14.5-(c)(1)(ii)). The court does have a responsibility to ensure that all policyholders and creditors have been treated fairly. Once the implementation order is entered, distribution to creditors may begin.

After implementation and upon completion of the commutation plan, the court can issue an order of discharge or dissolution. As a result of this order, the company is either i) dissolved or ii) discharged from the proceeding without any liabilities. At this point, any residual assets are distributed to the company owners (R.I. Gen. Laws § 27-14.5-4(d)).

One of the key aspects of the process is that the court's implementation order releases the insurer from all obligations to its creditors upon payment of the amounts specified in the commutation plan. This brings about a court-ordered finality to the run-off that would not be possible utilizing traditional run-off options. To this end, the order actually binds the insurer and all of its creditors and owners, whether or not a particular creditor or owner is affected by the plan or has accepted the plan, or whether or not the creditor or owner ultimately receives money under the plan. The order is also binding whether or not creditors had actual notice (R.I. Gen. Laws § 27-14.5-3(b)).

It is also important to note that because the restructuring mechanism provided for by the statute would not be appropriate or practical for companies with a large number of small creditors with very diverse interests, the statute is restricted to use by reinsurers and commercial property and casualty insurers. It includes express limitations on the lines of business that can be included in a commutation plan, and specifically excludes all life insurance, workers' compensation and personal lines (See R.I. Gen. Laws § 27-14.5-1(21)). However, in cases where a company does have excluded lines, the statute provides for a bifurcated process for disposing of all lines of business within the context of the runoff scheme. Commercial lines would be included in the commutation plan, and, if possible, excluded lines would be transferred to an eligible insurer through court-ordered and department-sanctioned assumption reinsurance (See R.I. Gen. Laws § 27-14.5-1(6) and R.I. Gen. Laws § 27-14.5-4(d)(2)(ii)). Again, the process is available only to solvent companies—the theory being that the restructuring would permit all liabilities to be paid in full.

The definition of “Commercial Run-off Insurer” under the statute was expanded by amendment in 2007 to include companies newly formed or re-activated under Rhode Island law solely for the

purpose of accepting transferred business for restructuring pursuant to the statute (See R.I. Gen. Laws § 27-14.5- 1(6)). The purpose of this amendment was to expand the population of insurers that might qualify for the process. The amendment permits an insurer to transfer some or all of its commercial liabilities (a very controversial process) to a newly formed run-off entity for the sole purpose of implementing a commutation plan pursuant to the statute. The original insurer would be allowed to continue writing business with no further obligations under the transferred policies. Any such transfer would require prior approval of the department.

Since the statute's enactment in 2002, no insurer has availed itself of the statute, and no other U.S. state has adopted a similar law.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Might provide a better solution for policyholders and investors than traditional run-off options (creditor democracy).
- Provides certainty of payment to creditors of present and future claims.
- Avoidance of a lengthy run-off with the associated ongoing administrative costs, adverse claim development and deteriorating reinsurance collections.
- Provides certainty of payment by reinsurers.
- Accelerated release of capital to shareholders at the conclusion of the process, allowing for more efficient deployment of capital to non-run-off operations.
- Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism for these companies will create an active market for investment in run-off companies.

DISADVANTAGES

- Permits an insurer to terminate coverage and extinguish liabilities over the objections of policyholders and creditors who are in the minority.
- Creditors are bound by the plan whether they had notice or not, and only those present or voting through proxy are counted toward establishing the requisite majority, which may create incentives to manipulate notice (though the department and court could take steps to prevent such manipulation).
- Although the process is limited to solvent insurers and the intent therefore is that full value will be paid to all creditors, there are no guarantees that all policyholders will receive full value, or even present value for their claims (especially those with IBNR claims).
- There is no reference to segregating and preserving reserve assets for excluded lines, or any explanation as to how policies and claims would be administered and paid during the interim period prior to completion of the plan.
- Questions concerning the enforceability of any such plan across state lines may leave companies exposed to further risk, litigation and disruption or termination of a plan—i.e., even if the Rhode Island court did approve the plan, it is possible that policyholder or claimant

actions could arise in other states' courts, (or perhaps federal courts), resulting in enforcement and implementation issues for the company attempting the restructuring.⁶⁶

- Although the Rhode Island plan is available only to commercial insurers and reinsurers in run-off, the plan is not exclusively limited to “troubled” companies; thus, any commercial run-off insurer could conceivably use this mechanism to cease operations and eliminate ongoing claims payment liability.
- Despite the fact that there is significant statutorily delineated regulatory guidance included in the Rhode Island framework (unlike UK solvent schemes), parties may view Rhode Island’s “commutation plan” statute as simply a domestic version of the UK’s solvent schemes and attribute all of the disadvantages associated with UK-like solvent schemes of arrangements (listed below in D-2) to the Rhode Island system.
- Because the Rhode Island statute allows for the formation or reactivation of a domestic company and the transfer of assets and liabilities to that company, certain parties view this as allowing a “ring-fence” of assets, unfairly shielding assets from creditors.

MECHANISMS AVAILABLE TO INSURERS OUTSIDE THE UNITED STATES AND RELATED TERRITORIES

D. UK-LIKE SOLVENT SCHEMES OF ARRANGEMENTS

1. DESCRIPTION

A scheme of arrangement is essentially a statutory compromise or arrangement between a company and its creditors. The process is allowed under Part 26 of the United Kingdom Companies Act 2006 that requires majority creditor approval representing at least 75% in value of obligations; confirmation by the UK Financial Service Authority (FSA) of no objections; and court sanction. If approved, the process will bind all creditors, but does not necessarily bind reinsurers. The process has evolved over the years and includes a process for insolvent and solvent insurers.

The FSA maintains a very active role in reviewing the schemes with a review document containing approximately 30 questions. In July 2007, the FSA issued a process guide related to decisions made with schemes that included the following:

- Stresses that the scheme must comply with principles for businesses (e.g., treating policyholders fairly and communicating in clear terms).
- Established an FSA schemes review committee.
- Stated that the run-off should be at least five years old.
- Distinguishes between individual retail and small commercial policyholders, large commercial policyholders and other risk carriers.
- Distinguishes between insolvent risk carrier, marginally solvent risk carrier and substantially solvent risk carrier.

⁶⁶ For a detailed discussion on the issue of enforceability, see David Wright, “A Question of Enforceability,” Run Off Business, Issue 12, Spring 2005, pp. 20-22.

- In case of substantially solvent risk carrier, the FSA is likely to object to a scheme unless the risk carrier offers benefits designed to ensure that policyholders are not in a worse position than in a solvent run-off.
- Provides for a role of policyholder advocate.
- The FSA may not object to a scheme, even if it fails to satisfy the criteria stipulated, if the risk carrier can demonstrate that the scheme treats policyholders fairly (e.g., through suitable additional benefits for policyholders and/or safeguards for dissenting procedures).

As of September 2008, there have been approximately 174 solvent schemes of UK non-life business. However, in every instance when policyholders have mounted serious opposition, the UK courts have ruled in the policyholders' favor. In particular, objecting policyholders have successfully challenged the British Aviation Insurance Co. Ltd. (BAIC), Willis Faber Underwriting Management (WFUM) and Scottish Lion solvent schemes in the UK courts. These are the only solvent schemes involving direct policyholder coverage that have been challenged to date, and all three have resulted in the court rulings favorable to the policyholders. To date, no UK court has agreed to sanction a solvent scheme involving direct coverage (as opposed to reinsurance) in the face of a policyholder legal challenge to the scheme.

Claims being paid can include IBNR, and most schemes have the ability to pay for IBNR based on estimation methodology. Additionally, schemes will allow a creditor's methodology to be used, if reasonable.

Chapter 15 of the U.S. Bankruptcy Code may be used to assist with a scheme of arrangement in the United States. The effect is to grant a U.S. bankruptcy court authority to enforce the scheme and protect the company's assets from creditors. However, although no UK solvent scheme has yet been challenged under Chapter 15 of the U.S. Bankruptcy Code, there is a possibility that such challenges may arise, and the U.S. bankruptcy courts could reject solvent schemes.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Some advocates state that solvent scheme mechanisms, in particular, have proven to be very effective in the UK and other jurisdictions to permit closure of companies that have reduced their liabilities to fairly minimal levels and that can reasonably estimate their future liabilities.
- Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism from these companies will create an active market for investment in runoff companies.
- Companies using UK schemes of arrangements have statistically improved their net asset position by approximately 5%.
- Some insurers have made payments to creditors at or near 100%.
- Schemes may allow a creditor's claim estimation methodology to be used, if reasonable.

DISADVANTAGES

- Schemes may undermine the value of insurance contracts by not honoring contractual obligations.

- Lost coverage may hurt policyholders at the expense of American citizens and the economy.
- Schemes could pose a formidable collective action problem.
- Schemes could undermine the reliability of insurance institutions.
- Schemes may allow for the reduction or cancellation of contractual obligations outside the scope of the current receivership system by not adhering to the statutory priority of distribution rules. Under such a scheme, a troubled company could force certain policyholders to commute (or buy- back) mutually agreed-upon insurance coverage despite their objections.
- The use of terms “debtor” and “creditor” used in the restructuring arena may tactically create a new environment for insurance where risk transfer is not necessarily part of the product purchased.
- Enforceability across state lines.
- Schemes could be used by companies to simply reorganize their corporate structure to move reinsurance operations unencumbered by old claims under a different name.
- In its latest proposal, the Reinsurance (E) Task Force had a provision where an insurer engaging in solvent schemes would not be allowed to take a reduction of collateral.
- Chapter 15 is a relatively new provision of the Bankruptcy Code with relatively little case law to support it, thus leaving the ability for judges’ discretion and leeway in its application.
- Schemes can involve reinsurers, where the reinsurance contract with an insurance company is negatively affected.
- Schemes could provide an opportunity for solvent insurers to avoid insurance and reinsurance obligations and return the risk to insureds of ceding companies who purchased the coverage in good faith.
- Schemes force creditors to trade insurance coverage for payments based on estimations of future claims that are inexact and possibly unfair.
- The individuals chosen to adjudicate claims under a scheme may lack expertise in the necessary legal issues.
- There is no oversight of solicitation by the company of scheme acceptances. Thus, some accepting creditors may have already achieved favorable settlements, while dissenting creditors are left to litigate their claims in an unfavorable forum.
- Schemes do not allow dissenting policyholders to opt out of the scheme.
- Schemes do not ensure continuation of coverage.
- Schemes do not include a safety net of guaranty association protection.
- Schemes do not allow a policyholder to seek judicial review of its claims against the insurer.

E. PART VII PORTFOLIO TRANSFERS

1. DESCRIPTION

Part VII of the Financial Services and Markets Act 2000 (FSMA) allows for a transfer of insurance business under a statutory and court process. The transfer allows a reinsurer to move all or certain of its reinsurance business (assets and liabilities) to another reinsurer without the consent of each and every policyholder but with the sanction of the UK High Court. The main statutory requirements are: 1)

policyholder notification; 2) a report by an independent expert; 3) UK High Court approval; and 4) no objection by the FSA or other regulators and interested parties, including policyholders.

The court is involved in the process with the directions hearing, which is when court will grant leave to proceed. The court is also involved in the hearing to sanction the transfer (or final hearing). The relevant legislation and requirements can be found in VII. Appendix D4.

The transferee must be an insurance company established in a European Economic Area (EEA) state. However, the transferor can be authorized in the UK, an EEA branch of a UK firm, a UK branch of an EEA firm, an EEA firm with no UK branch, or a non-EEA that is permitted to carry on business in the UK.

Per the FSA Web site, the following are reasons why reinsurance firms undertake Part VII transfers:

- Rationalization—combine similar business from two or more subsidiaries, putting all into a single regulated entity.
- Efficiency—transfer business between third parties, separating old liabilities in run-off from new business, putting each into separate firms.
- Capital reduction—transfer business to a new firm and extract any surplus shareholders' funds.
- Exit—transfer business such as employers' liability that cannot be schemed.

The legal effect of a Part VII transfer is a statutory unilateral novation of the affected contracts of insurance or reinsurance, including any rights attaching to those contracts.

The two primary aspects for the protection of affected parties are as follows: 1) the independent expert's report, which needs only to consider the effect on policyholders; and 2) the court is required to be satisfied that the transfer as a whole is fair as between the interests of different classes of persons affected by the transfer.

Per the FSA Web site, the FSA and the court are concerned whether a policyholder, employee, or other interested person or any group of them will be adversely affected by the scheme. This is primarily a matter of actuarial and regulatory judgment involving a comparison of the security and reasonable expectations of policyholders without the scheme with what would be the result if the scheme were implemented. The court will pay close attention to any views expressed by the FSA regarding whether individual policyholders or groups of policyholders may be adversely affected, though this does not necessarily mean that the transfer is to be rejected by the court.

The key question is whether the transfer as a whole is fair as between the interests of the different classes of persons affected. However, it is not the function of the court to produce what, in its view, is the best possible scheme. With regard to different transfers, the court may deem all fair, but it is the company's directors' choice to select the transfer to pursue. Under the same principle, the details of the scheme are not a matter for the court, provided that the scheme as a whole is found to be fair. Thus, the court will not amend the scheme, because individual provisions could be improved upon.

Overall, a loss portfolio transfer is a means of transferring outstanding net or gross legal liability from one insurer to another insurer. It has been viewed as a form of retrospective reinsurance. The transfers must be sanctioned by the court, and are subject to review and opinion by an independent expert that is approved by the FSA. Notice of the proposed transfer is usually required to be sent to all policyholders of the parties

unless the court decides otherwise. A detailed report must also be provided setting out all the details and the independent expert's opinion. The FSA and any party who feels adversely affected by the transfer can make representation to the court for consideration.

The FSA is also required to assess a number of aspects (e.g., whether policyholders will be worse off moving from one place to another, or if there is any potential risk posed by the transfer). Rating agency ratings or the effect on ratings could be a component as part of the FSA's considerations, as well as other regulatory bodies.

There have been over 100 Part 7 transfers, and the majority dealt with internal reorganization within holding groups. Over 50% were performed in the life industry. Very few Part 7 transfers have seen business go from a company to a third party; however, they are becoming increasingly popular. The receiving company's motives for entering into these arrangements may stem from tax advantages to potential profits based on one's claims handling experience.

COMPARISON OF PART 7 TRANSFERS WITH U.S. ALTERNATIVES (*BINGHAM TABLES*)

	Part 7 Transfers	Assumption Reinsurance Solvent	Assumption Reinsurance Insolvent	Rehabilitation Proceedings
Creditor Voting	No	Yes	No	No
Regulatory Review	Yes	Yes	Yes	Yes
Creditor Input	Low	High	Low	Medium
Transparency	Low	High	Low	Medium
Court Review	Yes	No	No	Yes
Hold-ups & Hold-outs	No	Yes	No	No

	Schemes of Arrangement	Run-off with Commutations	Rehabilitation Proceedings
Who Runs the Case	Management	Management	Regulator
Stay of Proceedings	Yes	No	Yes
Hold-ups and Hold-outs	Yes	Yes	No
Creditor Votes	Yes	Yes	No
Regulatory Involvement	Review	Ongoing Monitoring	Control
Claims Adjudication	Management Appointee	Variety of Courts	Receivership Court

The foregoing tables compare schemes of arrangement and Part 7 transfers with analogous mechanisms available under U.S. law. While it appears that the mechanisms are similar in many respects, in practice they have proven to be quite different. Under UK schemes of arrangement, policyholders have been forced to accept payouts based on estimations of their claims so that equity holders can recapture the capital of the company. Under UK Part 7 transfers, policyholders have been forced to accept the credit of another insurer in order to permit the insurer from whom they bought the policy to exit business and recapture its

capital. Current U.S. practice, with the possible exception of the Rhode Island statute, would not enable these results. Policyholders are only required to accept payment based on estimation in the U.S. where the company is insolvent and shareholders will not receive a return of their capital. Also, under current U.S. practice, policy transfers to a new insurer are not made involuntarily except where there is an insolvency of the transferor. While UK regimes certainly have safeguards in the form of voting (in the case of schemes) and court review (in the case of schemes and Part 7 transfers), the ultimate risk is left on the policyholder.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Permits more efficient management of transferred books of business, allows dedicated capital and focused solutions to be applied to run-off liabilities, and promotes efficient use of capital for ongoing business.
- Options can be explored to strengthen policyholder protections and reach regulator approval, such as altering deductibles, strengthening reserves, obtaining reinsurance, and other arrangements to share the risk.
- Might attract new capital to insurance businesses insofar as it can be invested directly in run-off liabilities, and strengthens ongoing companies by permitting the separation of those liabilities.
- Can reduce risk of exposure.
- A recent amended UK rule introduces a simpler alternative where no court sanction is required for pure reinsurance business transfers if all the policyholders affected by the transfer consent to the proposal.
- Substantial regulatory oversight is required.

DISADVANTAGES

- Could transfer obligations from the entity the creditor dealt with: to one that is completely unknown; to one with whom the creditor would have never willingly chosen to deal; from a differing country subject to different regulation; and to a less secure debtor.
- A Part VII-like transfer to an alien reinsurer from a U.S. domestic reinsurer may cause the primary insurer to lose its credit for reinsurance.
- Very difficult to quantify trapped capital in these scenarios.
- Problems could arise for a ceding company, if the Part VII transfer goes to a reinsurer with a lower rating, because the rating agency could lower the ceding company's rating.
- Could present unique accounting and reporting anomalies on both a statutory and GAAP basis.
- The regulator is not required to publicly explain its decision-making process.

IV. OBSERVATIONS AND CONSIDERATIONS BEFORE USING ALTERNATIVE MECHANISMS

A. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. STATE RECEIVERSHIP/GUARANTY FUND LAWS

Delinquency proceedings (receiverships) are instituted against an insurance company by an insurance department for the purpose of conserving, rehabilitating, or liquidating an insurance company. All require a court order, and the domiciliary state court will take jurisdiction over matters involving the resulting receivership estate. The court's role is to ensure transparency and due process and to be an independent arbiter of any disputes that may arise. The nature, timing, and extent of regulatory action in any given troubled insurer situation depend on the circumstances of the particular situation.

The U.S. Constitution in Article I, Section 10 states that "No state shall ... pass any ... law impairing the obligation of contracts." However, during certain delinquency proceedings, states may, on rare exceptions, impair contracts, but only where there is a legitimate public purpose behind the law.

It should be noted that the language in the rehabilitation statutes for most states is very broad and provides that anything that will restructure, revitalize, or reform the insurer can be proposed in a plan.

2. PRIORITY DISTRIBUTION STATUTES/PREFERENTIAL TREATMENT

One of the key consumer protections in the existing state delinquency proceedings are the priority distribution statutes that require payment of policyholder-level claims before the payment of any other claimants, including non-policy claims of the United States government, claims of other insurers and reinsurers, and general creditors. These same priority distribution statutes also require members of the same class or group of creditors to be treated similarly. The priority distribution statutes ensure that the needs of consumers, who might not be sophisticated in insurance matters, are placed ahead of non-policyholder level claimants and that everyone with the same level or type of claim is treated the same.

If assets are not sufficient to cover the remaining claims and administrative costs of an insurer using one of the alternative mechanisms, then all claims paid prior to that point have been given a preference at the expense of the claims to be paid in the future. As a result, the receiver could be statutorily required to attempt to recover these preferential payments.

B. CONSUMER PROTECTIONS AND PUBLIC POLICY CONSIDERATIONS

In order to ensure some baseline of protections for policyholders and consumers, there are certain core principles that regulators should strive to maintain with any alternative mechanism for troubled insurers. The first among these, a requirement that the company honor its contractual obligations to policyholders, is considered the primary and overriding principle. This first principle translates into no impairment of policy benefits and claims without the express, informed, voluntary consent of the policyholder. The others are corollary principles, all supporting that primary goal of honoring contractual obligations to policyholders. Any alternative mechanism for run-off or restructuring of a troubled insurance company's obligations should strive to establish parameters consistent with these principles.

Core Principles:

1. Honor Contractual Obligations to Policyholders. Alternative mechanisms should not be a way for an insurance company to sidestep its contractual obligations to policyholders. There should be no

involuntary restructuring of policies or impairment of policy benefits or claims permitted outside of receivership. This would preclude any changes to policies, or reductions to policy claims or benefits, without the express, informed, voluntary consent of individual policyholders. Accordingly, there should be no cram-down approval of a mechanism by majority vote over the objection of policyholders; no involuntary transfer of risk back to policyholders through forced commutation of claims or otherwise; and no cancellation, termination, or non-renewal of coverage, except as permitted under the express terms of the policy. In short, every policyholder should be entitled to continue coverage and to receive all policy benefits for the full term of their policy.

2. Meaningful Notice and Information Sharing. This contemplates accurate, consistent, and timely notice and disclosures to all policyholders, creditors, and guaranty associations of meaningful information (including financial information, status plans, and any proposed assumption reinsurance or other significant transactions) at inception and on an established schedule thereafter. Disclosures should also identify creditors (at least below the policy level) in order to permit some meaningful, organized discussion among creditors.
3. Adherence to Priority Scheme. Alternative mechanisms should require adherence to statutory liquidation priority schemes. They should not provide a mechanism for circumventing the distribution priority to benefit the company, its shareholders, employees, other stakeholders, or specific groups of policyholders at the expense of other classes of policyholders. Controls on preferences and the outflow of assets are needed, and will require regular ongoing review. The company and/or equity shareholders should not be permitted to retain assets unless all claims having priority, as measured under state liquidation laws, have been satisfied in full.
4. Coherent, Comprehensive Financial Planning. Any alternative mechanism should be based on a fully developed and comprehensive financial plan that includes complete and meaningful financial data, and projections based on reasonable and realistic financial assumptions. There should be full disclosure and transparency in financial planning, monitoring, and reporting as a condition to approval of any such plan and throughout implementation. In addition, any such mechanism should provide a global solution addressing all in-force policies and pending policy claims. There should be no ring-fencing or piecemeal disposition of assets and liabilities that may result in unequal treatment of policyholder claims, and give rise to preference and priority concerns. Moreover, the fairness and reasonableness of any mechanism cannot be reasonably assessed on a transaction-by-transaction basis without consideration of the overall impact on other policyholders and creditors.
5. Procedural Safeguards. Any alternative mechanism should provide substantive procedural safeguards, including clear standards for disclosure, reporting, and external review; appropriate and timely notice; access to information and the opportunity for informed participation for all stakeholders; court and/or regulatory approval for all significant actions to be taken; and meaningful compliance monitoring and reporting.

V. OBSERVATIONS AND CONSIDERATIONS WHEN USING ALTERNATIVE MECHANISMS

C. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. USE OF PERMITTED PRACTICES

There have been situations where an insurer would be able to maintain operations for 20 years, but to date, since liabilities barely exceed assets based on NAIC accounting practices and procedures, the insurer is nearly or technically insolvent. A carefully thought-out permitted practice could allow a troubled insurer time to dramatically restructure in order to provide better results for consumers in terms of timely claims payments.

2. MODIFICATIONS TO EXISTING STATUTORY AUTHORITY

In some circumstances, state insurance regulators may want to consider modifying laws and regulations to provide for a more favorable environment for certain alternative mechanisms. For example, the Illinois Division of Insurance strongly supported the General Assembly's adoption of 215 ILCS 5/204 in the Illinois Insurance Code's provision on Prohibited and Voidable Transfers and Liens to protect transfers made during the Division's supervision of a solvent run-off. The language reads as follows:

m) The Director as rehabilitator, liquidator, or conservator may not avoid a transfer under this Section to the extent that the transfer was: ***

(C) In the case of a transfer by a company where the Director has determined that an event described in Section 35A-25 [215 ILCS 5/35A-25] or 35A-30 [215 ILCS 5/35A- 30] has occurred, specifically approved by the Director in writing pursuant to this subsection, whether or not the company is in receivership under this Article. Upon approval by the Director, such a transfer cannot later be found to constitute a prohibited or voidable transfer based solely upon a deviation from the statutory payment priorities established by law for any subsequent receivership.

D. SURVEILLANCE MONITORING BY STATE INSURANCE REGULATOR

State insurance regulators need to consider whether the state has appropriate expertise on staff or whether the state needs to hire outside consultants of particular functions, such as claims assessment, reserves, reinsurance, etc. Please refer to the *Troubled Insurance Company Handbook* for a description of competency and skills of personnel assigned to conduct surveillance on troubled insurers.

1. SUPERVISION ORDERS/CONSENT AGREEMENTS/LETTER OF UNDERSTANDING

Regulators may want to consider various methods to articulate the regulator's expectations with an alternative mechanism, as well as the possible recourse that may occur with the insurer as a result of certain actions or behaviors. Such communication methods can be informal, such as a letter of understanding with the insurer, or formal, such as voluntary consent agreement or a confidential supervision order.

If a supervision order is taken under the commissioner's administrative provisions, the insurer's management will generally remain in place subject to restrictions in the supervision order and the direction of the supervisor. The supervision can be voluntary or involuntary and confidential or public. Confidential supervisions are becoming more infrequent, as disclosures of such regulatory actions have become more

necessary under federal law for insurers within publicly traded groups. Some states may require court approval, as well.

2. FINANCIAL REPORTING/ANALYSIS/EXAMINATION

All active insurers that are not in liquidation proceedings should be filing quarterly financial statements to the NAIC Financial Data Repository to provide regulators, policyholders, creditors, and claimants meaningful information. Enhanced monitoring, such as monthly financial statements and claims/exposure reports, should also be considered.

All states should conduct analysis and examination practices in compliance with Part B of the Financial Regulation Standards and Accreditation Program.

3. COMMUNICATIONS

As a result of utilizing various alternative mechanisms, regulators should attempt to coordinate the situation and supervisory plan with other affected insurance departments/jurisdictions, other regulatory agencies, and guaranty associations. Coordination may be useful to avoid actions that may be counterproductive. Interdepartmental and intradepartmental communication is also important to ensure that key departmental officials possess all relevant information to permit decisions to be made on a timely basis.

E. BENEFITS, RISKS AND CONTROLS: FOR U.S. CLAIMANTS/POLICYHOLDERS WHEN A NON-U.S. INSURER OR REINSURER RESTRUCTURES

1. INTRODUCTION

This section considers the impact upon U.S. policyholders and creditors of the restructuring of non-U.S. insurers and reinsurers. It will not consider the impact upon U.S. policyholders and creditors of the restructuring of the U.S. branch of a non-U.S. insurer, because that will be governed largely by familiar U.S. laws and procedures. However, it should be noted that the extent to which the U.S. branch may realize economic support from its non-U.S. parent and/or affiliates is likely to be governed primarily by the laws of the jurisdiction(s) in which the latter are domiciled.

What this section examines is the possible impact on U.S. policyholders and creditors of the restructuring of a non-U.S. insurer or reinsurer outside the U.S. The restructuring of a non-U.S. insurer or reinsurer may be governed simultaneously by the laws of several jurisdictions. For example, as Solvency II becomes the norm in the European Union, an insurer or reinsurer doing business in many member jurisdictions may be subject to their various laws to varying degrees. However, the jurisdiction in which the parent is domiciled (or the group supervisor, if different) may be particularly influential even over the fate of subsidiaries in other jurisdictions. The continued evolution of group supervision as an integral part of Solvency II is likely to enhance the influence of the parent's domicile. Less predictable will be the management of the restructuring of insurers doing business simultaneously in EU and non-EU jurisdictions. There remains a wide disparity in the core principles underlying insurance regulatory systems throughout the world—some

attributable to the pace of economic development, others to fundamental cultural differences, and still others to specific national public policies.

This section endeavors to identify the key considerations that should be evaluated from the perspective of U.S. policyholders and creditors when their non-U.S. insurer or reinsurer is restructured. It seeks also to provide a sampling of illustrations of how those considerations might evolve in specific circumstances. Pre-purchase evaluation of how these considerations are addressed in a particular jurisdiction may enable the astute policyholder to avoid purchasing coverage that is apparently reliable but for which there is little effective protection upon restructuring.

2. POTENTIAL ADVANTAGES AND RISKS OF RESTRUCTURING MECHANISMS

In many non-U.S. jurisdictions, mechanisms are available for the restructuring of insurers and reinsurers short of formal rehabilitation or liquidation proceedings. A distinction should be drawn between restructuring in the face of potential insolvency (the focus of this paper) and restructuring as a business strategy not in response to immediate solvency concerns. In the latter case, there is little justification for compromising policyholder interests, and regulatory schemes typically do not permit that result. It is in the face of a potential insolvency that restructuring can present a meaningful dilemma.

On the one hand, restructuring mechanisms can be advantageous when compared to rehabilitation or liquidation proceedings in three key respects:

- a. Such mechanisms typically offer at least a realistic prospect of a faster resolution of the underlying financial challenge.
- b. Often, these mechanisms are cheaper and therefore consume fewer scarce resources in the implementation of the process itself.
- c. Often these mechanisms serve to preserve coverage that might otherwise have to be terminated in the context of formal proceedings.

On the other hand, there can be some serious draw-backs in these alternative schemes. The next subsection considers key factors in more detail. However, the principal concerns that may arise in the context of these alternatives include:

- a. Reduced regulatory and judicial oversight resulting in diminished policyholder protection.
- b. Greater likelihood that policyholder interests will be compromised for the sake of other constituencies, such as owners, managers, and other creditors.
- c. The probability that policyholders will have less influence in the process and a diminished ability to protect themselves from potentially adverse outcomes.

3. KEY CONSIDERATIONS

In the U.S., state insurance regulators are accustomed to the fundamental principle that the interests of policyholders (used here as including insureds), especially consumers, should take precedence over those of unsecured non-policyholder creditors. This principle is not mandated in non-insurer bankruptcies in the U.S. and may not have the same importance in non-U.S. jurisdictions. It is helpful to identify the likely principal interests of policyholders (including insureds), as they may be affected in insurer restructuring.

In addition, this subsection will identify key considerations for reinsureds and creditors when a non-U.S. reinsurer restructures. The treatment of reinsureds is the primary consideration; however, a proper restructuring plan will keep tax authorities and other creditors informed as well. While the nature of the reinsured/reinsurer (sometimes referred to as cedent/assuming company) relationship invokes many of the same key considerations—because typically reinsureds are sophisticated business entities rather than individual consumers—slight differences may arise.

a. RIGHT OF PAYMENT

Not surprisingly, the principal interest of policyholders is likely to be assurance that claims (perhaps including those for return of unearned premium) will be paid promptly and in full. With the arguable exception of continuation of coverage, it is likely that policyholders' other interests (discussed below) are derivative of and ancillary to payment concerns.

The ability to obtain full payment of claims may turn on many factors, only some of which may be attributable to the nature of the proceeding. For example, the debtor's financial condition will always be a key consideration, regardless of the nature of the proceeding. The nature of the claim will also be an important consideration. For example, policyholders making claims based on IBNR must rely on actuarial estimates, which can vary widely. Such policyholders face a risk that any payment under a restructuring plan would be insufficient to meet future liabilities. This section does not address such considerations, which—however important—are unrelated to the nature of the proceeding or the regulatory or supervisory scheme under which it operates.

b. CONTINUATION OF COVERAGE

Under a variety of circumstances, it may be difficult for a policyholder to find acceptable coverage to replace that provided by the restructuring insurer. In the U.S., this interest is typically given more weight in the insurance rather than reinsurance context, and in the case of life accident and health insurance rather than in the context of property and casualty insurance.

c. CLAIM PRIORITIES

As noted, we are accustomed in the U.S. to the supremacy of policyholders over other unsecured creditors. This priority is critically important when available assets may not suffice to discharge fully all liabilities of the insurer. Of course, in insurer insolvencies, typically the category of general creditors includes most notably reinsureds. Thus, the interests of reinsureds and policyholders, treated as congruent in much of this section, may be very divergent in particular circumstances. Policyholder priority may not be observed as strictly, or at all, in other jurisdictions.

d. GUARANTY ASSOCIATION COVERAGE

Over the last four decades the U.S. insurance sector has implemented nearly universal guaranty fund mechanisms, providing at least basic protection for the insureds of most failed insurers. There are, of course, notable exceptions like HMOs, risk retention groups, surplus lines carriers and certain lines (separate account annuities, fiduciary bonds, etc.) in the main; however, this “safety net” serves to soften the impact of insurer failure and effectively provides a standard against which are measured the anticipated results of restructuring. Most non-U.S. jurisdictions have not implemented nearly as comprehensive an insolvency protection scheme. The guaranty association mechanism is typically not available to reinsureds in the U.S. or elsewhere.

e. RIGHT TO VOTE

Although largely foreign to U.S. insurer restructuring and insolvency proceedings, in other jurisdictions, policyholders may have a right to vote on the restructuring plan. Most often, however, that right exists when the plan does not require that policyholder contracts be fulfilled in their entirety. In such plans, policyholders whose claims consist of incurred but not reported losses may have different rights from policyholders who have unsettled paid claims or outstanding losses.

f. CRAM DOWN

In certain jurisdictions, it is possible for policyholders and reinsureds to be compelled to accept a restructuring plan that requires that they make economic concessions. The plan may require approval upon the votes of creditors, or it may simply require regulatory or court approval. This should be contrasted with U.S. laws, which typically do not permit restructuring plans in which policyholders’ interests are compromised for the benefit of non-policyholder creditors.

g. VOICE IN REPLACEMENT

The restructuring plan may entail coverages being transferred to other insurers or reinsurers with whom policyholders and reinsureds had no relationship. In some cases (including instances in the U.S.), policyholders and reinsureds may have little discretion in the transaction (except potentially non-payment of premium and forfeiture of coverage).

h. TRANSPARENCY

The ability of creditors, including policyholders or reinsureds, to obtain information about the proceeding, and the financial factors upon which key decisions will be based, varies considerably from jurisdiction to jurisdiction. Access to relevant information, however, is often the essential first step in policyholders’ ability to protect their interest in a restructuring.

i. ACCOUNTABILITY

The individual or entity responsible for managing the restructuring may be a private practitioner engaged by the restructuring entity’s management, a group of creditors, or a regulatory authority. Alternatively, the process may be placed in the hands of a public official. The degree to which the individual or entity in charge of the process is accountable to a superior or independent authority can be critically important

in ensuring the fairness and efficacy of the process. In those instances in which oversight consists principally of court supervision, the independence of the tribunal is important, as is the degree to which interested parties have access to that tribunal.

j. REGULATORY PROTECTION

In some jurisdictions (including the U.S.) statutory or common law (judicial decision) standards govern the manner in which an insurer may be restructured. They range from fundamental constitutional protections against the taking of property without due process to specific thresholds that must be satisfied before a Rehabilitation Plan can be approved. The availability of such protections and of viable enforcement mechanisms (such as an empowered administrative agency) are generally key to the prospect of a meaningful recovery or protection for policyholders and reinsureds.

k. ENFORCEMENT IN THE UNITED STATES

Non-U.S. restructuring plans have been enforced by the U.S. courts under Chapter 15 of the United States Bankruptcy Code. Chapter 15 governs cross-border insolvencies and is a framework whereby representatives in corporate restructuring procedures outside the U.S. can obtain access to U.S. courts. Chapter 15 permits a U.S. bankruptcy court to cooperate with a foreign procedure in which assets and affairs of the debtors are “subject to control or supervision by a foreign court, for the purpose of reorganization or liquidation.” Recent Bankruptcy Act amendments resulting in the current form of this provision were intended in part to bring U.S. law into greater harmony with the provisions adopted by the United Nations Commission on International Trade Law (UNCITRAL) and observed throughout much of the world. Applicability of these rules can be complex and often commences with a determination of which jurisdiction’s proceeding will control. The emerging trend is to defer to the jurisdiction in which lies the Center of Main Interest (COMI). However, it is important to note that the COMI may not necessarily be the domiciliary jurisdiction of the insolvent, and cases applying this principle sometimes reach puzzling results. While further discussion of these issues is beyond the scope of this section, the subject merits careful attention when applicable.

l. STANDING TO APPEAR

The ability to appear before the tribunal or agency conducting or overseeing the proceeding may be an important component of creditor protection. Of course, the fairness and impartiality of such a tribunal or agency are of critical importance. Moreover, the right to appear may be far less important when the individual managing or overseeing the process is charged principally or in material part with protection of policyholders and reinsureds and takes that responsibility seriously.

m. SET-OFFS, CLAIMS ACCELERATION AND ESTIMATION, PREFERENCES, AND VOIDABLE TRANSFERS

Insolvency proceedings can trigger a number of unique technical rules that are common in U.S. jurisdictions but may not receive the same treatment in other regimes. Among these are provisions that govern set-offs of claims and credits, acceleration and estimation of claims, when payments before commencement of a proceeding may be deemed to be reversible preferences, when such payments may constitute fraudulent or voidable transfers, and other such rules.

The issue of claims acceleration and estimation is illustrative of this difference in rules. Reinsurers have repeatedly expressed opposition to any system that could result in the accelerated and involuntary payment of their obligations based on any estimation of policyholder claims. Reinsurers oppose compelled payment of reinsurance recoverables based on IBNR on the basis that they are theoretical losses with theoretical values allocated in a theoretical fashion. Because reinsurance is a contract of indemnity, reinsurers assert that they cannot be required to pay losses, such as IBNR losses, which are unidentified or unknown.

While it is beyond the scope of this section to consider the details of each of these “technical” issues, it is important for the affected party to identify those that may be important in the particular case and determine how they are addressed in the specific proceeding. It should be noted that the application of these rules may not always be immediately evident. For example, if only part of a company’s business is subject to the restructuring plan, reinsurers may be concerned that they will lose existing set-off rights. This concern by reinsurers may affect the ability of reinsureds to receive full payment.

n. POLITICS

Finally, it should never be forgotten that “all politics are local.” In the U.S., the degree to which political considerations control an outcome is somewhat mitigated by cultural and legal constraints. These constraints, however, may not be as applicable in non-U.S. jurisdictions. Familiarity with the local environment is essential in order to avoid unpleasant surprises. And political considerations may not relate just to governmental entities—they may relate to the industry as well. For example, when the reinsured is also a reinsurer, it may be unwilling to help one of its potential competitors with a restructuring. The presence of existing disputes or investigations may also affect how a reinsured views a restructuring plan.

VI. CONCLUSION

Overall, although alternative mechanisms for troubled insurers can provide cost savings or greater efficiency over the current system, these mechanism can also pose unique risks for consumers and require specialized surveillance monitoring, practices, and procedures, particularly where the activities may occur outside of court-supervised receivership proceedings. In this context, regulators are encouraged to consider implementing standards and best practices responsive to these risks in order to preserve important consumer protections, increase transparency, and provide appropriate procedural safeguards.

First and foremost, it is the responsibility of regulators to protect insurance consumers. Thus, proponents of alternative mechanisms for troubled insurers should be pressed to prove to the regulator's satisfaction that the claims of greater efficiency or flexibility will not be used to strip policyholders and claimants of their policy rights so that value can be returned to investors. And regulators should ensure that all alternative mechanisms for troubled insurers place the interests of consumers ahead of other competing interests, coupled with a clear statement of goals and objectives and a meaningful oversight mechanism.

VII. APPENDIX

A. CASE STUDIES

This appendix describes troubled insurance company situations to illustrate some of the alternative concepts and techniques discussed earlier in this paper. The names of the insurers have intentionally been omitted. These case studies are not intended to reveal all problems or situations that may arise during the restructuring of a troubled reinsurance company. Additionally, the proposed actions with respect to the subject company may not be appropriate in all jurisdictions in light of changing market conditions and the possible differences in statutes, regulations, and implementing tools and resources.

1. RESTRUCTURED TROUBLED REINSURANCE COMPANY

Company characteristics, circumstances, and concerns:

- A property/casualty reinsurance company (treaty and individual risk basis).
- Primary reinsured lines included allied lines, commercial multiple peril, accident & health, workers' compensation, liability, and non-proportional reinsurance.
- Immediate parent and primary reinsurer of a direct property/casualty insurer.
- Non-U.S. ultimate parent.
- Parent refused to provide further financial support to its subsidiary.

BACKGROUND. Restructured Troubled Reinsurance Company (RTRC) was an established property/casualty reinsurer that appeared to be reporting significantly improving financials since two years earlier, accomplished through active re-underwriting and non-renewal of underperforming business. RTRC was a large reinsurer licensed or accredited in 27 states. Growth was moderate over the years, and the company remained adequately capitalized until significant adverse development constrained resources. Almost all property/casualty lines of reinsurance were written by RTRC with primary focus on workers' compensation, accident & health, liability, and proportional reinsurance. The group restructured through a series of transactions and separated its third-party assumed reinsurance business into an independent corporate structure. RTRC received a surplus note contribution from its ultimate parent that provided for semi-annual interest payments.

CAUSES OF TROUBLE. The Insurance Department had no information immediately on hand that would have raised a question regarding the solvency of RTRC. The financial statements reported much improved underwriting results, as well as ratios that were also continuing to show improvement. Approximately six months after the financial examination, but a few months prior to the restructuring, management met with the Department to discuss the rising amount of reinsurance recoverable related to its "Unicover" business. RTRC conducted a detailed internal review of its prior years' U.S. casualty business and found that significant reserve strengthening was necessary in its general liability and specialty liability lines, causing a substantial surplus strain and the triggering of the Department's hazardous financial condition regulation.

PRELIMINARY ACTIONS. The Department had several telephone conferences with RTRC management whereby the Department was informed that a capital contribution from RTRC's ultimate parent would be forthcoming as a result of the significant adverse development discussed above. Management then

contacted the Department for a meeting on the premise that the Chairman was in town and wanted a face-to-face meeting to discuss what was going on at the group. During that meeting, the Department was informed that RTRC and its direct subsidiary would be placed in run-off and neither would it receive a capital infusion as originally discussed. A firm was hired by RTRC's parent to assist in the development of a strategic plan for a solvent run-off.

CORRECTIVE ACTIONS. The Department sought to institute more rigorous financial monitoring. RTRC entered into a confidential letter agreement with the Department that required the Department's approval prior to, among other things, making any material changes to management; moving books and records; making any withdrawals from bank accounts outside the ordinary course of business; incurring any debt; writing or assuming any new business; or making dividend payments or other distributions. It also provided that the Department would receive a monthly report of commutation activity (which, as can be seen below, was the bedrock of the run-off plan); a copy of the final reserve analysis report prepared by an outside firm; and any additional reports the Department reasonably determined were necessary to monitor the financial condition. Finally, the agreement provided that senior management would meet with Department staff weekly, in person or by conference call.

RTRC hired outside actuaries to conduct an external audit. In addition to the reserve strengthening was a non-admission of its deferred tax asset.

A cash flow analysis was commissioned by the Department to conclude whether RTRC could, in fact, have a solvent run-off. RTRC developed a Business Plan/Run-off Plan, which combined commutations with expense cuts (staff and facilities reduction). Quarterly RBC filings were required. Employment levels were reduced commensurate with the Plan, and a retention plan was implemented to help retain talented, necessary staff and management. Surplus note interest payments were disapproved. The Department requested NAIC staff to set up a conference call for regulators to inform states of the situation and provide them time to ask questions or air concerns.

Ultimately, an RBC plan was approved by the Department. Subsequently, a revised Business Plan/Run-off Plan was filed and approved, and the agreement was extended for an additional year.

As commutations continued and improvements began to take hold, the company and its subsidiary were eventually sold. A new plan was developed, as—under new ownership with substantial resources—emphasis was no longer on an aggressive commutation strategy but was now on an aggressive asset management strategy. Monthly calls with management were temporarily put into place to ensure the Department would be aware of any changing circumstance. A less restrictive agreement was implemented as the Department was more comfortable with the possibility of a positive outcome. Ultimately, the subsidiary was again sold—another positive development for RTRC. The frequency of reserve reporting was reduced to an annual basis as long as there was no change in Chief Actuary, and RTRC was released from the agreement.

2. NEW YORK REGULATION 141 PLAN

Company characteristics, circumstances, and concerns:

- Professional property and casualty reinsurers and insurers that write such business and also assume reinsurance of property and casualty business.
- All property and casualty lines, but not life business.
- Member of a holding company group or stand-alone entity.
- Other members of the holding company would not or could not provide further financial help.

BACKGROUND. ABC Reinsurance Company (ABC) was a professional reinsurer incorporated in New York in 1977. ABC became capital-impaired and ceased underwriting in 1985. ABC's management sought approval to commute certain assumed contracts, but the New York Superintendent of Insurance maintained that these commutations would prefer certain creditors over others and that the Superintendent lacked statutory authority to approve such commutations under then-existing New York insurance laws.

CAUSES OF TROUBLE. The parent company refused to add capital. The Department, lacking the authority to authorize the commutations, moved to place ABC in rehabilitation pursuant to New York Insurance Law Article 74. In 1987, the Superintendent moved in Supreme Court, New York County, for an order of liquidation. ABC remained in liquidation until 1992.

During those five years, ABC's liquidator approved some cedents' claims, but paid none. In 1990, however, the New York Insurance Department introduced, and the legislature adopted, an amendment of NYIL 1321 to permit an impaired or insolvent New York insurer to commute reinsurance agreements and, with the Superintendent's approval, eliminate the risk that those agreements could be avoidable as a preference.

In May 1992, the Superintendent, in his role as ABC's liquidator, petitioned the court to approve a plan of reorganization based on a 100% quota share of ABC's portfolio of outstanding losses on all business that ABC wrote before its liquidation. XYZ Reinsurance Company of New York (XYZ) proposed the reorganization plan and provided the reinsurance cover.

After a July 1992 hearing, the court approved ABC's reorganization plan and entered a final order and judgment that terminated the liquidation proceeding. The XYZ quota share contained a \$305 million limit and an expansion of the quota share's limit that expanded based on a formula that included, among other things, paid losses, reinsurance recoveries, and interest income. ABC resumed operations with new directors and officers, but the plan also provided for a manager to administer ABC's run-off.

When the Superintendent petitioned the court in 1992 to approve the reorganization plan, ABC's projected liabilities were, as of December 31, 1990, \$295.3 million. By 1993, ABC and its quota share reinsurer had paid more than \$302.8 million to its ceding insurers. In 2002, ABC substantially increased its asbestos related IBNR reserves, as did much of the industry. As reported on its 2002 annual statement, ABC's capital became impaired by more than \$12.7 million.

PRELIMINARY ACTIONS. As a result of its 2002 impairment, and pursuant to New York Insurance Law § 1321 and Insurance Regulation 141 (11 NYCRR Part 128) (Regulation 141), ABC submitted to the New York Insurance Department a plan to eliminate capital impairment pursuant to Regulation 141. As required under Regulation 141, ABC's board and the company's sole shareholder stipulated that if ABC's implementation of the Regulation 141 Plan failed to restore ABC's surplus to policyholders to the

minimum required as determined in accordance with Regulation 141, ABC would not oppose a petition to again liquidate the company pursuant to New York Insurance Law Article 74.

Under Regulation 141, no commutation of ABC's assumed reinsurance could become effective, and no consideration for any such commutation agreement could be paid, until the Superintendent determined that a sufficient number of fully executed commutation agreements had been returned to restore ABC's surplus to the required minimum (11 NYCRR § 128.5). Regulation 141 also required that ABC provide the Superintendent with copies of all e-mail, correspondence, and other communications between ABC and its ceding insurers relating to the current Regulation 141 commutation offers, including any such communications rejecting the offer.

The proposed 141 Plan and Regulation 141 also required that ABC offer the same, non-negotiable commutation terms to all of its ceding companies. The 141 Plan further required that an offer to commute reinsurance agreements be made to every ceding insurer for which ABC had paid losses and LAE (Paid Losses) or known case losses and LAE (Case Reserves) on its books as of June 30, 2003.

Under its Regulation 141 Plan, ABC offered to pay 100% of Paid Losses and 60% of Case Reserves to commute obligations under the reinsurance agreements. Cedents were required to respond to this offer within 90 days.

CORRECTIVE ACTIONS. In January 2004, the Superintendent approved the 141 Plan and allowed ABC to extend commutation offers to its cedents. Shortly thereafter, ABC mailed commutation offers pursuant to the Plan to about 580 cedents. In October, ABC delivered to the Superintendent more than 300 executed commutation agreements along with copies of all correspondence with cedents relating to the Plan. The Superintendent subsequently determined that these commutation agreements would, upon his approval, eliminate ABC's impairment.

With the Superintendent's approval, ABC paid \$22,558,221 to those ceding insurers that accepted its Regulation 141 commutation offers. The post-Plan ABC balance sheet showed a positive surplus of \$3,675,366 and the elimination of its 2002 impairment.

The completed Regulation 141 Plan left ABC with many cedents. No cedents were compelled to accept the 141 commutation offers, and the Superintendent's approval of the Plan was premised on ABC's sufficient surplus to policyholders to complete its run-off. At the same time, Regulation 141 gave the Superintendent the statutory authority to permit commutation with a troubled company—avoid a protracted receivership—while also respecting every cedent's right to reject the proposed commutation offers and run the risk that ABC would lack sufficient capital to complete its run-off.

3. COMMERCIAL INSURANCE COMPANY RUN-OFF

Company characteristics, circumstances, and concerns:

- A property/casualty insurance company, writing primarily commercial lines on a national basis.
- Primary lines included commercial multiple peril, accident & health, workers' compensation, general liability.
- Member of a large multinational property/casualty insurance and reinsurance group with a non-U.S. ultimate parent.

- Parent sought to provide sufficient capital support to its subsidiary.

BACKGROUND. Restructured Troubled Insurance Company (RTIC) was an established property/casualty insurer pursuing a business model outsourcing most of its underwriting and claims functions to managing general agents (MGAs) and third-party administrators (TPAs), respectively. RTIC was licensed and operated in 50 states and wrote directly and through six subsidiary companies. The company had been operating for over 50 years and independent for approximately six years prior to being purchased by its current parent. Following the acquisition, RTIC pursued a modified business strategy for three years before being placed into run-off. RTIC wrote most lines of commercial liability insurance with primary focus on workers' compensation, accident & health, and general liability insurance.

CAUSES OF TROUBLE. Although the parent company installed new management and sought to reverse the business decline at RTIC following the acquisition, continued underwriting losses and adverse development from past years resulted in a ratings downgrade at the company. In addition, the California Insurance Department had been monitoring RTIC for some time due to the poor underwriting results and concern over the company's capitalization. The parent determined that the business model for the company was not appropriate for the then-current market and was not likely to result in a return to profitable business for the company. The parent also determined that the profitable lines of business RTIC was writing could be pursued through restructured and separately capitalized subsidiary companies, while the potential for continued adverse development in certain lines written by RTIC— particularly workers' compensation—would require substantial new capital for RTIC to regain its ratings. Accordingly, the parent determined to place RTIC into run-off.

PRELIMINARY ACTIONS. The parent developed a run-off plan that called for the capital and operational restructuring of RTIC. Representatives of the parent, RTIC, and the run-off manager met with the Department to present a detailed plan for RTIC in run-off. The plan included a restructured capital base intended to provide sufficient flexibility and liquidity for the run-off. A principal component of this restructuring was the merger of a subsidiary of the parent already in run-off into RTIC. This contributed company had been in solvent run-off for a number of years and held sufficient excess capital to support RTIC in run-off. The resulting merged entity was to be placed under the management team of the contributed company, a dedicated professional team with 10 years of experience in the operation of run-off companies.

Over the course of a three-month period, the Department and the company representatives met frequently to refine the run-off plan. The Department was receptive to a solvent run-off under the control of the parent, provided that the parent could demonstrate sufficient capitalization within RTIC, the establishment of certain financial standards for RTIC, and enhanced financial and operational reporting by the company. Upon approval by the Department of the run-off plan and the merger, RTIC was formally placed in run-off.

CORRECTIVE ACTIONS. The Department, the parent, and RTIC entered into an agreement that required RTIC to maintain a minimum RBC standard of 200%, a net-reserves-to-surplus ratio of no greater than 3-to-1, and a specified minimum surplus amount. The parent guaranteed that RTIC would meet these standards. RTIC also agreed to provide frequent and detailed reporting to the Department on the progress of the run-off.

Based upon the company's actuarial analysis and a separate review by the Department, RTIC strengthened reserves in certain lines. The run-off plan also included a restructuring of the capital of RTIC which, in addition to the merger, included the contribution of a three-year term note from the parent to insure liquidity and sufficient capital, and the transfer of the stock of certain affiliated companies from RTIC into a trust in favor of RTIC. Certain subsidiaries of RTIC were purchased by the parent to continue writing certain lines outside of the run-off. RTIC reduced staff, and certain operations were subsequently transferred directly to the run-off manager. A retention plan was created to help retain knowledgeable, talented staff and management for the run-off. RTIC met separately with the domestic regulators of its subsidiary insurance companies to inform them of the plan and obtain their approval where necessary. RTIC and the Department also coordinated with NAIC staff to inform all interested states of the situation at an NAIC regulator meeting and to provide regulators with the opportunity to ask questions or air concerns.

With the Department's agreement, RTIC began to terminate its MGA and most of its TPA agreements and assumed direct control of most of its claims. The company then began to aggressively settle claims, reduce its overall exposures, and commute certain reinsurance contracts where protection was uncertain or disputed. The investment manager restructured RTIC's investment portfolio to better address the anticipated cash flow and capital requirements of the run-off.

PROGRESS OF THE RUN-OFF. The Department's cooperation with management and establishment of clear operating guidelines, the capital support at RTIC provided by the parent, and singular focus of management on the satisfaction of RTIC's obligations and responsible management of the company's assets have resulted in a stable and successful run-off. Five years into the run-off, RTIC had reduced open claims by approximately 85%, reduced reserves by approximately 40%, and increased surplus by over 70%. The stabilization of RTIC, its successful execution of the run-off plan, and gains in its investment portfolio have resulted in the Department's agreement to terminate the trust arrangements created for the affiliated company investments, deferral, and subsequent forgiveness of the third installment of the parent note and the return of excess capital from RTIC to the parent. RTIC continues to adhere to the established financial standards, maintaining a comfortable margin over the minimum requirements established by the Department. RTIC management and the Department continue to meet approximately quarterly to review the progress of the run-off.

4. RESTRUCTURED TROUBLED LONG-TERM CARE COMPANY

Company characteristics, circumstances, and concerns:

- A stock life, accident and health company.
- Part of a large national life and A&H group.
- Primary line of business is a closed block of predominately long-term care in force.
- Ceased writing new business five years prior to restructuring.
- Received large capital contributions from parent for many years.
- Continuous premium rate increase requests.
- Adverse claim development and reserve strengthening.
- Low RBC ratio.

BACKGROUND. Restructured Troubled Long-Term Care Company was a writer of predominately long-term care business, operating in most of the 46 states, D.C., and the U.S. Virgin Islands. It had held a firm

niche position in the long-term care market with profitable operations and a conservative balance sheet. The long-term care block of business was written by the Company and its predecessor companies prior to being acquired by the Company in the 1990s.

CAUSES OF TROUBLE. Shortly after the acquisition of long-term care blocks in the 1990s, the Company reported a reserve deficiency. The Company phased in a new reserve valuation basis for long-term care policies, requested and implemented premium rate increases, and implemented tighter underwriting standards. The cause of trouble was under-pricing and under-reserving that became evident as the company experienced claim costs and utilization that exceeded expectations. The original pricing assumptions on long-term care assumed a 4% to 5% lapse rate, while the actual lapse rate was only 1% to 2%. Additionally, the Company's investment return assumptions were much higher than actual returns.

Over the course of more than a dozen years, the Company received capital contributions to offset losses. The Company reported an increasingly larger reserve deficiency each year from 1998 to 2007, several years in excess of \$100 million deficient. The Company reported net losses in each year from 1997 to 2007.

PRELIMINARY ACTIONS. In 2003, Company management decided to stop marketing insurance products and to place the Company in run-off. The insurance department began monitoring the Company monthly and meeting with Company management on a quarterly basis as a result of continued poor operating performance, reserve deficiencies, and multi-year rate increase requests. A study was conducted of the Company's incurred claims experience. As a result, the Company updated the claim cost assumptions underlying the contract reserves and unearned premium reserves for the long-term care policies. The change was made using the "pivot" method, such that the change in claim costs would be accrued into the reserve balance over time. Multiple premium rate increases were sought. Over the course of 15 years, the Company received over \$900 million in capital contributions from the parent. The parent company indicated that no future capital contributions would be forthcoming.

The Company also came under scrutiny for market conduct issues, including claims administration and complaint handling practices. The Company underwent a market conduct examination to get a further understanding of the market conduct problems within the Company and, as a result, a settlement agreement was reached, recommendations for corrective measures were made, and an improvement plan was developed. The settlement included a monetary penalty for violations; a contingent penalty for non-compliance with improvements, including systems upgrades and improved claims administration; and restitution and remediation regarding the reevaluation of denied claims.

CORRECTIVE ACTIONS. With the approval of the insurance department, the Company's parent transferred the stock of the Company to a non-profit independent trust. In connection with the transfer, the parent contributed additional capital to the Company to fund future operating expenses. The capital was in the form of senior notes payable, invested assets, cash, and the forgiveness of unpaid dividends. The trust is intended to operate the Company for the exclusive benefit of the long-term care policyholders, without a profit motive. It is governed by a board of trustees under the oversight of the insurance department, as outlined in the Form A Acquisition Order.

5. LIABILITY OF INSURERS TRANSFERRED TO THIRD PARTY – EUROPE

BACKGROUND. The European market is a provider of insurance and reinsurance to insureds and cedents worldwide.

Events that took place in Europe during the 1990s provide an example of an extreme case of a market coming to the brink of collapse, only to be saved by a series of transactions that were simple in concept but, of necessity, very complex in their implementation. Those transactions amounted to what has become a famous event in the history of insurance. Most recently the final transaction took place, which had the effect of removing the outstanding liabilities of the re/insurers in question.

CAUSES OF TROUBLE. In the early 1990s there was an unexpected, huge increase in long-tail liability claims (typically asbestos, pollution and health hazard) made against certain European market insurers. Many of these insurers faced collapse, as the liabilities swamping the market and the difficulty in estimating the IBNR and calculating an appropriate reinsurance premium were so great. The effect was that several troubled European insurers were without protection and remained exposed to the incoming claims.

CORRECTIVE ACTIONS. The situation was so dire that immense efforts were made to bring about a solution. One solution, in particular, allowed certain troubled European insurers to pay a premium (which varied according to exposure) and have all the liabilities for the exposed years 1992 and earlier to be reinsured by a specially formed company, ABC Reinsurer. Claims handling and all other aspects of the run-off were transferred to XYZ insurer (a wholly owned subsidiary of ABC Reinsurer). XYZ also reinsured ABC Reinsurer under a retrocession agreement. Certain rights of the original troubled insurers as reinsureds of ABC Reinsurer were held on trust for policyholders: In this way, the benefit of all reinsurance recoveries were applied in paying the liabilities due to policyholders. The intervening 10 years to 2006 found XYZ working to plan with a controlled program of inwards and outwards commutations as a means of dealing with the run off of these liabilities. In all practicality the original troubled insurers had finality—i.e. they were no longer financially exposed personally so long as XYZ remained solvent. However, as a matter of law, they did remain personally liable to policyholders for any excess liability over and above that paid by XYZ.

By early 2006, the market in the purchase of portfolios in run-off had taken off. XYZ was the world's largest business in run-off, so large that the number of likely purchasers was very limited. However, fortunately by the end of 2006, the two-stage deal with a large conglomerate—XOX—was announced, the stages being:

- 1) XYZ retroceded to XOX's subsidiary, BOB, its liabilities to ABC Reinsurer arising under the agreement. Cover was limited to approximately \$6 billion (U.S.) over and above existing reserves of approximately \$9 billion, as of March 2006. The premium was all of XYZ's assets less approximately \$340 million, plus a \$145 million contribution from some of the original troubled insurers. Staff and operations were transferred to another XOX subsidiary, RRR.
- 2) A "Part VII transfer" of all the liabilities of the original troubled European insurers (and the protection of the ABC Reinsurer–XYZ–BOB reinsurance chain) to a third party company. Provided the transfer was to take place before December 2009, XYZ would be entitled to purchase further reinsurance from BOB of up to \$1.3 billion if XYZ's net undiscounted reserves had not deteriorated by more than \$2 billion from their March 31, 2006, position.

Part VII of the UK Financial Services & Markets Act 2000 (FSMA) provides a statutory novation of business (i.e., reinsureds' obligations to their policyholders) by a transferor re/insurer to the transferee re/insurer, provided that strict procedures are complied with. The novation is effected by court order. The court order has the effect of vesting the transferor's business in the transferee without the need for consent of the policy holders/reinsureds. The court can and usually does order assets attributable to the underlying business to be transferred—i.e., including the outwards reinsurance contracts. There are strict definitions of business that are subjected to a Part VII transfer. Put broadly, it applies to transfers of business carried on in the UK or elsewhere within the European Economic Area (EEA) with a UK connection as defined and where the transferred business is to be carried on from an establishment of a transferee in an EEA state. There are various conditions and exclusions.

The unusual position of these particular re/insurers, should they wish to avail themselves of Part VII, was recognized at the time Part VII first became law. However, additional changes to the legislation had to be made to facilitate this transaction, and they became law in 2008. In particular, the Part VII provisions in the FSMA were extended to a further cohort of these particular re/insurers.

Under the Part VII transfer procedure, there are two court applications. The first gives directions as to notices to be served and other technical requirements allowing any opposing reinsureds or outwards reinsurers to object to the transfer. In the case of the XYZ Part VII, certain requirements were dispensed with taking into account the high volume of notices that would have to be given to individual names and other relevant parties. An essential part of the procedure is the report provided by an independent expert whose identity is approved by the Financial Services Authority (FSA). Furthermore, the FSA itself provides a report indicating its views that is made available to those interested in the transfer. Time is allowed for any objectors to produce their own case in the context of the independent expert report and the FSA's report. In the case of the XYZ transfer, the FSA indicated that it would not object to the transfer.

The second and final stage of the process is the application for sanction by the court. The court has discretion whether to sanction the transfer scheme but may not do so unless it considers it appropriate in all the circumstances of the case. Under case law on the statutory provisions, the court is concerned as to whether a policyholder, employee or other interested person will be adversely affected by the transfer scheme. The hearing took place in mid-year 2009, and the judge concluded that the Part VII transfer scheme should go ahead.

During the hearing, the judge was satisfied that other requirements protecting policyholders of the business being transferred had been fulfilled, such as that certificates of solvency for the transferee company were obtained confirming the adequacy of the transferee's solvency for the purpose. Presentations explaining the import of the transfer had been carried out in the UK and in the jurisdiction of XOX to transferring policyholders, the original troubled insurers, and their representatives. Help lines and a Web site had been set up. Numerous telephone calls, e-mails or letters had been sent in response by the Part VII advisers, with less than 10 people raising substantive issues.

ENFORCEMENT IN OTHER JURISDICTIONS. Part VII of the FMSA originates from EU Directives. The sanction order is thereby recognized throughout the EEA. A further step would be needed to ensure enforcement in the United States and other countries where policyholders were located. However, the shape of the scheme is such that enforcement in the United States and other jurisdictions is most probably unnecessary. Policyholders would be entitled to drawdown on trust funds located in the United States,

Canada, Australia and South Africa, providing them with security for amounts accruing due to them over time should there be any default payment.

PROGRESS. With the sanction of this transfer scheme granted during mid-year 2009, the two-stage transaction provided by the XOX group was completed in time. Because the transfer was affected prior to December 2009, it is believed that the further amount of \$1.3 billion (U.S.) reinsurance cover will be available to secure future payment of all policyholder claims.

B. SAMPLE DOCUMENTS

1. SAMPLE SUPERVISION CONSENT ORDER

----- §
 In the Matter of: §
 §
 The Administrative Supervision of §
 RESTRUCTURED TROUBLED §
 REINSURANCE CORPORATION, a § Docket No. EX xx-xx
 Connecticut domiciled property and casualty insurance company. §
 ----- §

CONSENT ORDER

This Consent Order is entered into by and between Restructured Troubled Reinsurance Corporation (RTRC) and the Insurance Commissioner of the State of Connecticut (the Commissioner) to provide supervision and regulatory oversight of RTRC in the run-off of its insurance and reinsurance obligations in force.

WHEREAS, the Commissioner hereby finds, and RTRC agrees, as follows:

1. The Commissioner has jurisdiction over the subject matter and of RTRC.
2. RTRC is a Connecticut-domiciled property and casualty insurer and reinsurance company having its principal office at XXX Street, Anywhere, XX 00000, and holds a certificate of authority to transact the business of insurance and reinsurance in Connecticut and is licensed or accredited in a number of other states.
3. RTRC is a wholly owned direct subsidiary of Restructured Troubled Corporation (RTC), a Delaware corporation and an indirect subsidiary of Restructured Troubled (Barbados) Ltd., a Barbados corporation which is a wholly owned direct subsidiary of Restructured Troubled Group Ltd. (RTG), a Bermuda corporation.
4. Due to the significant deterioration of RTG’s financial condition in 20XX, on December 3, 20XX, RTRC entered into a “letter of understanding” with the Connecticut Insurance Department (Department) as part of the Department’s continuing financial monitoring of RTRC pursuant to which RTRC agreed that it would not take certain actions without the prior written approval of the Connecticut Insurance Commissioner or her designee, including, among others, disposing of any assets, settling any intercompany balances or paying any dividends.

5. RTRC has submitted to the Department a risk-based capital report, (the RBC Report) pursuant to CONN. AGENCIES REGS. § 38a-72-2. The RBC Report indicates that RTRC was at the “Regulatory Action Level Event” as of December 31, 20XX. On July 30, 20XX, RTRC filed with the Department an updated RBC Report which estimates that RTRC was at the “Authorized Control Level Event” as of June 30, 20XX.

6. RTRC has ceased underwriting activities and has determined that it is in the best interests of its policyholders and creditors to run-off the existing operations of RTRC in such a manner as would maximize the availability of funds to satisfy the interests of policyholders, creditors, and other constituents.

7. RTRC has retained the services of a firm with expertise and experience in run-off management to review the operations of RTRC and its subsidiaries in run-off, to supplement its internal resources, and to accelerate the successful completion of the run-off, all pursuant to a comprehensive run-off plan (including therein, among other items, a plan to effectuate commutation of existing reinsurance obligations). The run-off management consultant will develop and submit, along with a more extensive run-off engagement agreement retaining their services to manage the run-off, to the RTRC Board of Directors for approval and, if such plan and agreement are approved, to the Commissioner, creditors of RTC, and other constituencies for approval.

8. On April 15, 20XX, the Department commenced a targeted examination of the financial condition of RTRC pursuant to CONN. GEN. STAT. § 38a-14. The examination was called based on RTRC’s submission of a Cash Flow Projection Model to demonstrate that RTRC has sufficient assets and cash flow to pay both claims and operating expenses as those obligations become due.

9. On August 20, 20XX, RTG and RTC filed for protection under Chapter 11 of Title 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware.

10. RTRC is in such condition that regulatory control of the insurer is appropriate to help safeguard its financial security and is in the best interests of the policyholders and creditors of the insurer and of the public as RTRC administers the run-off of its existing business.

IT IS THEREFORE ORDERED AND AGREED THAT:

11. RTRC hereby consents to and shall be placed under the administrative supervision of the Commissioner pursuant to CONN. GEN. STAT. § 38a-962b and under the terms herein.

12. RTRC hereby knowingly and voluntarily waives receipt of written notice under CONN. GEN. STAT. § 38a-962b of grounds for the Commissioner to effectuate administrative supervision by the Commissioner.

13. The period of administrative supervision by the Commissioner shall commence upon execution of this Consent Order. The period of supervision pursuant to this Consent Order shall be coterminous with the run-off of RTRC’s existing business, unless the Commissioner takes action pursuant to Paragraph 27 hereof.

14. The determination that RTRC shall be subject to administrative supervision by the Commissioner may be abated and thereby released from administrative supervision by the Commissioner if RTRC complies with the orders of supervision provided herein and, during the period of supervision, RTRC shall have attained sufficient liquidity, surplus, and reserves necessary to exceed and maintain Company Action Level RBC, as defined in CONN. AGENCIES REGS. § 38a-72-1, or the Commissioner in her sole discretion determines the supervision of RTRC is no longer necessary for the protection of policyholders, claimants, creditors, or is no longer in the public interest.

15. During the period of supervision, RTRC shall not undertake, engage in, commit to accept, or renew

any insurance obligations including without limitation, insurance or reinsurance policies or any similar arrangements or agreements of indemnity or, without the prior written approval of the Commissioner, make any material change in any insurance or reinsurance agreement which would increase the financial obligations of RTRC in any material respect. Moreover, RTRC shall not engage in activities beyond those that are routine in the day-to-day conduct of its business in run-off and are otherwise consistent with its comprehensive business run-off plan (Run-off Plan) to be filed with, and found acceptable by, the Commissioner, without the prior approval of the Commissioner or her designee. The routine day-to-day conduct of RTRC's business in run-off includes but is not limited to: (a) paying claims and operating expenses as such obligations become due and in accordance with the applicable law and the settlement and commutation of claims and insurance and reinsurance obligations, unless otherwise provided in the following paragraph or otherwise directed or approved by the Commissioner or her designee; (b) defending RTRC and persons insured or claiming to be insured by RTRC against claims arising from or related to insurance policies and reinsurance agreements previously issued, assumed, or ceded by RTRC; (c) settling or otherwise resolving or attempting to adjust and resolve such claims; (d) engaging, directing, discharging, and compensating counsel (including reasonable costs incurred) with respect to such claims or other matters; (e) paying settlements or judgments with respect to such claims; and (f) investing the assets of RTRC and liquidating such assets in an appropriate manner as required to pay claims, operating expenses, settlements, commutations, and other charges in the ordinary course of business and subject to the provisions of this Consent Order.

The routine day-to-day conduct of RTRC's business in run-off also includes but is not limited to: (a) submitting information to reinsurers with respect to RTRC's reinsured losses and loss adjustment expenses; (b) advising reinsurers of all sums due to RTRC under their respective reinsurance contracts and treaties with RTRC (including settlement and commutation thereof, provided, however, that RTRC shall not enter into commutation of liabilities (either inward or outward including obligations of others to RTRC) or settlements of claims other than for amounts not in excess of \$250,000 except as otherwise provided in the Run-off Plan or otherwise approved by the Commissioner or her designee); and taking all actions necessary and appropriate to recover all sums due to RTRC from reinsurers and others.

The following activities, to the extent not necessary for the adjusting and payment of losses and expenses associated with claims adjusting and settlement or commutation of reinsurance agreements are understood to be outside the day-to-day conduct of RTRC's business in run-off, and in no event shall RTRC engage in or undertake the following activities without the prior approval of the Commissioner or her designee:

- (a) Dispose of, convey, or encumber any of its assets or its business in force.
- (b) Withdraw any of its bank accounts.
- (c) Lend any of its funds.

- (d) Invest any of its funds.
- (e) Transfer any of its property.
- (f) Incur any debt, obligation, or liability.
- (g) Merge or consolidate with another company.
- (h) Write new or renewal business.
- (i) Enter into any new reinsurance contract or treaty.
- (j) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except for nonpayment of premiums due.
- (k) Release, pay, or refund premium deposits, unearned premiums, or other reserves on any insurance policy, certificate, or contract.
- (l) Make any material change in management.
- (m) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

RTRC shall make a recommendation with the reasons therefore in writing to obtain the prior approval of the Commissioner as to any of the foregoing actions.

16. The Commissioner shall have the final authority to approve or disapprove the initiation, settlement, or withdrawal by RTRC of any action, dispute, arbitration, litigation, or proceeding of any kind involving RTRC that is not in the ordinary course of business or would require payment in excess of \$250,000. RTRC shall prepare a written report to the Commissioner with a recommendation for approval or disapproval with the reasons therefore.

17. Without the prior written approval of the Commissioner, RTRC shall not (i) add any individual who is not currently a senior executive officer of RTRC, or one of its affiliates, to the board of directors of RTRC or (ii) move the principal offices or records of RTRC to a location outside of Connecticut.

18. RTRC shall file with the Department a monthly financial statement consisting of a balance sheet and income statement on the 25th day of each month as of the end of the prior month.

19. At least annually, RTRC shall submit an actuarial analysis prepared by a qualified actuary as defined in CONN. AGENCIES REGS. § 38a-53-1 of the loss and loss adjustment expense reserves.

20. RTRC shall submit a report on a quarterly basis containing detailed information on all commutations of reinsurance treaties and related activities which have occurred year-to-date, including specific impact on RTRC's statutory financial statement.

21. RTRC shall submit to the Department any additional reports that the Department reasonably determines as necessary to ascertain the financial condition of RTRC.

22. RTRC shall submit any and all reports or items required by this Consent Order, and all requests for the Commissioner's action or approval to:

_____ (name)

Connecticut Insurance Department P.O.
Box 816

Hartford, Connecticut 06142-0816

(860) 297-3823

(860) 566-7410 FAX

23. The Commissioner may retain, at RTRC’s expense, such experts (including, but not limited to, attorneys, actuaries, accountants, and investment advisors) not otherwise a part of the Commissioner’s staff, as the Commissioner reasonably believes is necessary to assist in the supervision of RTRC.

24. RTRC hereby knowingly and voluntarily waives all rights of any kind to challenge or to contest this Consent Order, in any forum now available to it, including the right to any administrative appeal pursuant to CONN. GEN. STAT. § 4-183.

25. This Consent Order of supervision, and proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the administrative supervision by the Commissioner of RTRC are subject to the confidentiality provisions of CONN. GEN. STAT. § 38a-962c and § 38a-8.

26. RTRC shall continue to comply with all obligations under law, including applicable financial, regulatory, and tax reporting requirements.

27. Nothing in this Consent Order shall preclude the Commissioner from taking further action as the Commissioner in her sole discretion deems appropriate and in the best interest of RTRC’s policyholders and the public, including commencement of further legal proceedings if and as necessary under Chapter 704c of the Connecticut General Statutes.

28. This Consent Order shall supersede in all respects the “letter of understanding” between RTRC and the Department referenced to in Paragraph 4 of this Consent Order, which letter shall have no further force and effect.

29. The Board of Directors of RTRC, at a specially called meeting or by unanimous written consent, has simultaneously, with the entry of this Consent Order, approved and provided resolutions complying with the terms of this Consent Order, which is effective upon entry of this Consent Order.

The foregoing Consent Order for Restructured Troubled Reinsurance Corporation is entered and shall be effective at 3:00 p.m. on this ____day of September 20XX.

(name)
Insurance Commissioner

Agreed and Consented to by RESTRUCTURED TROUBLED REINSURANCE CORPORATION on this_day of September 20XX.

(name)
President

(Corporate Seal)

On this _____ day of September 20XX, before me, the subscriber, personally appeared

_____, the President of Restructured Troubled Reinsurance Corporation, who I am satisfied is the person who has signed the preceding Consent Order, and he did acknowledge that he signed, sealed with the corporate seal, and delivered the same as such officer aforesaid and that the Consent Order is the voluntary act and deed of such company made by virtue of the authority vested in him by its Board of Directors.

(name), (Title)

2. SAMPLE REINSURER LETTER AGREEMENT

November , 20XX

President
Restructured Troubled Reinsurance Company XXX Street Anywhere,
XX 00000

Dear _____:

The Any State Insurance Department (Department) continues its financial monitoring of Restructured Troubled Reinsurance Corporation (RTRC or Company).

The Company’s parent, Restructured Troubled Group Ltd. (RTG) reported an operating loss of \$245 million for the third quarter of 2002 and an operating loss of \$252.6 million for the first nine months of 2002. The loss resulted principally from approximately \$100.7 million of loss reserve increases recorded by the operating subsidiaries and a \$64.5 million loss related to the establishment of a deferred tax valuation reserve. The operating results for the first nine months of 20XX included approximately \$33 million of loss development related to the September 11th terrorist attacks recorded in the first quarter of 20XX. On October 18, 20XX, A.M. Best Company lowered the ratings of the operating subsidiaries of RTG from A- to B+. Subsidiary Insurance Company was lowered from A- to B. The downgrade constituted an event of default under RTG’s bank credit facility, under which banks had issued \$336 million in letters of credit to support RTG’s underwriting at its Lloyd’s operation. On November 1, 20XX, with the approval of the Department, the Company entered into an Underwriting and Reinsurance Arrangement with Facility Re, Inc., whereby new business is underwritten by Facility Insurance Company, a member of the Facility Group. On November 14, 2002, A.M. Best again lowered the ratings

of the operating subsidiaries of RTG from B+ to B-. Subsidiary Insurance Company was lowered from B to C++.

In order to protect the existing quality and integrity of RTRC's assets, reserves, and management to protect policyholders/reinsureds and the public, it is requested that the Company agree to the following:

1. RTRC shall not take any of the following actions without the prior written approval of the Insurance Commissioner or her designee:
 - a. Dispose of, convey, or encumber any of its assets or its business in force.
 - b. Withdraw any of its bank accounts except in the ordinary course of business.
 - c. Settle any intercompany balances.
 - d. Lend any of its funds.
 - e. Transfer any of its property.
 - f. Make any investments other than cash equivalents.
 - g. Incur any debt, obligation, or liability, except liabilities in the ordinary course of business.
 - h. Make any material change in management.
 - i. Make any material change in the operations of the Company.
 - j. Move any books and records from its office in Stamford, Connecticut.
 - k. Pay any dividends, ordinary or extraordinary.
 - l. Enter into any affiliated reinsurance contracts, affiliated commutation agreements, or settlement agreements.
 - m. Enter into any unaffiliated insurance or reinsurance contracts that would constitute new or renewal business, or any unaffiliated commutation agreements or settlement agreements in excess of \$1 million not in the ordinary course of business.
 - n. Enter into affiliated transactions of any nature.
2. Senior management shall meet with the Department, in person or by conference call, with such frequency as may be deemed necessary by the Insurance Commissioner or her designee, to provide updates on the status of the parent and any changes in the status of the Company.
3. A monthly financial statement consisting of a balance sheet and income statement shall be filed with the Department on the 25th day of each month as of the prior month end.
4. The above-described terms shall continue in effect until such time as the Insurance Commissioner shall deem they are no longer necessary or issues an order that supersedes this agreement.
5. RTRC acknowledges that nothing contained herein shall in any way limit any power or authority given the Insurance Commissioner under the laws of the State of Connecticut, including the right to initiate any further actions as she deems in her discretion to be necessary for the protection of RTRC's policyholders/reinsureds and the public.

I have enclosed two originals of this letter to your attention. Please sign and date both originals, retain one for your file, and return one executed original to me. Sincerely,

_____, Chief Examiner
Financial Analysis & Compliance

AGREED TO this _____day of November, 20XX, by a duly authorized representative of RTRC.

C. SAMPLE OUTLINE FOR RUN-OFF PLANS

The following is a sample outline for a run-off plan.

I. Introductory Overview

A. Executive Summary: Providing an executive level summary of the history, current business conditions, recent significant transactions, and proposed run-off solution.

1. Status
2. Mission
3. Business (Guiding) Principles

B. Plan Objectives: Describing the ability of the plan to fully and timely settle all valid policyholder claims in compliance with the liquidation priorities of state distribution scheme.

C. Advantages

D. Benefits

II. Corporate History

A. Summary

B. Recent Happenings: Description of business plans, significant transactions, prior restructuring plans, and financial performance related thereto.

1. Mergers & Acquisitions
2. Employment
3. Internal Growth
4. External Factors
5. Current Position

C. Business Description: Including a comprehensive description of organizational and corporate structure, lines of insurance, nature of policyholder and other risks, and claim-handling function associated with the run-off.

1. Lines
2. Programs
3. Markets

D. Reserve Development

1. Environmental Issues
2. Underwriting Issues
3. Adverse Development
4. Reserves by Line – Summary

E. Financial Condition: Summary of recent financials

1. Summary
2. Statutory Surplus
3. Consolidated Financial Statement(s)
4. Operating Expenses
 - a. Staffing
 - b. Insurance
 - c. Real Estate
 - d. Fixed Costs
 - e. Information Technology
5. Taxes

F. Operations: Description and historical comparison of staffing, real estate, expenses, insurance and information technology, and other pertinent operations associated with run-off.

1. Claims Handling
2. Reinsurance
 - a. Outstanding Balances
 - b. Disputes
 - c. Solvency Issues
 - d. Uncollectable
 - e. Write-offs
 - f. Collateral
 - g. Lines of Business
 - h. Programs
 - i. Processes & Systems

III. Run-off Plan: Description of initiatives and priorities, including demonstration of Run-Off Plan serving the best interests of policyholders and other claimants.

A. Summary

B. Financial Projections: Including description of surplus-enhancing initiatives and transactions, loss development, liquidity and expense projections.

1. Key Factors
2. Assumptions
3. Revenues

4. Expenses
5. Surplus Projection
6. Liquidity Projection

C. Initiatives

1. Surplus Enhancing
 - a. Policy Buybacks
 - b. Expense Reductions
 - i. Operating Expenses
 - a. Staffing
 - b. Real Estate
 - c. Fixed Costs
 - d. Insurance/Benefits
 - e. Information Technology
 - ii. Allocated Loss Adjustment Expenses
 - c. Reinsurance Commutations
2. Liquidity
 - a. Asset Portfolio Assessment
 - b. Encumbered Assets
 - c. Unencumbered Assets
 - d. Statutory Deposits

D. Risk Factors: Description and projection of risks associated with Run-Off Plan, including regulatory concerns, preferences, and risks associated with policyholders, and guaranty funds/associations, including identification of critical elements for plan success.

1. Define Uncertainties
 - a. Business
 - b. Economic
 - c. Regulatory

2. Additional Adverse Loss Reserve Development
 3. Increased Reinsurance Disputes
 4. Unexpected Liabilities
 5. Drastic Asset Value Changes
 6. Financial Market – Investments
-
- E. Voluntary Run-off vs. Receivership: Analysis and comparison between the alternative mechanisms from best interests of policyholders, claimants, and guaranty funds/associations.
 - F. Regulatory Reporting: Description of proposed regulatory supervision and reporting requirements—e.g., monthly statutory basis financial statements (balance sheet, statement of income and statement of cash flow), including comparison of actual results to Plan projections; quarterly reports demonstrating reinsurance recoverables and premium receivables past due, in dispute, litigation or arbitration; report demonstrating material credit exposures, related collateral held, and identity of credit impaired transactions; unpaid losses on state-by-state basis; weekly cash flow report; periodic review of loss reserves and amortization of any permitted loss reserve discounting, including appropriate actuarial certification; copies of all internal and external audit reports within five business days of issue; approval of all transactions exceeding pre-determined thresholds; and identification of prohibited transactions.
 - G. Corporate Governance: Description of proposed governance and internal controls.

D. RELEVANT NAIC MODEL LAWS & REGULATIONS AND STATE STATUTES

This appendix section provides current and relevant NAIC Model Laws and Regulations, as well as specific state statutes that pertain to an insurance department's authority and responsibilities in dealing with troubled insurers. The sections are not intended to be all-inclusive, but rather a reference source.

1. NAIC MODEL LAWS & REGULATIONS

- Administrative Supervision Model Act
- Insurers Receivership Model Act
- Model Regulation to Define Standards and Commissioners' Authority for Companies Deemed to be in a Hazardous Financial Condition
- Criminal Sanctions for Failure to Report Impairment Model Bill

2. RULES AND REGULATIONS OF THE STATE OF NEW YORK – TITLE 11 INSURANCE

DEPARTMENT – CHAPTER IV FINANCIAL CONDITION OF INSURER AND REPORTS TO

SUPERINTENDENT – SUBCHAPTER D REINSURANCE – PART 128 COMMUTATION OF

REINSURANCE AGREEMENTS (REGULATION 141)

(Text is current through February 15, 2008.)

Section 128.0. Purpose.

Section 1321 of the Insurance Law authorizes the Superintendent of Insurance to permit an impaired or insolvent domestic insurer or an impaired or insolvent United States branch of an alien insurer entered through this state to commute reinsurance agreements as a means of eliminating such an impairment or insolvency. This Part sets forth applicable standards that the superintendent will use in determining whether such commutations will be approved.

Section 128.1. Applicability.

This Part shall be applicable to any domestic insurer or United States branch of an alien insurer entered through this state, other than a life insurance company as defined in section 107(a)(28) of the Insurance Law.

Section 128.3. General provisions.

- (a) Nothing in this Part shall require the superintendent to give prior consideration to a plan which contains the commutation of reinsurance agreements in lieu of taking any other action against an impaired or insolvent insurer in accordance with the Insurance Law, including proceeding against such insurer pursuant to article 74 of the Insurance Law.
- (b) All the terms and conditions of any plan which contains the commutation of reinsurance agreements are subject to approval by the superintendent and no such plan will be approved by the superintendent unless the effect of the plan shall eliminate the insurer's impairment or insolvency and restore the insurer's surplus to policyholders to the greater of the minimum amount required to be maintained pursuant to the applicable provisions of the Insurance Law or to the amount the superintendent determines is adequate in relation to the insurer's outstanding liabilities or financial needs. The

determination regarding the adequacy of the insurer's surplus to policyholders shall be made in accordance with the factors set forth in section 1104(c) of the Insurance Law.

Section 128.4. Requirements.

- (a) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall provide that:
 - (1) the offer to commute reinsurance agreements is made to each and every ceding insurer to which the impaired or insolvent insurer has obligations;
 - (2) the terms of the commutation agreement to be offered to each and every ceding insurer are the same, except that the percentage by which the impaired or insolvent insurer proposes to discount obligations due to each ceding insurer may vary in regard to the type of business being commuted. Any variance by type of business shall be reasonable, actuarially sound and supported by documentation justifying such a variance; and
 - (3) the impaired or insolvent insurer agrees to enter into a stipulation with the superintendent consenting to an order of rehabilitation or liquidation in the event that the implementation of the plan by the insurer does not result in restoring the insurer's surplus to policyholders to the minimum required as determined in accordance with section 128.3(b) of this Part.
- (b) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall include:
 - (1) a balance sheet that reflects the insurer's impairment or insolvency as determined by the superintendent, a pro forma balance sheet reflecting the financial condition of such insurer subsequent to the effective date of the plan, and a reconciliation between both balance sheets;
 - (2) an exhibit setting forth the obligations due to each and every ceding insurer as of the proposed effective date of such plan and the consideration to be offered each and every ceding insurer for the commutation of such obligations. The obligations shall be classified in accordance with the categories contained in the definition set forth in section 128.2(c) of this Part; and
 - (3) details regarding any retrocessionaire's participation in the plan.

Section 128.5. Procedures.

- (a) Any plan which contains the commutation of reinsurance agreements shall be submitted to the superintendent by the impaired or insolvent insurer within a period designated by the superintendent, which shall not be more than 90 days from the determination of the insurer's impairment or insolvency.
- (b) If the superintendent has no objection to any of the plan's terms and conditions and determines that the impaired or insolvent insurer's surplus to policyholders will be restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the proposed plan shall be approved and the insurer shall offer the commutation proposals to its ceding insurers. No commutation agreement shall become effective and no consideration for any commutation agreement shall be paid by the impaired or insolvent insurer until the superintendent determines that, as a result of the commutation proposals agreed to and executed by the ceding insurers, along with the effect of any other components of the plan, the impaired or insolvent insurer's surplus to policyholders is restored to the minimum required.
- (c) Within 10 days after the superintendent approves the plan, the impaired or insolvent insurer shall deliver the proposed commutation agreements to each ceding insurer. The terms of any commutation agreement shall not be subject to negotiation between the impaired or insolvent insurer and the ceding insurer.
- (d) The impaired or insolvent insurer shall submit to the superintendent, within a designated period as determined by the superintendent, copies of the executed commutation agreements from those ceding insurers agreeing to the proposed terms, copies of rejections of the commutation agreements by those

ceding insurers not agreeing to the proposed terms and copies of any other correspondence pertaining to all such offers made to the ceding insurers. This submission shall include a balance sheet that reflects the effect of the executed agreements, together with any other components of the plan, upon the insurer's impairment or insolvency as determined by the superintendent. The insurer shall also submit copies of executed agreements with any retrocessionaires which either modify, commute or assign any retrocession agreement.

- (e) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the executed commutation agreements shall become effective.
- (f) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer's surplus to policyholders is not restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the superintendent may proceed against the insurer in accordance with the stipulation executed pursuant to section 128.4(a)(3) of this Part.

Section 128.6. Reporting requirements.

Any impaired or insolvent insurer which eliminates such impairment or insolvency using commutations approved by the superintendent in accordance with the provisions of this Part shall exclude all historical data pertaining to such commutations from the loss development schedules contained in future financial statements filed in accordance with applicable provisions of the Insurance Law. The historical data pertaining to the business commuted shall be reported on a supplemental loss development schedule in a form consistent with the schedule contained in statutory financial statements as filed with this department. The supplemental schedule shall show the aggregate experience of such business as of the effective date of commutation agreement.

3. RHODE ISLAND STATUTE AND REGULATION – VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS TITLE 27 CHAPTER 14.5 AND REGULATION 68

§ 27-14.5-2 Jurisdiction, venue, and court orders.

- (a) The court considering applications brought under this chapter shall have the same jurisdiction as a court under chapter 14.3 of this title.
- (b) Venue for all court proceedings under this chapter shall lie in the superior court for the county of Providence.
- (c) The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this chapter. No provision of this chapter providing for the raising of an issue by a party in interest shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of process.

§ 27-14.5-3 Notice.

- (a) Wherever in this chapter notice is required, the applicant shall, within ten (10) days of the event triggering the requirement, cause transmittal of the notice:
 - (1) By first class mail and facsimile to the insurance regulator in each jurisdiction in which the applicant is doing business;
 - (2) By first class mail to all guarantee associations;
 - (3) Pursuant to the notice provisions of reinsurance agreements or, where an agreement has no provision for notice, by first class mail to all reinsures of the applicant;

- (4) By first class mail to all insurance agents or insurance producers of the applicant;
 - (5) By first class mail to all persons known or reasonably expected to have claims against the applicant including all policyholders, at their last known address as indicated by the records of the applicant;
 - (6) By first class mail to federal, state, and local government agencies and instrumentalities as their interests may arise; and
 - (7) By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in any other locations that the court overseeing the proceeding deems appropriate.
- (b) If notice is given in accordance with this section, any orders under this chapter shall be conclusive with respect to all claimants and policyholders, whether or not they received notice.
 - (c) Where this chapter requires that the applicant provide notice but the commissioner has been named receiver of the applicant, the commissioner shall provide the required notice.

§ 27-14.5-4 Commutation plans.

- (a) *Application.* Any commercial run-off insurer may apply to the court for an order implementing a commutation plan.
 - (1) The applicant shall give notice of the application and proposed commutation plan.
 - (2) All creditors shall be given the opportunity to vote on the plan.
 - (3) All creditors, assumption policyholders, reinsurers, and guaranty associations shall be provided with access to the same information relating to the proposed plan and shall be given the opportunity to file comments or objections with the court.
 - (4) Approval of a commutation plan requires consent of: (i) fifty percent (50%) of each class of creditors; and (ii) the holders of seventy-five percent (75%) in value of the liabilities owed to each class of creditors.
- (1) The court shall enter an implementation order if: (i) the plan is approved under subdivision (b)(4) of this section; and (ii) the court determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders.
- (2) The implementation order shall:
 - (i) Order implementation of the commutation plan;
 - (ii) Subject to any limitations in the commutation plan, enjoin all litigation in all jurisdictions between the applicant and creditors other than with the leave of the court;
 - (iii) Require all creditors to submit information requested by the bar date specified in the plan;
 - (iv) Require that upon a noticed application, the applicant obtain court approval before making any payments to creditors other than, to the extent permitted under the commutation plan, payments in the ordinary course of business, this approval to be based upon a showing that the applicant's assets exceed the payments required under the terms of the commutation plan as determined based upon the information submitted by creditors under paragraph (iii) of this subdivision;
 - (v) Release the applicant of all obligations to its creditors upon payment of the amounts specified in the commutation plan;
 - (vi) Require quarterly reports from the applicant to the court and commissioner regarding progress in implementing the plan; and
 - (vii) Be binding upon the applicant and upon all creditors and owners of the applicant, whether or not a particular creditor or owner is affected by the commutation plan or has accepted it or has filed any information on or before the bar date, and whether or not a creditor or owner ultimately receives any payments under the plan.

- (3) The applicant shall give notice of entry of the order.
- (1) Upon completion of the commutation plan, the applicant shall advise the court.
- (2) The court shall then enter an order that:
- (i) Is effective upon filing with the court proof that the applicant has provided notice of entry of the order;
 - (ii) Transfers those liabilities subject to an assumption reinsurance agreement to the assumption reinsurer, thereby notating the original policy by substituting the assumption reinsurer for the applicant and releasing the applicant of any liability relating to the transferred liabilities;
 - (iii) Assigns each assumption reinsurer the benefit of reinsurance on transferred liabilities, except that the assignment shall only be effective upon the consent of the reinsurer if either:
 - (A) The reinsurance contract requires that consent; or
 - (B) The consent would otherwise be required under applicable law; and
 - (iv) Either:
 - (A) The applicant be discharged from the proceeding without any liabilities; or
 - (B) The applicant be dissolved.
- (3) The applicant shall provide notice of entry of the order.
- (e) *Reinsurance.* Nothing in this chapter shall be construed as authorizing the applicant, or any other entity, to compel payment from a reinsurer on the basis of estimated incurred but not reported losses or loss expenses, or case reserves for unpaid losses and loss expenses.
- (f) *Modifications to plan.* After provision of notice and an opportunity to object, and upon a showing that some material factor in approving the plan has changed, the court may modify or change a commutation plan, except that upon entry of an order under subdivision (d)(2) of this section, there shall be no recourse against the applicant's owners absent a showing of fraud.
- (1) The commissioner and guaranty funds shall have the right to intervene in any and all proceedings under this section; provided, that notwithstanding any provision of title 27, any action taken by a commercial run-off insurer to restructure pursuant to chapter 14.5, including the formation or re-activation of an insurance company for the sole purpose of entering into a voluntary restructuring shall not affect the guaranty fund coverage existing on the business of such commercial run-off insurer prior to the taking of such action.
 - (2) If, at any time, the conditions for placing an insurer in rehabilitation or liquidation specified in chapter 14.3 of this title exist, the commissioner may request and, upon a proper showing, the court shall order that the commissioner be named statutory receiver of the applicant.
 - (3) If no implementation order has been entered, then upon being named receiver, the commissioner may request, and if requested, the court shall order, that the proceeding under this chapter be converted to a rehabilitation or liquidation pursuant to chapter 14.3 of this title. If an implementation order has already been entered, then the court may order a conversion upon a showing that some material factor in approving the original order has changed.
 - (4) The commissioner, any creditor, or the court on its own motion may move to have the commissioner named as receiver. The court may enter such an order only upon finding either that one or more grounds for rehabilitation or liquidation specified in chapter 14.3 of this title exist or that the applicant has materially failed to follow the commutation plan or any other court instructions.
 - (5) Unless and until the commissioner is named receiver, the board of directors or other controlling body of the applicant shall remain in control of the applicant.

The purpose of this Regulation is to outline the procedural requirements for insurance companies applying for the implementation of a Commutation Plan pursuant to R.I. Gen. Laws § 27-14.5-1, *et seq.* and related matters.

4. PART VII OF THE FINANCIAL SERVICES AND MARKETS ACT 2000 (FSMA)

www.opsi.gov.uk/acts/acts2000/ukpga_20000008_en_1

<http://fsahandbook.info/FSA/html/handbook/SUP/18>

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