CHAPTER 6 – GUARANTY FUNDS / ASSOCIATIONS

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I. INTRODUCTION

This chapter provides an overview of the operation of state Property and Casualty Insurance Guaranty Funds and the Life and Health Insurance Guaranty Associations and their relationship to a receivership. All 50 states, Puerto Rico, the United States Virgin Islands (property/casualty only) and the District of Columbia have a guaranty mechanism[1] in place for the payment of covered claims arising from the insolvency of insurers licensed in their state. In the case of life/health insurance, the guaranty mechanism also provides for the continuation of eligible contracts that would otherwise terminate because of the insolvency. Before the creation of guaranty association systems, policyholders might have waited years for payment of their policy claims and then receive only a small percentage of what was due under the policy or contract. Guaranty associations, subject to statutory limitations, alleviate these problems. Section II of this chapter will discuss in greater detail the operation of property/casualty guaranty funds. Section III is devoted entirely to life/health guaranty associations.

Insurance guaranty mechanisms obtain the funds necessary to pay claims from remaining estate assets, in some cases from statutory deposits collected by states, and by assessing member insurers. Assessments are limited by state law to a certain percentage of the members' written premium. In the case of property casualty guaranty funds, the members may be permitted by statute to recoup the assessments through premium increases, premium tax offsets or policy surcharges. As for the life/health guaranty associations, recoupment of assessments through premium increases or policy surcharges is typically not feasible because many life/health contracts are issued on a level premium basis.[2] The burden of the assessments on solvent insurers is mitigated in the majority of states, by statutes that allow insurers to offset a portion of the insurer's assessments, over a period of years, against the insurer's premium tax liability. Section 13 of the NAIC's Life and Health Insurance Guaranty Association Model Act (the "Life Model Act"), some version of which has been adopted in most states, permits offsets against premium, franchise or income taxes over a five year period for amounts paid by life/health insurers to meet their assessment obligations. In addition, Section 9G of the Life Model Act allows life/health insurers to consider the amount reasonably necessary to meet their assessment obligations in the determination of the premiums they charge.

Guaranty associations (both life and health and property and casualty) in most states are overseen by a board of directors, largely composed of representatives of member insurers. Some guaranty association boards also include public members. A minority of guaranty associations also have representatives of state departments of insurance or legislative representatives sitting on the guaranty association's board. The guaranty associations typically employ a Manager, Administrator or Executive Director to oversee daily operations.

Before a claim against an insolvent insurer can be considered a "covered claim" and eligible for guaranty association coverage, the guaranty association must be "triggered" with respect to the particular insolvency. Guaranty associations generally are triggered by the issuance of a court order of liquidation with a finding of insolvency. Some guaranty associations may be triggered under other circumstances. In the event of a multi-state insolvency, it is important that the receiver communicate and coordinate with NOLHGA or NCIGF, as appropriate, before preparing an order of rehabilitation or liquidation. This will ensure that guaranty associations are triggered as intended, and are not triggered prematurely or inadvertently. NOLHGA and NCIGF have the ability to help with coordination and communication with affected guaranty associations.

The guaranty associations and the receiver both have statutory duties to protect policyholders of the insolvent insurer. The duties of the guaranty associations to protect policyholders are limited to covered policies or claims, as set forth in state guaranty association statutes. The guaranty associations can be very helpful, if not critical, to the receivership process. In a life/health insolvency, for example, the guaranty associations may, in some cases, be

[1] The term "guaranty fund" typically refers to a property and casualty insurance guaranty fund. The term "guaranty association" typically refers to a life and health insurance guaranty association. However, in various places throughout this handbook, the terms "guaranty fund" and "guaranty association" are used synonymously, particularly when referring to both types of guaranty mechanisms. Efforts have been made in this chapter to specify property and casualty or life and health when referring specifically to one or the other type of guaranty mechanism or insurer insolvency proceeding.

[2] A few states do permit policy surcharges to recoup assessments for health insurance insolvencies.

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able to arrange for and facilitate transfer of covered obligations to a solvent insurer upon entry of an order for liquidation with a finding of insolvency, provided there has been sufficient pre-liquidation planning and coordination.[3] Maintaining open communication and cooperation between the guaranty associations and the receiver (subject to appropriate confidentiality agreements) during pre-receivership planning and throughout the course of the proceedings will enable both the guaranty associations and the receiver to function more efficiently for the benefit of those whose interests they are obligated to serve.

II. PROPERTY AND CASUALTY GUARANTY FUNDS

A. Introduction

Most property/casualty guaranty fund enabling acts are based on the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act (Model Act). Although the Model Act is useful for a better understanding of how guaranty funds operate, the law in each state should be consulted, as most states have modified provisions of the Model Act.

The property and casualty guaranty funds have formed an organization known as the National Conference of Insurance Guaranty Funds (NCIGF). Its address is:

National Conference of Insurance Guaranty Funds
300 North Meridian Street
Suite 1020
Indianapolis, IN 46204
Phone: (317) 464-8199
Facsimile: (317) 464-8180
Web site: http://www.ncigf.org

NCIGF can be a useful source of information to receivers when a new property/casualty insolvency occurs. It can help disseminate information to triggered guaranty funds, schedule initial meetings between the receiver and guaranty funds, and establish a coordinating committee to work with the receiver to resolve issues that may arise during the receivership. This organization can also provide names and addresses of guaranty fund contacts and assistance in establishing data reporting to and from the guaranty funds. The Secure Uniform Data Standards (SUDS) is managed by the NCIGF and has become the standard mechanism to transfer data in a secure manner. (See supra for more information on UDS and SUDS.)

The NCIGF Web site (See at http://www.ncigf.org) has tables that summarize the key provisions contained in each state's property/casualty guaranty fund enabling act, including lines of insurance covered, whether coverage is provided for unearned premium, whether the guaranty fund has net worth limitations or a claims bar date and the per claim limit and deductible that applies to each claim. The tables are intended to provide a general summary of the guaranty fund laws. The applicable state statute should be reviewed to determine coverage for a specific claim.

B. Triggering Fund Liability See Chapter 1(II) (G) (4)

1. General Statutory Activation Requirements

Previously, the Model Act defined insolvent insurer as "(a) an insurer authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and (b) determined to be insolvent by a court of competent jurisdiction." Due to a variety of triggering related issues that could not be readily resolved by such a general, simplistic definition, amendments to the Model Act expanded the definition of "insolvent insurer" to read as follows:

[3] In some instances, it is possible to arrange for the transfer to close as of the effective date of the liquidation order.

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> "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

This amended language makes it clear that guaranty fund resources are only to be used in situations where any doubt pertaining to the insurer's insolvent status has been fully considered and resolved by a judicial proceeding. It must be noted, however, that there are a number of variations found within enacted guaranty fund statutes around the country. While many jurisdictions have either adopted or moved toward the current Model Act triggering test, there are numerous others that fall at various points along the spectrum between the current version and the original 1969 version. It is imperative that the statutes be carefully reviewed in each jurisdiction where activation is anticipated.

2. Regulatory Status of Company

In addition to being declared insolvent, an insurer must have been "licensed," either at the time the policy was issued or when the loss occurred, to be eligible for guaranty fund coverage.[4]

New Jersey has a separate statutory mechanism for the payment of covered claims arising in connection with coverages issued by eligible surplus lines insurers. This mechanism exists in addition to the guaranty fund for insolvent licensed property and casualty insurers. Even in New Jersey, however, there is no statutory protection for ineligible surplus lines insurers.

The initial triggering inquiry must not be limited to whether the insurer in question was licensed at the time of the finding of insolvency.[5] Many, probably most, guaranty fund acts contain language that is sufficiently broad to include claims against an insurer whose license has been surrendered or revoked prior to the declaration of insolvency, so long as the insurer was licensed at the time the policy was issued or when the insured event occurred. When this situation arises, the receiver should contact the relevant guaranty fund as it will be most familiar with its enabling statute and local court decisions interpreting the statute.

3. Court of Competent Jurisdiction

The requirement of a finding of insolvency can only be satisfied by a judicial declaration. The rationale for this requirement is that activation triggers numerous consequences, many of which are irreversible once put in motion. Judicial review is perceived to be an effective safeguard against arbitrariness and ambiguity.

The current version of the Model Act gives exclusive competent status to the court that is within the insurer's state of domicile. Although it is theoretically possible for a court in another jurisdiction to be viewed as competent for the purpose of triggering guaranty fund obligations, the Model Act's current version does not confer jurisdiction on these courts.

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[4] In this context, "Licensed" means holding a Certificate of Authority, which authorizes an insurer to do business in a state. Such insurers are also referred to as "admitted insurers." Insurers doing business on a surplus lines or other non-admitted basis are not authorized.

[5] At the time of publication of this Handbook, the NAIC is considering "restructuring mechanisms" permitted under the laws of some states (i.e., insurance business transfers and corporate divisions). Whether claims of an assuming or resulting insurer in one of these transactions would be considered "covered claims" eligible for guaranty fund coverage in the event of its liquidation is a question of state law. NCIGF is working with the NAIC to address this issue and provide clarity going forward.

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4. Liquidation Order

Were a court of competent jurisdiction to issue a declaration of insolvency that is later modified or reversed on appeal, after guaranty funds have been triggered and claim payments have been initiated, problems can arise. To remedy such consequent dilemmas, both the Model Act and many state legislatures have modified the triggering test, requiring that the judicial declaration of insolvency be final. In other words, activation of guaranty funds in such jurisdictions can be deferred, and perhaps avoided, depending upon the pursuit or exhaustion of stays or appellate remedies.

Nonetheless, although the Model Act drafters clearly contemplated that activation of the guaranty funds would occur only where liquidation had been ordered, the wording of the initial triggering clause left open the possibility that companies placed in rehabilitation could trigger guaranty fund benefits. The more current view, which has also been incorporated in the Model Act, is to require not only a final determination of insolvency, but rather an actual order of liquidation with a finding of insolvency. This limiting language precludes the use of guaranty fund resources as bail-out funds to be used in an attempt to rehabilitate—rather than liquidate—the company. There are a few guaranty funds, however, which still trigger with a finding of insolvency without an order of liquidation. Because of the complexity and variation from state to state of the trigger, it is important to seek legal assistance and to work with the NCIGF when drafting the orders of liquidation or rehabilitation to ensure the appropriate activation of the guaranty funds. (See the Laws and Laws Summaries under Resources on the NCIGF Web site at http://www.ncigf.org).

C. Scope of Coverage

Guaranty funds that have been properly triggered by a liquidation order are obligated to pay "covered claims," that is, claims that are defined as covered under the applicable guaranty fund act(s). Generally speaking, unpaid loss and unearned premium claims under specified property/casualty lines of business written by an insolvent insurer are covered claims, but only to the extent of the lesser of either (1) the applicable policy limits; or (2) the statutory guaranty fund limits on covered claim payments. Residency is usually determined at the time of the insured event. In addition, in order for claims to be covered, the various acts typically require that: the claim be incurred either prior to the entry of the liquidation order or within 30 days of the entry of the order, or before the policy expires or the insured replaces the policy if either of the latter occurs within 30 days of the entry of the liquidation order. Claims of an affiliate of the insolvent insurer typically are not covered, even if such claims otherwise meet the definition of covered claims.

Property/casualty lines of business usually not covered by a guaranty fund include: mortgage guaranty; financial guaranty; fidelity and surety; credit insurance; insurance of warranties or service contracts; title insurance; ocean marine insurance; and any insurance provided by or guaranteed by government. Only direct insurance (not reinsurance) is covered. The receiver should consult with the affected guaranty fund(s) to determine which lines are covered and which lines are excluded.

Usually the guaranty fund of the state of the insured's residence has primary responsibility for a claim, and the guaranty fund of the state of the claimant's residence has secondary responsibility. One exception to this rule involves workers' compensation claims. The guaranty fund of the state of residence of the claimant has primary responsibility for these claims. With respect to claims involving property with a permanent location, the guaranty fund of the state where the property is located has primary responsibility. Guaranty funds are usually entitled to take credit for amounts paid by other guaranty funds on the same claim.

Some guaranty fund statutes provide for a per claim deductible. A majority of guaranty fund statutes provide that coverage is limited to $300,000 per covered claim, except for workers' compensation claims, which are covered to the extent of benefits provided by state law.

Most guaranty fund statutes require a claimant to first exhaust all other sources of recovery, including other insurance. The guaranty fund's obligation is reduced by any amounts recovered from other sources.

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The majority of the property casualty guaranty funds' enabling acts contain "net worth" limitations. These net worth limitations either exclude high net worth insureds (and in a few cases, third party claimants) from coverage in the first instance or permit the guaranty fund to recover from the high net worth insured amounts paid on their behalf.

Most of the guaranty funds' enabling acts also require the claim to be timely filed either with the liquidator or the guaranty fund. Bar date restrictions vary from state to state and specific state law should be reviewed on this matter. See Section D (3) for more information regarding bar dates.

D. Notice and Proof of Claims

1. Notice

a. Notice to Claimants

Most state receivership statutes give the receiver the primary responsibility for issuing notice to all persons known or reasonably expected to have claims against the insolvent insurer. The guaranty funds have a secondary responsibility in this regard under the Model Act. Because of the extensive interrelationship between the receiver and the guaranty funds regarding claims resolution, the receiver should coordinate the drafting of the receivership claims notice with the guaranty funds so that accurate information concerning the following is included:

- Brief general explanation of the guaranty fund system: the policyholder protection it offers, its anticipated role in the receivership and any delay that will be necessary while the receiver assembles and forwards the files to the guaranty funds.

- Receivership bar date and its legal significance: the fact that many guaranty funds will have no obligation regarding claims filed after the receivership bar date, recommendation to check with the appropriate guaranty fund immediately in order to ascertain whether the guaranty fund has a separate bar date in addition to the receivership bar date.

- Receivership proof of claim form: information, if available, about whether a separate guaranty fund proof of claim form may be required by certain participating guaranty funds; information concerning the address to which proof of claim forms must be sent.

- Clarification that questions regarding the claims determination process should be directed to the appropriate guaranty fund; include here any comments deemed necessary regarding the determination process for claims which are in excess of the statutory maximum coverage of the guaranty funds.

Insolvencies involving long-tail business present notice challenges to liquidators. Company records may not exist to provide addresses for occurrence based policyholders that were in force from 5 to 25 years ago. Public policy considerations confront the receiver.

A supplemental notice may also be used in situations where additional relevant information becomes available after the first notice has been sent.

b. Notice to the Guaranty Funds

The receiver must notify the guaranty funds that may become obligated as a result of the receivership as soon as possible. Even if such notice is not a statutory requirement, the receiver should notify all interested guaranty funds as a matter of courtesy. That notice should include a copy of the claimants' notice issued by the receiver, along with copies of the receivership order and any domiciliary injunction which has been entered. The regulator, receiver, and guaranty funds

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should coordinate and share information well before the liquidation order is rendered. See Section E for more information in this regard.

2. Proof of Claim

a. Claims Determination Framework

Nowhere is the interrelationship between the receiver and the guaranty funds more prominent than in the area of claims determination. This relationship is defined by Section 11(3) of the Model Act that provides that the receiver shall be bound by settlements of covered claims by the guaranty funds. However, Section 703 A of the Insurer Receivership Model Act (IRMA) and many state receivership statutes contain provisions that prohibit the receiver from accepting any claim for an amount in excess of or contrary to the terms of the policy.

There has been uncertainty between guaranty funds and receivers as to who determines whether a claim is covered under the policy terms. The receiver and the guaranty funds should discuss questionable coverage issues as they arise in order to prevent subsequent problems.

b. Forms of Proof

The information to be contained in the proof of claim form is usually established under the receivership statutes in the insolvent insurer's state of domicile. However, some guaranty funds require that each claimant submits a separate proof of claim form, the contents of which will be dictated by the law and practice of the guaranty fund's state. This is because statutes creating the guaranty funds contain a series of specific eligibility requirements and limitations on allowability, each of which may require additional information in order to establish the fund's obligation. For this reason, the receiver should coordinate with the guaranty fund prior to any notification to potential claimants regarding the proof of claim form.

c. Protective Filings via Proof of Claim Forms

Many guaranty funds are not permitted to recognize general proofs of claim (intended as a protective filing for claims that are unknown to the insured at the time of filing) as sufficient notice. These guaranty funds require that specific claim information about known claims must be provided in the proof, including the date and other particulars relating to the insured event.

3. Late-Filed Claims

a. Rationale

Most receivership statutes contain a provision that requires claims to be filed by the claims filing date established by the liquidation court. See IRMA § 701. If a claim is filed after that date, it is usually not allowed or is subordinated to a lower distribution priority. In addition, many guaranty funds are not permitted to pay claims filed after the earlier of the claims filing date or a bar date established pursuant to the guaranty fund's enabling act.

The receiver may have the ability to allow policyholders to file "omnibus" or "policyholder protection" claims to meet the bar date requirements, but guaranty fund statutes may not allow coverage of such claims.

b. Extensions

Once a receivership's bar date has been established, guaranty funds generally take the position that the receiver should not extend the bar date, as such an extension may result in guaranty fund coverage issues.

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c. Excused Lateness

Some receivership statutes provide a procedure for allowance of late-filed claims which authorizes the receiver to allow such claims under certain circumstances. See IRMA § 701. The receiver should consider claimant requests on a case-by-case basis, through the specific mechanism established in the receivership statutes. The receiver should also consider giving notice to those guaranty funds that may be affected prior to allowing a late-filed claim in order to provide those guaranty funds the opportunity to address how allowance of the claim would impact them.

E. Claim Files Information

1. Information Needed by Property and Casualty Guaranty Funds

The key to the successful handling of filed claims is cooperation between the receiver and the guaranty funds throughout the claim process. Receivers should keep in mind that the guaranty funds require reasonable access to those insurer's records which are necessary for them to carry out their statutory obligations.

Recent experience has shown that pre-liquidation coordination and information exchange are essential for the smooth transition of claims servicing responsibilities to the guaranty funds without disrupting ongoing benefit payments. Regulators, receivers and guaranty funds should coordinate and communicate, even if liquidation of the company is not a certainty. A "two-track" approach is recommended. While efforts continue to revitalize the company, the receiver and the guaranty funds should also be taking steps to ensure a smooth transition to liquidation if liquidation becomes necessary.

The receiver's cooperation in providing information and making files available to the guaranty funds is essential to minimize claim interruption. More specifically, the receiver should locate and forward to the involved guaranty funds the following information (See § 405 of IRMA):

- A general description of the business written or assumed by the insurer;
- Information concerning licensure of the insurer;
- Claim counts and policy counts by state and line of business;
- Claim and policy reserves;
- Unpaid claims and amounts;
- Sample policies and endorsements;
- Listing of locations of claim files;
- Listing of third party administrators, description of contractual arrangements and copies of pertinent executed contracts;
- Listing of claims in litigation or dispute and assigned defense counsel; and
- Such other information as may be needed by the guaranty funds.

Please note, loss adjustment expenses incurred prior to the liquidation order are not covered by guaranty funds, and therefore, should not be sent to the guaranty funds for payment.

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2. Claim Files

To facilitate the protection of policyholders and claimants; regulators, receivers and guaranty funds should coordinate transition of claim files well before the company is liquidated. The receiver should forward claim files as soon as possible to the appropriate guaranty funds. Some guaranty funds may require access to or copies of the filed proof of claims forms. Receivers and guaranty funds should consider entering into agreements as to ownership, return of files, auditing rights, inventory controls and reporting.

Most company claim records are held in electronic format. It is essential to address data conversion to Uniform Data Standards (UDS) well before the guaranty funds are triggered. (See chapter 2 of this handbook.) If there are non-electronic claims records, UDS records will need to be prepared.

Priority should be given to identifying and forwarding all active workers' compensation files and all active files where major litigation or settlement is imminent.

Determination of which guaranty fund should be the recipient of a particular file will depend on a series of factors. Generally, the receiver should deliver the file to the guaranty fund of the insured's place of residence. However, if it is a first-party claim for damage to property with a permanent location, the receiver should deliver the file to the guaranty fund where the property is located. In most instances, if it is a worker's compensation claim, the receiver should deliver the file to the guaranty fund of the state with jurisdiction over the claim.

Claim files sometimes are delivered to the wrong guaranty fund. In this situation, the preferable course of action is for the guaranty fund that received the file to secure from the appropriate guaranty fund their concurrence. After that, either fund will ask the receiver to resend the UDS record to the appropriate guaranty fund or will notify the receiver if the receiver does not make the actual UDS records transfer. The receive will let the parties know if it prefers the original fund to close the file or to report the transfer with UDS "C" record with transaction code "080". See the UDS Manual[1] for additional information. NCIGF can assist in cases where a high volume of files needs to be transferred.

In multi-state insolvencies receivers and guaranty funds should work together on protocols for transmitting files to the appropriate guaranty fund.

F. Unearned Premium Claims

Although most guaranty funds cover unearned premium claims, some do not (see the NCIGF Web site at http://www.ncigf.org at the Guaranty Fund Laws tab for unearned premium coverage by state). For those states where unearned premium is covered, the receiver should prepare and disseminate the necessary calculations as soon as possible. This will allow guaranty funds to make timely refunds to enable the insureds to make arrangements for replacement coverage.

To make payments possible, guaranty funds will need the following information for each potential claimant: policy identification, insured name and address, policy periods and expiration dates, cancellation date, current payment status, and the amount of the unearned premium. If possible, this information should be provided by the receiver by Uniform Data Standards (UDS) B Record. (The initial B Record may not have the calculation but will advise of the "potential" claimants. A subsequent B Record would provide the calculation/audit.) In addition, the receiver should forward to the guaranty funds a general explanation clearly showing how the unearned premium was calculated. The calculations should be on a pro rata basis rather than short-rated. The information should be as accurate as possible, given the state of the insurer's records, and should be accompanied by the receiver's initial evaluation of the information's reliability.

The receiver should be prepared to provide a sampling of the insurer's records and the receiver's calculations to demonstrate the reliability of the unearned premium figures to guaranty funds. Where agents

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have advanced unearned premium to the insureds in exchange for valid legal assignments, the receiver and guaranty fund should coordinate their positions on acceptability.

It should be kept in mind that where the insured's return premium claim is based on a premium audit or retrospective rating plan, it may not be covered by some guaranty funds. Additionally, net worth limitations embodied in a number of guaranty fund acts may preclude payment of unearned premium claims to certain high net worth insureds.

Premium financing arrangements often create special problems for the affected guaranty funds in processing return premium claims. If the receiver has information concerning premium financing arrangements, the receiver should provide that information to the guaranty funds to facilitate payment of returned premium to the appropriate person or entity.

G. Claim Reporting

How guaranty funds report claims and expense payments, outstanding reserves and administrative expenses to a receiver is an item of concern in every insolvency. This reporting is not only important for the guaranty funds as a creditor, but it also assists the receiver in gathering what is usually the major asset in most receiverships—reinsurance recoverables.

The NAIC in December 1993, adopted the UDS to be used for the reporting of policy and claim information between guaranty funds and receivers. UDS was the result of a joint effort of a number of receivers and guaranty funds to facilitate (1) reporting between receivers and guaranty funds, and (2) reporting to reinsurers by the receiver. The use of UDS file formats to transmit information at the policy or claim level will provide both receivers and guaranty funds with needed information in a uniform, easily usable format. Currently, most guaranty funds and receiverships are able to send and receive information in the UDS format. (The NAIC endorsed the use of UDS by receivers and guaranty funds effective March 31, 1995. Most insolvencies instituted prior to that date did not use UDS, nor did they later convert to UDS.) It is very important to note that an Operations Manual exists, and should be reviewed and used by receivers and guaranty funds for understanding UDS. Version 2 of the UDS was adopted by the NAIC for implementation on Jan. 1, 2005. Version 2 includes many improvements and revisions based upon the collective experience of receivers and guaranty funds with the original version over several years and insurer insolvencies. In 2006, the NAIC adopted the Standardized Financial Report (D Record) for addition to the Uniform Data Standards. A copy of the updated UDS Manual and file formats are at the National Conference of Insurance Guaranty Funds (NCIGF) Web site at https://www.ncigf.org/resources/uds/.

It is important to remember that the earlier the receiver determines what information is needed, and communicates those needs to the guaranty funds, the better and more efficient the reporting process will be. UDS, through the implementation of several lettered record formats, has simplified the aforementioned receivers' requirements. The formats were designed by the UDSTSD (UDS Technical Support Group), a group comprised of members of the receiver and guaranty fund communities and approved by the NAIC.

As stated above, almost all claims data for the insolvent insurer will be in electronic format. Security concerns are paramount. The NCIGF addresses the security concerns with a system called the UDS Data Mapper. Using the Mapper, the receivers can map raw data to, or fully created UDS files to UDS record fields in a database. The Mapper will then create new UDS files to be placed in the guaranty funds' SUDS directories. This process has the dual benefit of ensuring UDS compliance and scrubbing the data of any unknown malicious code. This service is available at no charge to the receiver.

Recent estates with significant reinsurance recoveries have found it useful to also develop claims protocols setting out additional information that is needed for reinsurance recovery purposes and dealing with other matters such as new and reopened claims and closed files. Needed information often extends beyond that which can currently be provided by UDS data feeds. Some guaranty funds have agreed to give receivers

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limited, read-only access to their claims database. Assistance from the UDSTSG can also be found by submitting a help request to help@udstsg.org.

H. Claims Exceeding Guaranty Fund Limits and Aggregate Claims

1. Claims Exceeding Guaranty Fund Limits or Claims Excluded from Guaranty Fund Coverage

Under the Model Act and state enabling acts, guaranty funds have per claim limits, or "caps," that can limit the guaranty fund's obligation to an amount less than the insolvent insurer's policy limits. For example, the amount paid in satisfaction of a covered claim (either non-workers' compensation or unearned premium) under the NAIC Model Act may not exceed $500,000 per claimant, even if the actual policy limits are greater. The caps vary among the states and the receiver must review applicable state guaranty fund acts. Here, the interrelationship between the guaranty fund and the receiver becomes critical (i.e., both act to pay or determine claims made against the insolvent insurer arising under the same policy and are eventually allowed against the insolvent insurer's estate).

The guaranty fund has a claim against the insolvent insurer's assets for the amounts paid as indemnity and the expenses and costs of handling the claims it pays. Furthermore, anyone with a claim over the guaranty fund's cap, subject to a guaranty fund deductible or subject to a statutory net worth exclusion has a claim against the estate for that portion of the claim not covered by the guaranty fund. From this perspective, the role of the guaranty fund and the receiver are not easily distinguishable. The guaranty fund is concerned with determining and paying its covered claims obligations under its statute while the receiver is determining how much of the claim should be allowed as a claim in the receivership. As a result, whenever a covered claim is filed in excess of the cap, it gives rise to a situation where extra effort and cooperation between the guaranty fund and the receiver will be necessary.

It should be noted here that, in some states, the guaranty fund will not settle a claim without a complete release, which may require participation by the receiver prior to any settlement. In some cases, however, the guaranty fund may pay the claim up to its statutory limit, leaving the excess to be paid by the insured, who will then retain a claim against the estate for the excess amount. Where the insured is unwilling or unable to pay the excess, the claimant may have a direct claim against the estate for the unpaid amount. In either instance, there is a portion of the claim above the cap that is left unsatisfied by the guaranty fund's payment. After approval by the receiver, the "over-cap" claim, as other allowed claims, will be paid as part of a distribution, pursuant to the applicable priority statute.

There may be other situations where the guaranty fund and the receiver will both have an interest in handling a claim. For example, where a claim includes allegations of bad faith or seeks punitive damages, the claim would not be covered by the guaranty fund but may be a claim in the estate.

The successful handling of over-cap claims is dependent upon early communication between the guaranty fund and the receiver. To prevent, or at least minimize, potential conflicts between the guaranty fund and the receiver regarding the payment of over-cap claims, full disclosure, communication and cooperation between the guaranty fund, the insured and the receiver's claims department must begin as soon as it is determined that an over-cap claim may exist. Prior agreement with the receiver should be obtained, where possible, on the amount of the over-cap claim. The guaranty fund has no authority to settle the claim in excess of its limit, and without the consent of the receiver, the claimant or insured (if paid by the insured) is taking a risk that all or a portion of the over-cap claim may be denied by the receiver. In fact, arranging to have the over-cap claims allowed as a claim in the estate may provide the needed leverage to settle the claim.

Receivers and guaranty funds have found it useful to develop specific procedures for dealing with claims where the cap will be exceeded and including such procedures in the claim protocols described above.

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2. Aggregate Claims

Certain types of policies are often written on an aggregate basis. Aggregate policies may be in terms of a policy aggregate, a coverage aggregate, or both. In a policy aggregate, all claims are accumulated until the maximum limit of liability is reached. A coverage aggregate is one where claims against a specific coverage, such as products liability, are accumulated until the maximum coverage limit is reached. When an insurer is solvent, it monitors the erosion of all of its outstanding policies—in other words, the insurer keeps track of how much of a policy's aggregate limit is left as various claims under it are satisfied.

When an insurer is declared insolvent, and one or more guaranty funds begin to satisfy claims against such aggregate policies, problems can arise. The most obvious problem occurs when a guaranty fund paying claims under a policy is not aware that the policy has an aggregate limit. The receiver should take special care to advise the guaranty funds which policies are subject to an aggregate limit. The receiver should not assume the guaranty funds will discover this information on their own.

It is equally important that the receiver and the affected guaranty funds work together to monitor the erosion of aggregate limits. The receiver should advise the affected guaranty funds of claims that have been paid under the policy by the insurer before insolvency and track payments made by the guaranty funds after insolvency. Similarly, guaranty funds should not pay a claim under an aggregate policy prior to coordinating with the receiver. When the aggregate limits are close to being exhausted, the receiver should alert the guaranty funds and require that they obtain prior approval on any payment against such policy. See IRMA § 706 D.

The following example should help illustrate the problem. Assume that there is a products liability policy with an aggregate limit of $2,000,000. Assume further that there are 10 claimants filing claims under the policy with 10 separate guaranty funds. If each guaranty fund has a cap of $300,000, but is unaware of the other claims, then potentially, payments totaling $3 million could be made, thereby exceeding the aggregate limit. In this situation, regardless of the original extent of an individual guaranty fund's knowledge of a policy's aggregate nature, it cannot independently keep track of the policy's erosion. In situations like this, it is critical that the receiver monitor each guaranty fund's activity closely and keep all affected guaranty funds apprised of the situation as it develops.

When adequate safeguards are not in place, payments may be made in excess of a policy's aggregate limit and conflicts will arise between the receiver and the guaranty fund. Although the guaranty fund may have made the payment in good faith and within its statutory guidelines, the receiver may feel compelled to deny reimbursing the guaranty fund for that portion of the claim in excess of the aggregate limit. These problems are sometimes not discovered until long after the guaranty fund has settled all of its claims. To avoid such problems, the guaranty funds should not pay a claim covered by an aggregate policy without first consulting the receiver. State liquidation acts vary on the handling of estate distributions for amounts paid in excess of aggregate caps. These laws should be carefully reviewed in dealing with these matters. Section 706 D of IRMA addresses policies with aggregate limits and provides that the liquidator may apportion the policy limits ratably among timely filed allowed claims or notify the insured, third party claimants and affected guaranty funds of the erosion of the aggregate limit.

In summary, upon taking control of the estate, it is recommended that the receiver institute the following procedures:

- Determine which policies have aggregate limits;
- Determine policy erosion and continue to monitor aggregate accumulations resulting from payments made by guaranty funds;

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- Advise guaranty funds of these policies and keep them apprised of any pre- and post-insolvency erosion;
- Require guaranty funds to determine how much of the aggregate limit remains available before making any settlements under these policies;
- As soon as it appears that the aggregate limit is about to be reached, notify the guaranty funds immediately that all future settlements should be cleared with the receiver;
- Require guaranty funds to immediately report to the receiver any paid or settled claims that affect aggregate limits; and
- Initiate a system that can earmark pending settlements. One of the benefits of the UDS is that it facilitates the tracking of policies subject to aggregate limits (See the Publications tab of the NCIGF Web site at http://www.ncigf.org).

I. Early Access

Most state receivership statutes contain a provision that requires the receiver to submit to the court a proposal to disburse general assets to guaranty funds. Such proposals are commonly referred to as "early access plans," and apply equally to life and health and to property and casualty insolvencies. The statutes typically contain provisions specific to both.

The purpose of an early access plan is to distribute funds from the estate to the guaranty funds as soon as possible and in the maximum amount possible in order to reduce the assessment burdens on member companies. Early access distributions are essential to the guaranty funds' continued ability to fulfill their statutory duties. See IRMA § 803.

1. Timing

The standard early access provision requires that the receiver submit an early access plan within 120 days of entry of the liquidation order. IRMA requires that the receiver apply to the receivership court for approval to make early access distributions, or report that the receiver has determined that there are not sufficient distributable assets to make any distribution to the guaranty funds at that time, within 120 days of entry of the liquidation order, and at least annually thereafter. See IRMA §803 B. In practice, in order for the receiver to make the calculations necessary to demonstrate to the court that there are insufficient assets at that time to make any distribution, receivers should formulate an early access plan and file the form of the plan within the 120-day period for approval by the court. This procedure will fulfill the receiver's statutory obligation for filing a plan and will ensure that a plan is in place to make distributions when assets become available.

2. Reserves

Most early access provisions in state receivership statutes require an early access plan to include, at a minimum, reserve amounts for the expenses of administration and the payment of the higher priority claims. See also IRMA §803 A(2). The reserve for expenses should take into account all administrative expenses anticipated to be incurred during the duration of the receivership proceeding. (See specific state statutes to determine if guaranty fund administrative expenses are Class I or Class II; see also IRMA §801 A & B.) The reserve for receivership expenses and for other claims that are at a higher priority than the guaranty funds' claim payments need not, however, be reserved 100% out of current liquid assets of the estate, as long as there are sufficient non-liquid assets that will be liquidated during the course of the receivership proceedings to cover those claims. The receiver should reserve a portion of the liquid assets to cover receivership expenses that will become due in the near term and prior to the liquidation of other non-liquid assets.

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It may be difficult for the receiver of some estates to accurately determine the amount of policyholder claims not covered by the guaranty funds. An absolute determination of the amount is not necessary for purposes of the plan, however, as an estimate for calculation purposes is all that is needed. This estimate will be updated from time to time, and any overpayment to guaranty funds must be returned to the receiver. This "claw back" requirement is mandated by Section 803 F of IRMA and should be included in any written agreement between the receiver and the guaranty funds.

3. Liquid or Distributable Assets

Most early access agreements provide for payments from distributable assets, which generally means cash and cash equivalents, less reserves for Classes I and II. In developing early access plans, it is anticipated that the receiver will liquidate non-liquid assets as soon as economically prudent.

The receiver, however, is not required to increase liquid assets for purposes of the plan by making forced or quick sales of non-liquid assets that result in obtaining less than market value. In other words, receivers are not expected to hold "fire sales" in order to generate liquid assets for distribution as early access. It is in the interest of all creditors, including the guaranty funds, for the receiver to attempt to obtain full value for the estate's assets. On the other hand, where an asset can be sold at a fair market price, the receiver should consider liquidating the asset in order to generate early access funds and thereby reduce the assessment burden on solvent insurers and their policyholders. The public policy behind maximizing the value of estate assets and reducing assessment burdens on guaranty funds through early access distributions sometimes conflict and special understanding and cooperation between the receiver and the guaranty funds is necessary to resolve this conflict amicably.

Liquid assets do not include real estate, the book value of a subsidiary, assets pledged as security, special or general deposits held by other states that are unavailable to the receiver, or any assets over which the receiver does not have complete control.

4. Early Access Agreements

Any payment to be made under the provisions of an early access plan typically is conditioned upon the guaranty fund executing and returning an early access agreement to the receiver., IRMA obviates the need for an agreement by incorporating the key provisions of a typical agreement in the statute; however, currently, only a small minority of states have adopted this IRMA provision. In the context of a property and casualty insolvency, such agreements include provisions requiring the guaranty funds to:

- Submit to the exclusive jurisdiction of the receivership court, but only for the purpose of the early access plan;
- Return to the receiver any previously disbursed assets, plus interest if applicable, that are required to pay claims that are of an equal or higher priority; no bond shall be required of any guaranty fund. See §803 F of IRMA; and
- Periodically report to the receiver: all amounts paid by the guaranty fund on claims to date; the amount of expenses entitled to priority that have been paid by the guaranty fund; the reserves established by the guaranty fund on open claims; the amounts collected by the guaranty fund as salvage or subrogation recoveries; the amounts collected by the guaranty fund from any state deposit; and other information needed by the receiver. See §803 B of IRMA; UDS is the platform commonly utilized by the property and casualty guaranty funds for the transfer of this data. See Chapter 2 for a broader discussion of UDS.

Calculations and distributions by the receiver should be done at least annually; however, in instances where the guaranty funds are reporting on a quarterly or more frequent basis and sufficient assets are

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available to make distributions, the receiver may consider making distributions on a more frequent basis.

5. Expenses

Early access plans typically contemplate that the guaranty funds should receive prompt reimbursement of their administrative expenses. The calculation of liquid assets available for distribution as early access should be made after payment of all incurred receivership and guaranty fund administrative expenses.

Certain categories of guaranty fund expenses may or may not be included in the administrative expense priority class. Therefore, it is necessary to consult the applicable statute to determine appropriate treatment.

In a case where there is disagreement between the receiver and guaranty funds concerning the priority of particular guaranty fund expenses, it may make sense to make administrative expense distributions under a reservation of rights, clearly specifying that the priority of certain expenses was a matter of dispute and that such payment does not preclude the receiver from later challenging the priority of particular expenses. Dealing with the issue in this manner ensures that the guaranty funds receive maximum distributions early in the proceeding—when the need for cash can often be critical. Resolution of expense classification issues, which may involve protracted discussions or even litigation, can be conducted while the funds have the necessary cash to pay claims.

6. Basis of Distribution

Most early access statutes provide that distributions to guaranty funds will be based on claims paid and to be paid by the guaranty funds. Some states, however, have based distributions solely on paid claims. In states that follow the reserve language, early access should be based on both paid claims and reserves. This permits a more equitable distribution of assets among the guaranty funds instead of benefiting guaranty funds that make claim payments at an early stage of the receivership proceeding (e.g., a state that has mostly workers' compensation claims). See §803 A(2)(c) of IRMA.

7. Special Deposits

Early access plans typically take into account state deposits by excluding such assets from the calculation of liquid assets available. Similarly, the plans typically take into account payment to guaranty funds from general or special state deposits by essentially treating such payments as prior early access distributions, thereby reducing the early access distribution to those guaranty funds receiving state deposits. If after receiving early access distributions, a guaranty fund receives payment from a special state deposit, then the guaranty fund may be required to return all or part of the early access distribution. Most early access plans do not allow the receiver to take credit for a special or statutory deposit that has not been paid to or is unavailable to the guaranty fund. See § 803 G of IRMA.

8. Salvage/Subrogation

Historically, the majority of receivers have taken the position that salvage or subrogation recoveries collected by a guaranty fund, based on payments made by the guaranty fund, are the property of the guaranty fund. The recoveries are applied to reduce the net guaranty fund payment total that is the ultimate claim of the guaranty fund against the insolvent estate. These receivers accept reimbursement on a pro rata basis in instances where a guaranty fund has made a recovery that includes consideration of both pre-liquidation payment by the insurer and subsequent payment by the guaranty fund. Early access agreements will not be affected when receivers take this position.

A minority point of view is that salvage or subrogation recoveries by a guaranty fund become general assets of the liquidation estate, regardless of whether the payment on which the recovery is based was

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made by the insurer or the guaranty fund. Specific language to address concerns may be needed in early access agreements when a receiver adopts this view.

J. Large Deductible Policies

In 2016, the NAIC adopted a white paper titled *Workers' Compensation Large Deductible* Study. The paper revisits and reconsiders issues raised in an earlier 2006 *Workers' Compensation Large Deductible Study.* The 2016 study provides valuable information about how large deductible policies work and special issues that can arise with their use.

As used in workers' compensation coverages, large deductible policies allow employers to retain a certain amount of claims risk, thereby reducing the cost of their workers' compensation coverage. Typically, these policies are administered by the insurer or a third-party administrator paying claims within the deductible and obtaining reimbursement from the insured employer. In the receivership context, where guaranty funds pay claims within the deductible, there is an issue as to the handling of the insured employer's reimbursement of payments within the deductible. That is, should the reimbursement be paid to the guaranty fund outside the receivership distribution scheme, or should the reimbursement be treated as an asset of the receivership estate subject to the claims of all creditors? Several states have provisions in place in their respective receivership statutes which provided that large deductible reimbursements should be paid directly to the guaranty fund outside the receivership distribution scheme.

Where the insolvent insurer wrote large deductible policies, the receiver should be mindful of this issue and should consult with the affected guaranty funds as soon as possible. The receiver should also review those states' guaranty fund statutes where the claims will be processed to determine whether claims within large deductibles are "covered claims" as defined in the appropriate guaranty fund act. Typically, claims under workers compensation policies will be covered. However, claims under policies for other lines of business may not be covered. The availability of guaranty fund coverage is to some extent dependent upon the specific language of the policy involved.

IRMA provides for a different treatment of large deductible collections. Under IRMA § 712, payments of such monies to the guaranty funds are treated as early access.

Under the *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) deductible recoveries are paid to the guaranty fund to the extent of their claim payments and are not considered early access distributions. Subsection B of this Guideline states, "Unless otherwise agreed by the responsible guaranty fund, all large deductible claims that are also "covered claims" as defined by the applicable guaranty fund law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty fund for handling." Refer to the Guideline subsection B for further discussion of deductible claims paid.

K. Coordination among Regulators, Receivers and Guaranty Funds

In 2005, the NAIC adopted a white paper titled Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System. The white paper addresses the various issues relating to communication and coordination among regulators, receivers and guaranty funds, and how the parties might better work together to protect consumers.[6]

[6] A copy of this White Paper may be obtained from the NAIC at: http://www.naic.org/store_home.htm
Phone: 816.783.8300; Fax: 816.460.7593; E-mail: prodserv@naic.org

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III. LIFE AND HEALTH GUARANTY ASSOCIATIONS

A. Introduction

In 1970, the NAIC adopted the Life and Health Insurance Guaranty Association Model Act (the Life Model Act). Since 1970, the Life Model Act has undergone several major revisions. The most recent revisions to the Life Model Act were made in 2017 (the "2017 Amendments").[7] All 50 states, the District of Columbia and Puerto Rico have enacted guaranty association laws based on some version of the Life Model Act. (For summaries of the provisions in each state's guaranty association laws see the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) Website at https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

The Life and Health Insurance Guaranty Associations were created to protect certain policy, contract and certificate holders (and their beneficiaries, assignees and payees) from loss due to the insolvency or impairment of a member insurer. Life/health insurance guaranty associations pay benefits and continue coverage, subject to statutory limitations, either directly or through a third-party administrator. With early communication, information sharing and coordination between guaranty associations and receivers, the guaranty associations can work with receivers to help develop and put in place the infrastructure and solutions that may be able to provide for a seamless transition into liquidation, thereby avoiding unnecessary delays and disruptions, and maximizing protections for policyholders. Early coordination between the receiver and the guaranty associations will also help minimize confusion, avoid duplication of effort and lead to greater administrative efficiency and lower costs for both the receiver and the guaranty associations.

NOLHGA is a vital resource for receivers in multistate life/health insolvencies. NOLHGA, whose members are the life/health guaranty associations of all the states and the District of Columbia, collects and distributes information for its members and receivers. It performs analyses of various alternatives by which guaranty associations can fulfill their statutory obligation to protect policyholders and serves as the guaranty associations' national coordinating mechanism for resolving issues. Through its Members Participation Council, NOLHGA works with its affected member guaranty associations and the receiver to develop and implement plans for the disposition of covered claims and contractual obligations through, for example, assumption reinsurance or claims administration.

Ideally, the receiver and NOLHGA, on behalf of the guaranty associations, should commence planning and coordination efforts at the earliest practicable opportunity. As discussed in the NAIC's 2004 white paper on Communication and Coordination Among Regulators, Receivers and Guaranty Associations, cited in Chapter 1 of this Handbook and earlier in this Chapter, coordination and communication with guaranty associations should begin "no later than when a company is placed into rehabilitation, and in many cases, involvement even earlier will enhance consumers' protection and decrease costs of the insolvency to all stakeholders" subject to entering into a confidentiality agreement as appropriate. NOLHGA can be reached at:

National Organization of Life and Health
Insurance Guaranty Associations
13873 Park Center Rd., Suite 505
Herndon, VA 20171
Phone: (703) 481-5206
Web Site: https://www.nolhga.com

[7] All references in this chapter to the "Life Model Act" are to the 2017 version, unless otherwise specified. As of this writing, a majority of states had adopted or substantially adopted the 2017 Amendments, and further legislation is expected in additional states. It is always important, however, to check individual state statutes for variations from the Life Model Act in actual cases.

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B. Triggering Guaranty Associations

1. "Insolvent" Insurers

Under the Life Model Act, guaranty associations are triggered when a member insurer is determined to be an "insolvent insurer," as defined therein, i.e., it has been placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency. A member insurer is defined in the Life Model Act as "an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn…." Certain types of insurers are excluded from the Life Model Act definition, such as fraternal and mutual assessment companies.

The 2017 Amendments added health maintenance organizations ("HMOs") as member insurers and extended guaranty association coverage to HMO products.[8] At the time of this Handbook update, the 2017 Amendments had been largely adopted in 40 states, resulting in coverage for HMOs in the vast majority of states, and legislation to adopt the 2017 Amendments was pending or expected to be introduced in additional states. State guaranty association laws should be consulted to determine whether HMOs are member insurers for purposes of guaranty association coverage in a given state.[9]

2. "Impaired" Insurers

Under the Life Model Act, a guaranty association may act in its discretion if a member insurer is "impaired," subject to certain conditions and limitations. An insurer is an "impaired insurer" as defined in the Life Model Act, if it has not been declared insolvent but is under a court order of rehabilitation or conservation. In such situations, the Life Model Act provides that the guaranty association may, in its discretion and subject to any conditions imposed by the guaranty association that do not impair the contractual obligations of the impaired insurer, and that are approved by the Commissioner, take certain actions to provide protections to policyholders of the impaired insurer. However, the primary purpose of the guaranty associations is to protect policyholders, not to bail out impaired or insolvent insurers so that they can continue as going concerns. Guaranty associations, therefore, have traditionally been extremely reluctant to trigger before entry of a final order of liquidation with a finding of insolvency, particularly in the case of a multi-state receivership.

3. Uniform Triggering

Because the life and health insurance guaranty associations continue coverage under policies and have responsibility for administration of the business upon triggering, the uniform triggering of guaranty associations across affected states is very important. However, there can be subtle variations among some state guaranty association laws which could potentially impact uniform triggering. Coordination with guaranty association representatives and NOLHGA (in multistate insolvencies), as early as possible and, subject to appropriately executed confidentiality agreements, before a petition for receivership is filed will help to reduce the risk of complications in regard to guaranty association

[8] Historically, a few states had stand-alone guaranty funds for HMOs that were separate from the life and health guaranty associations. The nature and scope of such stand-alone guaranty funds for HMOs varied from state to state. With the wide adoption of the 2017 Amendments, fewer stand-alone guaranty funds for HMOs remain.

[9] The NAIC state adoption map shows status of states' adoption of these amendments. Refer to individual state laws for specific language adopted in each state. https://content.naic.org/sites/default/files/smi_state_adoption_maps_models.pdf.

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triggering. For individual state provisions, see the NOLHGA Web site (https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

C. Scope of Coverage

1. Covered Policies and Limits of Coverage

Guaranty associations were created to provide a limited, but substantial safety net to protect policyholders from loss as a result of the impairment or insolvency of a member insurer. Under the Life Model Act, the following coverages are provided:[10]

- Life insurance: $300,000 in death benefits, but not more than $100,000 in net cash surrender and withdrawal values, per life. In the case of corporate-owned or bank-owned life insurance, however, overall benefit coverage is capped at $5,000,000 per owner.

- Health insurance: i) $500,000 in benefits for health benefit plans, which are defined to include "any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract", subject to certain enumerated exclusions. The term "health benefit plan" which was introduced in the 2017 Amendments, replaces the prior reference to basic hospital, medical and surgical insurance and major medical insurance, and includes coverage under HMO subscriber agreements; ii) $300,000 in benefits for disability income insurance and long-term care insurance; and iii) $100,000 for other health policies not defined as disability income insurance, long-term care insurance or health benefit plans. All limits are applied per life.

- Individual (allocated) annuities: $250,000 in present value of annuity benefits, including net cash surrender and withdrawal values, per life.

- Structured settlement annuities: $250,000 in present value of annuity benefits, per payee or beneficiary. See Chapter 3 for a discussion of structured settlements.

- Unallocated annuities: Coverage for unallocated annuity contracts[11] is typically limited. As of this writing, 28 states provide coverage for limited types of unallocated annuity contracts. The remaining 22 states, plus the District of Columbia and Puerto Rico, do not provide coverage for unallocated annuity contracts. For those states that do provide coverage for unallocated annuity contracts, coverage is typically limited to unallocated annuity contracts issued to or in connection with specific employee benefit plans or government lotteries. Life Model Act §3(A)(3). Coverage limits are stated as (i) $5,000,000 per contract owner/plan sponsor for unallocated annuity contracts issued in connection with either governmental lotteries or private employer employee benefit plans that are not protected by the Pension Benefit Guaranty Corporation, and (ii) $250,000 per plan participant for unallocated annuity contracts issued to governmental retirement plans. Life Mode Act §3(C)(2)(b) and (e). Unallocated annuity contracts are not covered in every state, and the Appendix to the Life

[10] While there are a few exceptions, these coverage limits have been fairly uniformly adopted in most states. For individual state limits, see the NOLHGA website (https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo) or consult the applicable state guaranty association.

[11] For purposes of guaranty association coverage, an unallocated annuity contract is "an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate." Life Model Act §5(Y).

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Model Act includes alternate Section 3 text adopted by several states that do not provide coverage for unallocated annuities.

- Aggregate limits across policy types: Aggregate benefits covered with respect to any one life for life insurance, individual annuities, and health insurance (other than health benefit plans) are capped at $300,000. Aggregate coverage for health benefit plans and other policy types is limited to $500,000 with respect to any one life.

2. Exclusions

Products excluded from coverage, in whole or in part, are described in Life Model Act Section 3(B)(2). Under the Life Model Act, coverage is expressly excluded for policies or portions of policies under which the risk is borne by the policyholder or that are not guaranteed by the insurer, as well as certain interest crediting rates that exceed the limits described therein. Self-funded employer-provided welfare benefit plans are also among the products excluded, as are unallocated annuity contracts issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation. Reinsurance is also specifically excluded unless assumption certificates have been issued. For a more complete listing of products or portions thereof generally excluded from guaranty association coverage, refer to Section 3(B)(2) of the Life Model Act. For specifics concerning coverage exclusions in any particular state, consult with the guaranty association in that state.

In addition to the product exclusions referenced above, the Life Model Act excludes coverage for policies or products issued by entities that are not regulated under the standards applicable to legal reserve carriers, and are therefore excluded from the definition of Member Insurer under the model, such as insurance exchanges, assessment companies, fraternals, and hospital or medical service corporations. Hospital or medical service corporations that are members of the Blue Cross/Blue Shield Association may be required by their franchise to participate in their state's guaranty association if permitted by statute, or to establish some other form of insolvency protection for their participants. Whether these entities are included as member insurers for purposes of guaranty association protection may vary by state and must be considered based on the circumstances in each case.

3. Residency Requirements

Residency is determined on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer, whichever occurs first. Typically, this results in the state of residence being determined on the date an order of liquidation with a finding of insolvency is issued. If there is a gap between the start of the receivership and the date an order of liquidation is issued, policy and contract holders may relocate, which could affect the situs of coverage.

The Life Model Act generally provides for coverage of policyholders and certificate holders under group policies who are residents of the state, as well as their beneficiaries, regardless of where the beneficiaries reside. It also provides coverage for contract owners of unallocated annuities if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in the state. Nonresident policyholders and contract holders may be covered under certain limited circumstances. If the insolvent insurer's domiciliary state follows the Life Model Act, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty association law and the policyholders in that state are not eligible for coverage there because the insurer was not licensed in that state at the time specified in that state's guaranty association law. An example of such a situation might be a resident of State A, who owns a policy of the XYZ Life Insurance Company, domiciled in State B, and placed in liquidation in state B. If the State A resident policyholder is not eligible for coverage by the State A guaranty association because the company was not licensed in State A (and therefore was not a member insurer of the State A guaranty association), coverage may be provided by the State B life and health insurance guaranty association.

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D. Guaranty Association Claims Administration

In the case of a multi-state insolvency, life/health guaranty associations work through NOLHGA's Members' Participation Council (MPC) to develop and implement a plan for providing guaranty association coverage, whether through transfer of the covered policies to a solvent insurer, making arrangements for providing ongoing policy and claims administration, or some combination thereof.

For multi-state insolvencies, NOLHGA appoints a guaranty association task force that includes representatives from the domestic guaranty association and other state guaranty associations affected by the insolvency. The size of the task force depends in large part on the number of affected state guaranty associations and the size of the insolvency.

1. Information Needs of the Guaranty Associations

For guaranty associations to evaluate and discharge their functions with the least possible duplication and delay, they must have detailed information about the insurer and its business. While information needs may vary from case to case, NOLHGA typically requests this information from the receiver on behalf of its members and, if necessary, will offer to assist the receiver in obtaining and assembling the information. Types of information routinely requested include:

- All administrative and judicial petitions and orders with attachments or exhibits;
- The insurer's most recent annual statement;
- The insurer's most recent financial statement, audited or unaudited, and department or independent financial audits or reviews, including identification of assets that are hypothecated or not publicly traded and unbooked contingent liabilities;
- A list of states that have terminated or suspended the insurer's license;
- A breakdown, by state, of the insurers' estimated liabilities/reserves by line of business;
- A list of third-party administrators and administrative offices, identifying the policies, claims and group policyholders they served, and copies of all provider/vendor agreements;
- Actuarial evaluations of the insurer's business;
- Copies of policy and contract forms;
- Copies of reinsurance contracts, assuming or ceding;
- Drafts of the receiver's notices to policyholders, including any cancellation notices;
- A breakdown of assets, by category, at the most recent market value available and other valuations of assets that would be helpful in cash flow analysis;
- The names and addresses of policyholders and certificate holders with in-force coverage during the preceding year, broken down by state, indicating the type of coverage each had, the date to which premiums have been paid, cancellation or non-renewal dates for business that was

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canceled or non-renewed according to policy terms, copies of cancellation notices, and the date to which claims have been paid; [12]

- Policy values (face amounts, cash surrender values, policy loans, interest crediting rates, rate crediting history, etc.);
- Premium files (and status indicators, such as Reduced Paid Up, Extended Term, or Waiver of Premium status);
- Claims data/claims history (including plan of care and related information for LTC lines);
- Rate files/history;
- Provider contracts and information about provider networks (for health and HMO lines); and
- Information concerning the receiver's marketing contacts and expressions of interest received about the insurer's business.

2. Notice to Claimants

Shortly after a receiver is appointed, the receiver should collaborate with NOLHGA to provide notices to policyholders. Several notices may be necessary over the course of the receivership. Because of the special nature of life and health insurance guaranty association obligations, the receiver and the guaranty associations should collaborate closely on the contents of all notices to policyholders that involve guaranty association obligations, and may, in some instances, send joint communications to policyholders. Normally, the notices should:

- Provide notice of proceedings against the company;
- Explain the existence of the guaranty associations and their role in the receivership
- Provide basic information concerning guaranty association continuation of coverage, including general reference to the statutory limitations;
- Where applicable, advise regarding the possibility that a portion of the policies or contracts may be assumed or reinsured by another insurer;
- Provide instructions on filing claims under their insurance policies and remitting future premiums (during rehabilitation);
- Indicate how the guaranty associations intend to treat cancelable policies;
- Provide information about conversion policies in the event of policy terminations;
- Provide notice of liens or moratoriums;
- Identify any applicable claims bar date;

[12] Specific policy data needs will depend on the facts and circumstances of each case as well as the types of business involved. Initial, critical data needs will typically include all relevant summary policy and reserve information. If the policy master/eligibility records can be provided, that file may contain sufficient information for preliminary coverage determinations and to consider the potential feasibility of an assumption transfer. Additional information will be needed to coordinate coverage and begin planning for implementation of any administration, transfer or other disposition strategies.

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- Describe the receiver's handling of claims in excess of guaranty association statutory maximums; and

- Describe the receiver's handling of claims that are ineligible for guaranty association coverage.

When a company goes into liquidation, the guaranty associations will typically send their own notice to policyholders, sometimes as part of a joint mailing with the receiver. The guaranty association notices will provide information about guaranty association coverage and limits, contact information for the state guaranty association providing coverage for insureds in each state, instructions for continuing to pay premiums and submitting claims, customer service contact numbers, and other relevant details depending on the unique facts and circumstances of the case.

3. Notice to Guaranty Associations

In many states, the receiver is required to provide notice of the receivership to all guaranty associations that may be triggered as a result of the receivership. Even if the notice is not a statutory requirement, the receiver should provide NOLHGA (in the case multi-state receiverships) and all affected guaranty associations as much advance notice of receivership as is reasonably possible under the circumstances subject to appropriate confidentiality agreements in order to facilitate the coordination that will be necessary for a successful receivership and achieve the best outcomes for policyholders. NOLHGA and the affected guaranty associations should also be provided with an advance copy of all notices being issued by the receiver to policyholders, as well as copies of the receivership order and any domiciliary injunctions that may have been entered.

4. Proof of Claim

A proof of claim form is less frequently required in life/health receiverships, due in part to the fact that in many instances the guaranty associations will be continuing coverage. Generally, policyholders are not required to file formal proofs of claim for policy benefits. However, policyholders may assert claims for extra-contractual liability against the insurer, such as claims for bad faith. The receiver should consider requiring a proof of claim where extra-contractual liability is involved. Neither the guaranty associations nor assuming reinsurers accept liability for extra-contractual claims.

Receivers and guaranty associations must have data on the policy deductibles and benefit caps under health insurance policies. If the business is transferred to a new carrier, incurred claims will have to be allocated between pre- and post-assumption date periods. In addition, special provisions in the assumption agreement may require additional information in the proof of claim form.

5. Claim Files

The information needs of the guaranty associations generally are addressed earlier in this section of the Handbook. To ensure secure data transfer, receivers or insurance department personnel typically establish a secure website portal or FTP site to provide NOLHGA and its member associations with secure access to the data needed. Otherwise, NOLHGA (or a designated Third-Party Administrator or consultant) can establish a secure file portal where designated users can upload records. Files and records should be made available at the earliest practical opportunity to allow for the planning and coordination needed for a smooth transition and to avoid any disruption to benefits and claim payments.

6. Premiums

The continued and timely payment of premiums is necessary in order for a policyholder to receive continued coverage from a life/health guaranty association. Under the Life Model Act, "premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association." Receivers should work with NOLHGA and the guaranty associations to ensure smooth transition of premium collection. For premiums collected before the

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liquidation order but providing coverage for periods after the liquidation order, the Receiver should coordinate with the guaranty association to facilitate appropriate allocation of those funds.

E. Early Access

The guaranty associations' administrative costs, like the receiver's, typically have the highest priority in distribution of funds from the insolvent insurer's estate. In addition, guaranty associations have a statutory claim and right of subrogation, allowing them to recover from the estate to the extent they pay covered benefits. Guaranty association claims for the payment of covered benefits are accorded the same priority as policyholder claims (Class 3 under §801 of IRMA), and are taken into account in the calculation of association benefits as part of a rehabilitation or liquidation plan. The guaranty associations' claims in the aggregate often make the guaranty associations the largest claimants against the estate.[13] In recognition of this fact, most state laws provide for the guaranty associations' "early access" to payments from the estate. See §803 of IRMA. Early access is typically accomplished by specific agreement, which should include a provision that the guaranty associations will return excess funds.

F. Claim Reporting

Guaranty associations should make timely reports to receivers of their costs for policy transfers, policy administration (including TPA costs), claim payments and administrative expenses. In multi-state insolvencies, NOLHGA will typically collect the necessary data from the affected guaranty associations and report to the receiver on their behalf in the form of an Omnibus Proof of Claim, which may be updated from time to time.

G. Guaranty Association Obligations During the Formulation of a Rehabilitation or Liquidation Plan

The successful creation and implementation of a plan to protect policyholders requires good communication and cooperation between receivers and guaranty associations. To the extent consideration may be given to restructuring of covered policies or contracts, the receiver should coordinate with the guaranty associations early in the development of the plan to consider whether the proposed restructuring is consistent with the guaranty association statutory obligations with respect to those policies or contracts. Any restructuring needs to be carefully considered in light of all applicable statutory requirements.

H. Reinsurance

The guaranty associations may find it advantageous to keep in-force ceded reinsurance treaties that the insolvent insurer had in place on covered blocks of business. Accordingly, the receiver should not cancel ceded reinsurance contracts with reinsurers or stop paying premium to reinsurers without consulting NOLHGA or the affected state guaranty associations. The existence of a ceded reinsurance treaty covering a block of business may make the business more attractive to prospective purchasers. In the case of health insurance, reinsurance recoveries may lessen the impact of catastrophic claims upon the affected guaranty associations. See Section 8 N of the Life Model Act and Section 612 of IRMA, both of which provide that the guaranty association(s) may elect to succeed to the rights and obligations of the insolvent insurer under ceded indemnity reinsurance agreements.

J. Special Issues

Under the Life Model Act, guaranty associations have the power and discretion to "guarantee, assume or reinsure . . . the policies or contracts of the insolvent [or impaired] insurer." Relying on this authority, guaranty associations have, on more than one occasion, acted collectively to establish an insurance company for purposes of collectively managing assets and assuming or administering guaranty association

[13] In some cases, the guaranty associations may also present claims against the estate for the insolvent insurer's unpaid guaranty association assessments. These claims have general creditor status ranking below other guaranty association claims and all policyholder claims.

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covered obligations. Whether similar arrangements may be appropriate in future insolvencies depends entirely on the circumstances.

J. Guaranty Association Procedures for Collective Action

Many individual state guaranty associations may be triggered in connection with a multistate insolvency. Simply communicating with each guaranty association individually would be a difficult task for a receiver's staff. The receiver should work closely with NOLHGA, through the MPC's appointed task force, to communicate and coordinate with the affected guaranty associations. Recognizing the need for concerted action when multiple guaranty associations must cover the insurance obligations of an insolvent company, the guaranty associations have developed and institutionalized procedures that, through NOLHGA, enable them collectively to administer continuing policy obligations, pay covered claims and, ultimately, discharge the covered obligations. These procedures provide a valuable mechanism for resolving major issues and entering into binding contracts

[1] USD Manual link to be included when published.

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