

# Property Casualty 360

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## Guaranty funds solid in spite of shadow of insolvency

BY LAURA MAZZUCA TOOPS, PROPERTYCASUALTY360.COM,  
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***Back in the 1990s, the property-casualty insurance industry underwent a rash of large insurer insolvencies. Today, aside from what's happened to AIG, the current financial services mess has pretty much spared property-casualty insurance companies from insolvencies. However, some investors are voicing concerns about potential insolvencies by insurers that have taken financial hits stemming from write-downs on their investment portfolios.***

***In its recently released "Insolvency Trends 2009," the National Conference of Insurance Guaranty Funds (NCIGF), the Indianapolis-based nonprofit trade association for state guaranty funds, takes a look at developing trends on the state and national levels (for a copy of the report, go to [www.ncigf.org](http://www.ncigf.org) and assures us that the system can handle whatever lies ahead.***

***AA&B recently spoke with NCIGF president and CEO Roger Schmelzer about what he sees as the future of the system.***



**AA&B:** Aside from AIG, the current financial services mess has pretty much spared property-casualty insurance companies. Are we in a situation where we are waiting for the other shoe to drop, or is this a testimony to the fact that the industry is stable and well capitalized?

**Schmelzer:** The current stability is primarily due to the fact that insurance and solvency regulation have improved over the years. State regulators have created new testing devices where they can determine if a company has enough money to operate, which most do. Since 1976, there have been about 600 insolvencies of property-casualty insurers, which is a pretty good record considering the number of players in the market.

And the industry is well capitalized, too. Even after last year, insurers had more than \$1 trillion in reserves to pay claims directly. Solid statutory measurements seem to be in place, so we're not really expecting any significant insolvency activity this year.

Everything is cyclical. In the early '90s and earlier in this decade, insurers were looking for different ways to be competitive. We're now in a more stable period, except for AIG, and their problems weren't on the insurance side.

If you're running a property-casualty company now, you've probably made sure that you have exactly the investment portfolio you want, and that you are underwriting the risks you really want to underwrite. It's a time for fundamentals.

**AA&B:** What are some of the biggest trends in insolvency protection taking place in NAIC and at the state level?

**Schmelzer:** I don't see any overarching trend. Typically after a commercial insolvency period, there is movement to try and make sure the guaranty fund system will be able to pay claims for the everyday auto and homeowner policyholder. Everything for the most part is designed to strengthen the system for them.

What we try to do is advise our members on things that will weaken or strengthen the system for average policyholders. We have done quite a bit; it's a time for fundamentals on this end as well.

**AA&B:** The current guaranty fund system has worked well for 40 years. Have current market conditions put new stressors on the system, and is it in need of an overhaul?

**Schmelzer:** This is not likely because there have not been many insolvencies as of late. Historically, the biggest insolvency was Reliance Insurance Co. in 2001, a top 25 carrier with a \$2.9 billion payout. During that same period, state guaranty funds had a capacity of more than \$55 billion, so the Reliance insolvency was more than covered. You must also take into account that we recovered \$1.8 billion from the Reliance estate, so there was a net liability of only \$1.1 billion.

We don't believe there are stressors in the state guaranty fund system, which was built to accommodate pretty much anything that will come along.

**AA&B:** Coastal states like Florida are currently on the edge of crisis because of catastrophic exposures, insurer market pullouts and underfunded state-run insurers. What do you believe is the best panacea for these unique situations?

**Schmelzer:** The best thing for Florida from a public policy standpoint would be to let the markets work. You can't control the pricing the way the legislators want to in Florida and expect companies to stay. As far as the impact on us, our projections are we could withstand quite a bit if we had do. Even if several companies went under, claims would be paid. Based on the information we collect, we don't see anything that indicates the state guaranty fund

couldn't handle it. If you were butting up against assessment limits, there would be other things to be done as in other states, such as raising assessment caps, bonding, and borrowing between different accounts to beef up the guaranty fund. There's plenty of capital to cover a catastrophic situation there.

**AA&B:** Why do you think the federal government has not attempted to play a role in the state guaranty fund system, and do you think this will change in light of current economic conditions?

**Schmelzer:** Based on the current political situation, I could see the potential for a federal role with respect to systemically significant companies, whatever that might be. Not because the state guaranty funds couldn't handle the insolvency, but because there is a big disconnect in the minds of people in Washington when they think of doing more on a federal level to regulate insurance. With the FDIC as a model, it's difficult for them to see that you wouldn't need a federal guaranty with the current system.

A point that hasn't been developed yet is if there are federal guaranties, what would be guaranteed? Guaranty funds do more than write checks like the FDIC; you've got the entire claims adjustment process that must be undertaken. If indeed you use the FDIC model for insurance on a federal level, how do you address claims adjustment and the other variables of the claims process? I don't know the answer, but it's certainly an interesting period.

**AA&B:** Looking back at "historical" insolvencies of the 1990s, how does today's marketplace compare?

**Schmelzer:** One of the primary differences is in the regulation itself, which is now very much oriented to failures of that magnitude. Regulators learned from that; they know what to look for and how involved they need to be in a company's affairs to ensure they are properly capitalized.

I'm not sure that insurers are doing anything differently. We'd like to know and understand this better. We didn't understand much about the large deductible policies and learned about that but so did the regulators; now they're more educated on some of these products. But companies are probably being more careful, too.

**AA&B:** How should retail agents and brokers advise their clients in the event of a carrier insolvency?

**Schmelzer:** This is a very fluid time for the insurance industry, and it behooves all of us on the front line to be very aware that we're going through a transitional period in the industry. Agents need to stay up on the ratings of the companies, as that's a pretty good indicator of where things are. I think your readers can be comforted to know that their clients are going to be paid if there's a claim, even if their company fails. The guaranty fund system is healthy, very tested and dedicated to paying claims. People will be paid.

#### Top 5 largest insolvencies:

Reliance Insurance Co., October 2001: \$2.3 billion

Legion Insurance Co., July 2003: \$1.3 billion

California Compensation

Insurance Co., Sept. 2000: \$1 billion

Fremont Indemnity

Insurance Co., July 2003: \$848 million

PHICO Insurance Co., Feb. 2002: \$726 million

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## **Failed insurance firm still gobbling up money Pa. lists expenses of \$250 million in two years.**

By Joseph N. DiStefano INQUIRER STAFF WRITER

**POSTED: AUGUST 11, 2003**

The Pennsylvania Insurance Department spent \$100 million on lawyers, accountants, and other private contractors to help it run the failed Reliance Insurance Co. over the last two years. Salaries, rent, and other operating expenses cost an additional \$150 million.

This money comes not from Pennsylvania's Treasury but from Reliance's dwindling coffers, which the state now controls. But every dime spent deepens the failed Philadelphia insurer's yawning deficit, estimated at an industry-record \$2.8 billion, much of which will be paid by homeowners and businesses through higher insurance premiums.

"Yes, we've spent a lot of money. But this is a very large company," Insurance Commissioner M. Diane Koken said. "I think we've spent the money very efficiently," she said, comparing the cost to that of a big corporate bankruptcy. Last week, for example, a Cincinnati law firm requested \$13 million for three months' work in the Enron bankruptcy; PricewaterhouseCoopers requested \$18 million for three months' accounting work in the same case, according to federal court records.

With \$9 billion in assets, Reliance is the biggest American property-and-casualty insurer ever to fail. Last week, the state provided its first accounting of who it hired and how much they were paid to run Reliance. The disclosure was ordered by Commonwealth Court Judge James Gardner Colins, who is overseeing Reliance's liquidation.

By far the largest single contractor for Reliance has been the Philadelphia law firm of Blank Rome L.L.P., which has collected \$10.7 million from the Reliance estate.

"Their fees are modest when you compare them" to New York bankruptcy lawyers, Koken said. She said she chose Blank Rome because it was well-qualified and because several other large Philadelphia firms "had a conflict of interest." They represented Reliance.

Blank Rome was among the top campaign donors to former Gov. Tom Ridge, who appointed Koken in 1997. Democrats have questioned the volume of state work the firm received under Ridge. Jerome Richter, a Blank Rome partner, referred questions on Friday to Koken's office.

The state also listed more than 50 other law firms it has hired to handle Reliance cases. They include Philadelphia firms, such as Pepper Hamilton and Obermayer Rebmann Maxwell & Hoppel, and national firms, such as Baker Botts in Texas, Fulbright & Jaworski in Washington, and Stroock & Stroock & Lavan in New York.

The department refused to identify two firms it hired - dubbed "Investigation Consultant/Expert No. 1" and "No. 2" in court records - but will later disclose their names when they testify in court, Koken said.

The disclosure also lists payments to accountants, led by Ernst & Young's \$1.2 million; information technology vendors, led by Reliance's own RCG Information Tech unit, which received \$616,000; and premium collection fees paid to unnamed "various vendors," totaling \$1.9 million.

Koken said Reliance needs lots of lawyers because, as a nationwide property and workers' comp insurer specializing in complex and often unique insurance accounts, it is defending against 15,000 lawsuits.

The state is also trying to persuade a group of large insurers, including John Hancock Life Insurance Co. and Lloyd's of London, to pay Reliance money they say they don't owe. The state may sue, Koken said.

Among other duties, Blank Rome is handling Koken's lawsuits against former Reliance chairman Saul P. Steinberg and his lawyers, accountants, executives and directors, whom Koken accused of either looting the company or failing to stop Steinberg from doing so. Steinberg and the others deny wrongdoing and say the Pennsylvania Insurance Department knew and approved of their business practices.

So many unexpected claims are pouring into Reliance that the insurance department's liquidators, who earlier cut the staff from 1,255 to 435, now plan to hire and train more than 150 additional claims specialists and other professionals to handle the workload.

Koken's agency took control of Reliance in October 2001, citing a more than \$1 billion gap between the value of its investment assets and the tens of thousands of claims it expected to pay to big corporations, injured workers, and other Reliance policyholders.

In a separate report filed in Commonwealth Court in June, the state estimated the deficit at \$2.8 billion, and warned that it could rise even more. But Koken said such numbers are still just guesswork.

When an insurer can't pay its claims, funds are provided by a network of state guarantee associations. Those associations are funded by solvent insurers, who typically pass the costs on to policyholders - and sometimes, as in Pennsylvania, receive state tax breaks for the payments, passing the cost to other taxpayers.

Pennsylvania insurers are already being assessed the legal maximum 2 percent annual surcharge on premiums to help pay losses from Reliance and other failed Pennsylvania insurers. Those surcharges will be paid for many years to come.

In contrast to federal bankruptcy cases - in which detailed contractor-expense reports, accounting for every employee's hours and payment rates, are filed regularly by each private firm seeking payment - the Insurance Department seldom discloses the names of or payments to hundreds of private firms it is paying to run 23 failed insurers.

Department officials said last month that it would cost hundreds of thousands of dollars to produce such a list for all the failed insurers it now runs.

The Reliance list became public last week only because the judge ordered the state to produce it. Colins did not explain his decision, and Koken said she didn't know why the judge wanted the information.

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View this article online: <http://www.insurancejournal.com/magazines/features/2001/07/23/18590.htm>

## Reliance Insurance 1817-2001 — R.I.P'

Reliance Group Holdings (RGH), the parent company of Reliance Insurance Company (RIC), one of America's oldest insurers which traces its roots back to 1817, filed for bankruptcy protection in the Southern District of New York on June 12. The petition listed total assets of \$12.598 billion and total liabilities of \$12.877 billion.

The parent's fate is now in the hands of the Trustee in Bankruptcy, but the 184-year-old Pennsylvania-based company's future will be decided by Diane Koken, state insurance commissioner.

Financier Saul Steinberg and his family controlled RGH, which owns 100 percent of Reliance Financial Services Corp. (RFS). It in turn owns RIC and nine other insurance subsidiaries. All of them are included in the bankruptcy proceedings, but only RIC and its related companies are being administered by the Pennsylvania Insurance Department (PID), which obtained an "order of rehabilitation" for RIC from the Commonwealth Court on May 29. RIC isn't yet in liquidation. "We're mainly interested in protecting the assets so that policyholders can be protected as well," said Rosanne Placey, PID press secretary.

Steinberg resigned in May, but he's not forgotten. He acquired a controlling stake in RGH in 1968 through a leveraged buyout. For years the high profile corporate raider used it as the base of a financial empire that anchored his takeover attempts of Chemical Bank in 1969, and his raids on Walt Disney, Quaker Oats and other companies in the 1980s.

Unfortunately the indiscriminate issuance of debt instruments, and the mounting losses at RIC finally caught up with him. The first signs of real trouble emerged with the collapse of the Unicover pool in 1999. Reliance was heavily involved in issuing workers' compensation policies at extremely low rates, and when the pool was overwhelmed by huge losses RIC's reserves began to vanish.

As recently as 1998 the company was still profitable, earning \$326 million on gross revenues of \$3.4 billion. Steinberg's aggressive acquisition strategy and quest for ever higher dividend payments, however, left RIC vulnerable in the cutthroat competition for market share, which led to a deterioration in underwriting standards that eventually resulted in the unsustainable losses.

As it became more apparent that RGH and its subsidiaries were in deep financial trouble, Steinberg sought to sell the company. Leucadia National offered to buy it in May 2000 for \$295 million in shares of stock, but withdrew the offer in July, as the financial condition worsened. A similar agreement to sell RIC's European operations to London's Candover Investments fell apart in September. A.M. Best began to downgrade RIC's claims paying ability from "A-" in June to "C" by August. It effectively stopped writing new or renewal business in all its lines last June, and began looking for ways to downsize.

As a result insurance regulators sought more information and assurances that the RIC entities could pay claims. In August RIC entered into an agreement with the PID, agreeing not to pay dividends or make other disbursements without its approval. After having twice strengthened its claims reserves in 2000, a September filing showed a statutory surplus of \$624 million.

This surplus began to evaporate, however, as claims increased, due in part to potential claimants accelerating their demands, as RIC's shaky financial condition became more widely known. At the end of January 2001 RIC agreed to regulatory supervision by the PID. A.M. Best downgraded its claims paying ability to "E" to reflect this.

The bankruptcy filing revealed that RGH was unable to complete a full audit of its accounts for 2000, but it estimated that underwriting losses at RIC were between \$1.9 and \$2.2 billion, with an additional loss estimate for the first quarter of 2001 between \$110 and \$150 million. While investment income and the sale of various properties may mitigate the net exposure, bankruptcy reorganization became mandatory. RGH wrote off its entire investment in RIC last month, as it had indicated it planned to do, and sat down with its creditors.

The May 29 court order had already put RIC under the full control of the PID, and one of Commissioner Koken's first acts was to file suit against RGH and RFS in an attempt to recover an estimated \$95 million allegedly wrongly transferred to them from RIC. She also sought an order blocking any cash disbursements from RGH, alleging that the money should go to RIC. RGH has denied the claims.

Most of RGH's major creditors approved the reorganization plan set out in the bankruptcy filing, except legendary financier Carl Icahn, who controls an estimated \$69 million in RGH debt through his investment company High River LP. Under the plan the banks, which are owed around \$261 million in secured debt by RFS, would receive new notes totaling around \$238 million and 86 percent of the voting rights for the operation. It would in theory continue to be RIC's parent company.

RGH also owes interest and principle on about \$463 million worth of bonds to various creditors, including Icahn. They would receive new notes, payable over 10 years, and would take over the company. All other shares would be cancelled. Icahn has previously indicated that he would oppose any restructuring plan that did not protect bondholders, and has yet to comment, but he isn't expected to go along with it.

The PID has engaged independent consultants to review RIC's financial condition. "In the coming weeks and months, we will use that review to develop the factual information we need to make a reasoned determination of whether to proceed with rehabilitation, or to move to liquidation," Koken stated. Placey indicated that the Department at first expected this would take around six months, "now we're sure it will take at least six months," she affirmed. The PID has so far taken no position on the bankruptcy reorganization.

Its main concern is to assure that there will be sufficient resources to satisfy the claims of policyholders, if so RIC might actually be rehabilitated, and survive in a truncated form. If not, then liquidation appears to be the only alternative, as funds would be required from other insurers who are pledged to participate in paying the claims only of insolvent companies to Pennsylvania residents or property holders through guarantee associations, established along insurance lines. Their burden is proportional to the amount of insurance each association member writes in Pennsylvania, so that large insurers like Chubb and AIG would pay more than smaller companies.

Reliance is one of three middle range commercial insurance companies currently in bankruptcy proceedings. Australia's HIH collapsed last March with an estimated \$1 to \$2 billion in debts. The U.K.'s Independent Insurance, after failing to raise £180 million (\$252 million) in capital refinancing, closed its books to new business, and went into liquidation on June 18, when irregularities were uncovered in its claims accounts.

There are remarkable similarities. Flamboyant insurance industry mavericks – RGH's Steinberg, Independent's Michael Bright and HIH's Ray Williams – headed all three. The latter two founded their companies, and while RIC is a lot older than Steinberg, he radically changed the insurer's business operations after he acquired it in 1968 – the same year Williams founded HIH.

All three ran into trouble from over-expansion and inadequate underwriting standards, which set premiums too low. The mounting losses strained their capacity until it broke. RCI and HIH were particularly vulnerable to the low premiums, and increasingly higher claims, of workers' compensation coverage, and both wrote a lot of business in California. It was RIC's biggest market, accounting for 14 percent of premium sales. All three gained market share at the expense of larger, more established carriers, but the price they paid was ultimately too high.

#### **Demise of Reliance Likely to Have a Big Impact on Texas**

The failure of Philadelphia-based Reliance Insurance Co. could negatively affect the pocketbooks of Texas taxpayers to the tune of \$750 million, according to the *Dallas Morning News*. That figure would likely make Texas' share of the cleanup of Reliance's mess the largest in the nation.

Reliance and several company subsidiaries sold a variety of insurance lines in Texas, including workers' compensation, auto insurance and commercial liability. If Reliance is not revived, other insurers operating in Texas may be required to step in and cover the failed company's obligations. They would do so through involvement in insurance guaranty associations, which are industry-backed safety nets for consumers. The guaranty associations would help pay outstanding claims and in Texas, like most other states, any guaranty money used for the bailout can be deducted from the insurers' tax obligations to the state.

The Morning News reported that Steve Durish, special projects director for the Texas Property & Casualty Insurance Guaranty Association, came up with the \$750 million estimate and acknowledged that Texas Department of Insurance officials asserted the figure may be closer to \$413 million.

Companies through which Reliance conducted business in Texas include: Reliance Insurance Co.; Reliance National Indemnity Co.; United Pacific Insurance Co.; Reliance Insurance Co. of Illinois; Reliance Lloyds; Reliance National Insurance Co. and Reliance Surety Co.

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### NEWS & UPDATES

[Joint Submission of NOLHGA & NCIGF Regarding Application of FSB Key Attributes to Insurers](#)

#### NCIGF Releases Winter **Insolvency Trends 2014 White Paper**

National Conference of Insurance Guaranty Funds (NCIGF) has released the winter issue of its biannual *Insolvency Trends 2014* white paper.

Authored by the NCIGF legal and public policy staff, *Insolvency Trends 2014* provides a complete update on recent developments in insolvency law and practice, and a look at what is on the horizon in the year ahead.

The white paper can be downloaded by [clicking here](#).

## FREQUENTLY ASKED QUESTIONS ABOUT GUARANTY FUNDS

### What is a guaranty fund?

Property and casualty guaranty funds are part of a non-profit, state-based, statutorily-created system that pays outstanding claims of insolvent insurance companies. By paying these claims, guaranty funds, sometimes called guaranty associations, protect policyholders and claimants.

Guaranty funds are active in every state, the District of Columbia, Puerto Rico and the Virgin Islands. State laws require that all licensed property and casualty insurance companies belong to the guaranty funds in every state where they are licensed to do business.

Most guaranty funds were created in the 1960s as state insurance commissioners and lawmakers responded to an increase in insolvencies of insurers writing policies in the high-risk auto insurance business.

A guaranty fund system also exists for the life, health and annuity insurance industry, but it operates independently from the property and casualty system. This information concerns only the property casualty guaranty funds.

### How prevalent are insurance insolvencies?

The potential failure of insurance companies, like the potential failure of all businesses, is an unfortunate, but inevitable, part of doing business in a free-market system.

Since inception of the guaranty funds, there have been about 550 insolvencies. The system has paid out about \$27 billion.

### Why have the amounts the guaranty funds paid gone up so much in the past few years?

When they were created 40 years ago, insurance companies tended to write simple personal lines policies in single states. This resulted in generally small insolvencies that were comparatively simpler and easier to administer.

The 1990s brought a growing number of large insolvencies among insurers writing large amounts of commercial insurance. Some recent insolvencies have involved complex multi-state commercial insurance products, such as large deductible policies. In addition, many of these insolvencies, such as Reliance Insurance Company, Fremont Indemnity Company and Legion Insurance Company, were larger than any the system had before absorbed.

These factors have significantly changed the landscape for guaranty funds - and considerably raised the costs of covering claims following an insolvency.

### You say the guaranty funds pay these claims. Where do they get the money to pay them?

Guaranty funds largely are funded by industry assessments, which are usually collected following insolvencies. These assessments raise funds to pay claims and administrative and other costs related to the guaranty funds claim paying activities.

Assessments typically are capped at two percent of a company's net direct premium written in similar lines of business in the guaranty association state the prior year, although in exceptional circumstances amounts can be increased by state legislatures. The other source of funding is recoveries from receivers of the insolvent insurance companies. Assessment costs are recouped by various means.

### How are these assessments computed?

With the exception of New York (which uses a pre-insolvency system), the states' guaranty funds assess after an insolvency occurs. Assessments are computed and billed based on the immediate needs of the guaranty association that has claims it needs to pay. Claim files come in from the insolvent insurance company; the adjusters review them, and set appropriate reserves on those files. (Reserves are the projected ultimate liability under terms of a given policy.)

In most states the assessment cap is two percent of net direct-written premium or less. Guaranty funds can not assess an insurance company over the statutorily set cap on assessments. In exceptional circumstances, for instance when a natural catastrophe causes several large insolvencies and creates a need for additional assessments, state legislatures may enact emergency legislation that grants additional assessments or permits guaranty funds to borrow money, such as through a bond issue, or grant assessments to repay borrowed funds.

### What happens when a company is liquidated?

The state insurance commissioner or a representative is appointed receiver and begins the process of collecting assets and determining the company's outstanding liabilities. When this process is concluded a final distribution is made to the company's creditors. This is almost always less than 100 percent of

what is owed; usually this final distribution is made a number of years after the company is ordered liquidated.

In most cases, an estate will not yield sufficient money to pay claims in full; and most are not able to pay claims in a timely manner. For this reason, one or more guaranty funds step in (depending on the number of states in which the failed company wrote business) to cover claims. The estate's creditors not covered by the guaranty funds (among them large corporate entities that opt to buy less expensive alternative risk products) usually receive only partial payment on their claims.

#### **What is the role of the guaranty funds?**

Guaranty funds ease the burden on policyholders and claimants of the insolvent insurer by immediately stepping in to assume responsibility for most policy claims following liquidation. The coverage guaranty funds provide is fixed by the policy or state law; they do not offer a "replacement policy."

By virtue of the authority given to the guaranty funds by state law, they are able to provide two important benefits - prompt payment of covered claims and payment of the full value of covered claims up to the limits set by the policy or state law.

#### **Are there limits on the amount that guaranty funds will pay?**

Yes. Most guaranty funds limit the amount they pay to the amount of coverage provided by the policy or \$300,000, whichever is less. These coverage "caps" are fixed by state law; the guaranty funds play no role in setting coverage caps. Most guaranty funds pay 100 percent of their state's statutorily defined workers' compensation benefits.

#### **How long does a policyholder have to wait to receive a payment from the guaranty fund?**

It varies, but claim payments usually begin as soon as possible once a company is ordered liquidated. The process is speeded by the guaranty funds' "early access" to estate assets provided by state law. It is not uncommon for claims to be paid within 60-90 days after the order of liquidation.

Guaranty funds, coordinating with the receivers of the liquidating companies, work hard to avoid any interruption in periodic benefits that are being paid to claimants, such as workers' compensation loss-of-wages payments.

#### **Does a guaranty fund pay all claims of an insolvent insurer?**

No. The state insurance guaranty funds are designed as a safety net to pay certain claims arising out of policies issued by licensed insurance companies. They do not pay non-policy claims or claims of self-insured groups, or other entities that are exempt from participation in the guaranty fund system.

In addition, some lines of business are excluded from guaranty fund coverage, such as surety bonds, warranty coverage, credit insurance. (Life and health claims and annuity claims are covered by the life and health guaranty funds, not the property and casualty system.)

Guaranty fund coverage is limited to licensed insurers (the members of the guaranty funds that, in turn, pay insolvency-related assessments.) When a licensed insurance company becomes insolvent, the guaranty funds pay eligible claims; but a company does not have guaranty fund coverage if it is writing non-admitted or unlicensed products, such as surplus lines or is a self-insurer covered in the non-admitted market.

These limits on guaranty fund coverage are necessary to balance the need to provide a safety net to those who would be most harmed by the insolvency of their insurance company and keep the burden of providing the safety net at an acceptable level.

#### **Do guaranty funds provide new policies to policyholders whose company has failed?**

No. Guaranty funds do not sell insurance. The affected policyholder must purchase new coverage through an insurance company. Guaranty funds cover claims; they do not provide replacement policies.

#### **How many guaranty funds are there?**

Guaranty funds are active in every state, the District of Columbia, Puerto Rico and the Virgin Islands. State laws require that all licensed property and casualty insurance companies belong to the guaranty funds in every state where they are licensed to do business.

Every state has a guaranty fund for property and casualty insurance claims covering things like auto and homeowners insurance policies. Several states also have separate funds for workers' compensation claims.

In addition, every state also has a separate entity set up to handle claims related to life, health and annuity insurance companies that become insolvent.

#### **Why are there guaranty funds in every state?**

Unlike other industries, such as banking, insurance has long been regulated by the states. On the property and casualty side of the insurance business, the state tort and workers' compensation laws and benefit amounts vary from state to state. For this reason, guaranty funds exist for every state.

#### **A Florida insurer fails, let's say, and the guaranty funds of other states get involved. Why is that? Isn't this a Florida issue?**

Generally, state statute assigns guaranty funds the responsibility of paying claims for insureds residing in their states. The exception to this is workers' compensation coverage, for which covered claims are administered in the state of residence of the workers' compensation claimant.

Insurance companies write business across many state lines. For this reason, when a company that writes workers' compensation claims fails, these claims, which by law are paid in the state of residence of the claimant, triggers involvement of guaranty funds of many states.

That's why the failure of an insurance company domiciled in Florida that writes business all over the

country, for instance, may trigger guaranty fund involvement in any state where a claimant resides and coverage premiums (and any post-insolvency-related assessments) are collected.

**Who regulates or oversees guaranty funds?**

Typically, state guaranty funds are administered by an industry board that is elected by the guaranty fund members (that is, all companies writing licensed business in that state). There is oversight authority by a state's commissioner of insurance, who reviews the fund's plan of operation, and may also audit a guaranty fund. In most states appointment to the guaranty fund board is subject to the approval of the commissioner of insurance.

**Are all of the state guaranty funds the same?**

While many of the funds are based on a model set forth by the National Association of Insurance Commissioners (NAIC), there are differences in statutes that govern the funds and their operation from state to state, including the amount of coverage provided by the fund.

**Do insurance companies pass the cost of insolvencies along to their customers?**

Ultimately, yes. The cost of this consumer protection system, which was established by the states, is passed on to the public either in the form of increases in the cost of insurance policies, surcharges on policies or tax offsets. For this reason, it is important to have a well managed, financially sound guaranty fund system to keep the costs as low as possible.

**What role does the National Conference of Insurance Guaranty Funds (NCIGF) play in the guaranty fund system?**

The Indianapolis-based NCIGF is a non-profit association incorporated in 1989 to provide national assistance and support to the property and casualty guaranty funds located in each of the 50 states and the District of Columbia.

The NCIGF monitors and responds to issues that might impact state guaranty funds. The group serves as a trusted expert, informing trade and other organizations as they develop model legislation.

**Where can I find a list of the various guaranty funds?**

[You'll find a list here](#)

# **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)<sup>1</sup> or a similar law. In

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

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.<sup>2</sup>

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,<sup>3</sup> 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.

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<sup>2</sup>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...."

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

## 2. Insurance Code Provisions

### a. Insurance Holding Company Act<sup>4</sup>

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 control<sup>5</sup> of a domestic insurer, the transaction must be pre-approved by the regulatory authority in accordance with certain stated criteria.<sup>6</sup>

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.<sup>7</sup> 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 inter-company 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.<sup>8</sup>

### 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.<sup>9</sup> The regulatory authority has the discretion within statutory confines

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

<sup>5</sup> Control is presumed to exist with the power to vote 10% or more of the voting securities of an insurer.

<sup>6</sup>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).

<sup>7</sup>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.

<sup>8</sup>*Id.* at Section 5B.

<sup>9</sup>The Model Law on Examinations adopted by the NAIC has been enacted in 41 states, see Section 3A.

to determine the scheduling, nature and scope of an examination. The regulatory authority is also granted examination powers under the Holding Company Act.<sup>10</sup>

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.<sup>11</sup> Given the extraordinary nature and complexity of LBRs, it is essential that the regulatory 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.<sup>12</sup> 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,<sup>13</sup> demutualization, or redomestication<sup>14</sup> 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

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<sup>10</sup>The NAIC Insurance Holding Company System Regulatory Act at Section 6A.

<sup>11</sup>The NAIC Model Law on Examination at Section 4D.

<sup>12</sup>*Id.* at Section 5F (Six of the 41 states that have enacted the Model Law have not adopted the section on confidentiality).

<sup>13</sup>See N.J. Stat. Ann. § 17:33 8-30 (1994).

<sup>14</sup>The Redomestication Model Bill adopted by the NAIC is enacted in 37 states.

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.<sup>15</sup> The regulatory authority should consider whether interested parties should be allowed to present 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.*, non-insurance) 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

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<sup>15</sup> 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).

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.<sup>16</sup> 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,<sup>17</sup> 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.*,<sup>18</sup> 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.*,<sup>19</sup> 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.*,<sup>20</sup> 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*,<sup>21</sup> 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.*,<sup>22</sup> 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

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<sup>16</sup>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...."

<sup>17</sup>NAIC Assumption Reinsurance Model Act § 1 (1993).

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

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

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

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

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 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.

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

## **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.<sup>23</sup>

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

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<sup>23</sup>It might be questioned whether such exclusions are appropriate if policies are transferred to a restructured entity without the insured's consent.

### **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 on-going 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 on-going entity.

## **VII. CONCLUSIONS AND RECOMMENDATIONS**

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

A. 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.

B. 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.<sup>24</sup>

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<sup>24</sup>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.

C. 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.

D. 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.

E. 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.<sup>25</sup>

F. 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.

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

H. 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.

I. 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.

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<sup>25</sup>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.

J. 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.

K. 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.

L. 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.

**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 inter-affiliate 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.

## 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 write-ins.

## 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.

**ON-GOING REGULATORY OVERSIGHT**

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

1. Reporting
  - a. Require periodic operating reports.
  - b. Require financial statements and management reports more frequently than required by statute.
  - c. Require periodic reports on certain losses, including payments.
  - d. Require financial projections annually.
  - e. Require reports on actual results compared to plans.
2. Balance Sheet Discipline
  - a. Require recurring actuarial reviews of reserves. This requirement could include departmental approval of the actuarial firm selected and the scope of the review.
  - b. Require periodic independent reviews of reinsurance recoverables.
  - c. Establish guidelines for future investments of inactive operations.
  - d. Limit discounting of reserves as allowed by law, so long as investment earnings continue to support the rate of discount.
3. Specific Transactions
  - a. Prohibit dividends by inactive operations without prior approval.
  - b. Prohibit dividends by active operations for a set period of time.
  - c. 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.
  - d. Require intercompany balances with the inactive operations be settled within 90 days of each quarter.
  - e. Require prior approval of affiliated transactions between inactive and active operations.
  - f. Require prior approval for inactive operations to establish security deposits with any other jurisdictions except to the extent required by law.

4. Communications

- a. Require notice to all known policyholders and claimants affected by the transaction.
- b. Require a written response to any inquiry regarding the LBR.

5. General Monitoring

- a. Require on-site monitoring facilities.
- b. Require right to notice of and right to attend all Board of Directors meetings.

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