DEALING WITH INSOLVENCIES IN THE COLLECTION OF REINSURANCE

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DISCLAIMER AND CREDIT

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I. INTRODUCTION

Insurer/reinsurer insolvency is a considerable problem for all major participants in large commercial insurance transactions, whether the participant is an insurer of an insolvent reinsurer, a reinsurer of an insolvent insurer, a major commercial insured of an insolvent insurer, or the producer (agent, broker or intermediary) that brought the participants together.

For the insurer with a valid reinsurance claim against an insolvent reinsurer, the problem is two-pronged: time and money. The claim will probably not be paid for a considerable period of time, and certainly will not be paid in full.

A reinsurer of an insolvent insurer may be faced with aggressive collection by the receiver, or faced with the prospect of being forced to pay future claims prematurely as receivers attempt to close out estates. Reinsurers may also be subject to attempts by insureds claiming direct access, particularly in fronted programs or through cut-through endorsements.

Insureds without guaranty fund protection, generally large commercial insureds, may be faced with severe cash-flow problems of having to fund old claims while finding substituted coverage for the future. There may be funding mechanisms – such as claim payment accounts or letters of credit -- controlled by the insolvent insurer acting as a claims administrator and/or excess carrier, that fall within the receiver's control upon the insurer's insolvency.

The producer, in addition to claims by receivers for premiums or other funds held, may be faced with significant issues of responsibility for placing coverages with financially troubled companies, or with finding replacement coverage under very difficult circumstances.

No matter what your perspective – insurer, reinsurer, insured or producer – knowledge of the insurance insolvency process is an essential element in protecting your interests. The

purpose of this article is to provide a guide to the insurance insolvency process in the US, point out the traps, pitfalls and weaknesses of the process, and offer some common sense guidelines to help minimize or control the consequences of the process where possible.

II. THE REHABILITATION/LIQUIDATION PROCESS

Insurance regulation, including the regulation of insurer insolvency, is primarily left to the states. Unlike bankruptcies in other industries, insurance company insolvencies are not handled under the federal Bankruptcy Code, but are governed by state insurance receivership laws. Under the McCarran-Ferguson Act[1], state insurance laws regulating the business of insurance are exempt from preemption by conflicting federal laws that do not relate to the business of insurance, unless the federal law specifically provides otherwise.

Most state laws provide that when an insurer is placed in receivership (which includes conservation, rehabilitation, and liquidation) the Commissioner of Insurance of the domiciliary state is appointed receiver.[2] As a practical matter, the insurance commissioner does not have the time or expertise to manage the day-to-day operations of an insurer subject to a receivership. Therefore, the statutory scheme permits the commissioner to appoint a special deputy to serve as the "on-site" receiver to administer and manage the day-to-day operations.

Receiverships vary from state to state and even within a state. Insurance departments handle some receiverships, outside contractors handle others, and special bureaus may be created to handle some or all receiverships within a state. In Texas, for instance, the law provides for the extensive use of professionals outside of the Department of Insurance to run insurance receiverships.[3] At the other end of the spectrum, New York has an entire bureau, the Liquidation Bureau, responsible for the handling of insurers in rehabilitation or liquidation in the state. As of

year-end 2001, the New York Liquidation Bureau had thirty two (32) insurance company estates under its supervision,[4] all but two of which are companies in liquidation, with assets in excess of $4.6 billion. At year-end 1998, the New York Liquidation Bureau employed almost 500 people – more than half of all the receivership personnel employed by all 50 states plus DC and the possessions.[5]

If an insolvent insurer has assets or affiliates in other states, that state's commissioner of insurance may seek to be appointed as an ancillary receiver to protect the assets and insured in that state. For example, the New York Superintendent of Insurance has been appointed Ancillary Liquidator of Reliance because of the substantial operations of Reliance in New York.[6]

A. Grounds for Rehabilitation and Liquidation

The grounds for rehabilitation and liquidation are substantially similar, except that an order of rehabilitation may be entered without a finding of insolvency.[7] The NAIC Insurers Rehabilitation and Liquidation Model Act ("NAIC Model Liquidation Act"), which in full or in part has been adopted by most states, provides for a number of grounds to place an insurer into a receivership proceeding:[8]

- The insurer is insolvent;
- The insurer fails to comply, within the time established by law, with the Commissioner's order to correct any deficiency, whenever its capital and minimum required surplus (if a stock company) or its surplus (if a non-stock company) is impaired;
- The insurer is unable to meet organization and authorization requirements provided by law in excess of the minimum surplus required to be maintained;
- The insurer has either: a) concealed, removed, altered, destroyed, or failed to establish and maintain books, records, documents, accounts, vouchers, or other material pertinent to the

determination of its financial condition by examination; or b) failed to properly administer claims or maintain claims records adequate to determine its outstanding claims liability;

- At any time after the issuance of an order, or at the time of instituting proceedings, the Commissioner believes that, upon good cause shown it is not in the best interests of policyholders, creditors or the public to allow the insurer to continue conducting business.
- Further transaction of business would be hazardous (financially or otherwise) to policyholders, creditors, or the public based on the insurer's condition
- Reasonable cause exists to believe that there has been illegal conduct in, by, or with respect to the insurer that, if established, would endanger assets in an amount sufficient to threaten insurer solvency;
- The insurer fails to remove any person with executive authority, if that person has been found, after notice and hearing by the Commissioner, to be dishonest or untrustworthy in the control of the insurer or affecting the insurer's business;
- A person having executive authority in the insurer refused to be examined under oath by the Commissioner concerning the insurer's affairs, whether in the participating state or elsewhere; and, after reasonable notice of the facts, the insurer fails to terminate promptly the employment and status of the person along with all his or her influence on management;
- After demand by the Commissioner, the insurer fails to make available promptly for examination the property, books, accounts, documents, or other records, or those of any subsidiary or related company within the insurer's control, or those of any person having executive authority in the insurer, as far as they pertain to the insurer;
- The transfer, or attempted transfer, by the insurer of substantially its entire property or business, or the entering into of any transaction, the effect of which is to merge, consolidate,

or reinsure substantially its entire property or business in or with the property or business of any person, without the Commissioner's prior written consent;

- The insurer or its property has been, or currently is, the subject of an application for the appointment of a receiver, trustee, custodian, conservator, sequestrator, or similar fiduciary of the insurer or its property, otherwise than as authorized under the insurance laws of the state;
- If within the preceding five years, the insurer has willfully and continuously violated its charter or articles of incorporation, by-laws, any insurance law of the participating state, or valid order of the Commissioner;
- The insurer has failed to pay, within sixty days following the due date, obligations due to any states or subdivisions or judgments entered in any state, if the court in which the judgment was entered has jurisdiction over the subject matter; except, non-payment is not grounds until sixty days after any good faith effort by the insurer to contest the obligation (whether before the Commissioner or in courts), or the insurer has systematically attempted to compromise or renegotiate previously-agreed settlements with creditors on grounds that it is financially unable to pay its obligations in full;
- The insurer fails to file annual reports or other financial reports required by statute within the time specified by law;
- The board of directors, a majority of voting shareholders, or a majority of the individuals entitled to control those entities specified in the Act, requests or consents to rehabilitation or liquidation; or
- The insurer fails to comply with the requirements of its domiciliary state for issuance to it of a certificate of authority, or if its certificate of authority has been revoked by its state of domicile.

B. Duties and Obligations of a Receiver

When the domiciliary Commissioner of Insurance is appointed receiver, he/she is empowered to act on behalf of the creditors of the estate to secure, marshal and eventually to either rehabilitate the company or distribute its assets to its policyholders/creditors on a fair and equitable non-discriminatory basis. The largest asset of a property/casualty insurer or reinsurer is usually its reinsurance receivables. The receiver assumes the rights to these receivables, not only by statute, but also under the insolvent insurer's reinsurance agreements. The receiver assumes obligations to the reinsurers under those same agreements as well.

There are significant differences between rehabilitation and liquidation, although neither is specifically defined in the Model Act or in most state statutes. In an extensive study of the insolvency process titled "*Managing the Cost of Property-Casualty Insurer Insolvencies in the U.S.*", the Center for Risk Management and Insurance Research at Georgia State University, issued in November 2002, the authors provide an excellent summary of the difference between a rehabilitation and a liquidation.[9]

> ". . . A rehabilitation order can be used to remedy an insurer's problems without resorting to liquidation, or it may precede liquidation if rehabilitation is unsuccessful. Rehabilitations are sometimes used to "run-off" an insurer's existing business without liquidation proceedings. The court essentially vests the regulator with title to all of an insurer's assets and records and the powers necessary to manage the rehabilitation. A rehabilitation order requires formal proceedings, due process, and proof that the order is justified.
>
> "The receiver must develop a rehabilitation plan that is in the best interests of the policyholders, creditors and the insurer. Rehabilitation may involve reorganization, consolidation, conversion, reinsurance, merger or some other form of transformation. The supervising court must approve, disapprove or modify the plan. Typically, state laws require the court to hold a hearing on the plan. The receiver then implements the plan approved by the court.

> "If the regulator determines that the insurer's problems have been resolved, he may petition the court for an order terminating the rehabilitation. The order will typically permit the insurer's owners and officials to resume possession and control of the company and conduct business. If the rehabilitation is failing or increasing the risk of loss to stakeholders, the regulator may petition the supervising court for an order of liquidation."
>
> . . . .
>
> "In liquidation, the receiver must identify creditors, marshal and distribute assets as prescribed by law, and dissolve the insurer."

The duties and obligations of a rehabilitator and a liquidator, although similar, do differ significantly, particularly in the discretionary authority that is given to a rehabilitator, by statute and by the court through the order of rehabilitation.

1. Duties and Powers of a Rehabilitator

The rehabilitator manages the insurer's affairs for an indefinite time period, until the company can be returned to its prior management or perhaps a new management or, it is placed in liquidation. The primary purpose of rehabilitation is the preservation of the insurer. The typical rehabilitation order vests the rehabilitator with title to all of the insurer's assets, books, records, accounts, property and premises, and generally includes an injunction against pending and threatened litigation - not only against the insurer, but also against the insurer's policyholders.

A rehabilitator has the power to act as necessary or appropriate to reform and revitalize the insurer. Generally this involves the rehabilitator formulating a plan to rehabilitate the insurer during the initial period after the entry of an order of rehabilitation while the stay or stays are in place. The plan of rehabilitation should be in the best interests of the policyholders, creditors, shareholders and the insurer itself. The Plan must be approved by the receivership court, with an opportunity for interested parties to be heard.

If after the rehabilitator's initial assessment of the company, or at any time during the rehabilitation process, the rehabilitator believes that further attempts to rehabilitate the insurer would substantially increase the risk of loss to policyholders, creditors, or the public, the rehabilitator may petition the court for an order of liquidation on insolvency grounds.

2. Duties and Powers of a Liquidator

Once it is determined that an insurer should be placed in liquidation, the domiciliary commissioner will petition and the court will enter an order of liquidation, with a finding of insolvency, appointing the commissioner as liquidator and vesting the liquidator with title to all of the insurer's assets and records. The order enables the liquidator to control all aspects of the insurer's operations under the general supervision of the court. Unlike a rehabilitator, the liquidator's role is to wind up the insurer's affairs in a comprehensive and efficient manner.

Specifically, the liquidator is authorized to

(i) Marshall assets

(ii) Sue a defendant in the insurer's name

(iii) Sell the insurer's assets

(iv) Appoint one or more special deputies

(v) Employ attorneys, accountants and consultants as necessary

(vi) Borrow on the security of the insurer's assets

(vii) Enter into contracts as necessary

(viii) Obtain title to all of the insurer's assets

(ix) Coordinate with guaranty funds and associations, NCIGF (for property/casualty insurers) and NOLHGA (for life insurers)

Most jurisdictions have held that a liquidator steps into the shoes of the insolvent insurer and possesses the same rights and obligations as the insurer. The Courts have affirmed a liquidator's right to: disaffirm fraudulent sales, to act as the statutory receiver of the insolvent insurer's property, to sell the insurer's property, and to conduct business using the insurer's assets.

C. Notice of Receivership

Most state receivership statutes specify the minimum requirements for notice of the receivership proceeding to be sent to creditors and those known or reasonably expected to have claims against the insurer. Notice must, at a minimum, be given to the insurance departments in each jurisdiction where the insurer does business, to guaranty funds, to the insurer's agents, to brokers, and to policyholders at their last know address. Notice must also be published in a newspaper of general circulation in the county in which the insurer has its principal place of business. The Notice must be clear and simple, and for liquidation proceedings, should include the Proof of Claim Form, along with the instructions for completion and filing with the court.

D. Proof of Claim Forms

Policyholders, third-party claimants, beneficiaries, other creditors, including cedants, reinsurers, agents, brokers, intermediaries, MGAs, the Internal Revenue Service and the Department of the Treasury, and all potential claimants, are required to file their claims on a specific Proof of Claim form, on or before the designated Bar Date, as stated in the Notice. Most statutes require claims to be valued as of the date of liquidation. Provisions may be made for the filing of contingent claims - claims that exist as of the date of liquidation, but may not mature or be liquidated for some time in the future.

Creditors who do not timely file a claim may be barred from participating in the distribution of the insurer's assets or be subordinated to a lower distribution priority.

While the individual notice to creditors of an insurer in rehabilitation and the filing of a Proof of Claim may or may not be utilized in a rehabilitation proceeding, the statutory Notice, which must advise all potential claimants of an insurer's liquidation and the procedure to follow to file a claim against the estate, is mandatory in a liquidation proceeding.

E. Payment of Claims

1. In a Rehabilitation

The rehabilitator needs to make a determination concerning the payment of claims to preserve the value of the book of business of the insurer. In a true rehabilitation – where the objective is to correct the problems creating the need for the rehabilitation, and returning the company to its own management – claims handling should continue as close as possible in the normal course of business. Each situation is different, and the rehabilitator must determine the best course of action to meet these objectives. For instance, in life and health insolvencies, the receivers need to consider whether a moratorium on cash surrenders, policy loans and dividends should be imposed and for how long.

The rehabilitation process is less structured than the liquidation process. The Rehabilitator's powers are stated broadly, thereby giving a rehabilitator a great deal of discretion to take whatever action is necessary to correct the problems while maintaining the business of the company.

2. In a Liquidation

Once a liquidator has made a determination on a claim or a class of claims, a notice of determination is sent to the claimant, with a provision for an opportunity to be heard. Once the claim is "finalized" and "allowed", the amount of the "allowed" claim is in line to participate in any distributions of assets, dependent upon and subject to subsequent orders of the court. Although a claim may be "allowed", usually only a portion of the "allowed" amount will ever received by the claimant. Reinsurers, however, under the terms of the statutorily required insolvency clause, will be required to pay to the receiver the full amount of the "allowed" claim and not the portion actually paid. Because of this unusual effect of the insolvency clause on reinsurance, tensions are often high between the liquidator seeking to collect reinsurance as soon as possible, and the reinsurers (and retrocessionaires) seeking to make sure claims are properly handled and their obligations not unduly accelerated. Some of these tensions and issues are discussed later in this paper.

In a liquidation proceeding, the priority for the payment of claims is statutory. All claims within a class must be paid in full, or reserves set aside to cover the class in full, before any payment is made to the next class. In some states, claims in a class must be paid in full, plus interest, before claims of a lower priority can be paid. Priority of distribution statutes are substantially similar in most states. The priority of claim distribution, in Pennsylvania, for example, has 9 classes and can be summarized as follows:[10]

1. The costs and expenses of administration.
2. Claims under insurance policies and contracts issued by the insurer. (This includes claims of guaranty funds and associations)

3. Claims of the Federal government other than claims falling under insurance policies and contracts.
4. Debts due to employees, up to $1,000, for services performed within 1 year before the liquidation proceeding.
5. Claims under nonassessable policies for unearned premiums, and claims of general creditors.
6. Claims of state or local governments.
7. Other claims, including late filed claims. (This includes claims of cedants and reinsurers).
8. Surplus or contribution notes: or similar obligations.
9. The claims of shareholders or other owners.

Reinsurance is not specifically mentioned in this list of classes of claims. If you were to assume that reinsurance must therefore come under Class 2 as claims under insurance policies you would be wrong. Reinsurance claims are considered general creditor claims under Class 5 in practically all states. However, in a case of first impression, the Ohio Court of Appeals has determined that reinsurance agreements are "policies of insurance" entitled to Class 2 treatment rather than Class 5 general creditor treatment.[11] The case is on appeal.

Before this case policyholders and guaranty funds did not have to concern themselves with competition from reinsurers for assets available for distribution from an estate of an insolvent insurer. If the Ohio case is upheld or followed in other jurisdictions, however, the current view of reinsurers as simply debtors of insolvent estates would have to be broadened to include their role as policyholder claimants. This development could have significant impact on the balance among policyholder claimants.

F. Role of Guaranty Funds and Associations

Statutorily created guaranty funds or associations ("guaranty funds") are an important player in the state insurance insolvency scheme. Guaranty funds refund unearned premiums and handle and pay covered claims, up to a statutory cap, of policyholders and third-party claimants of insolvent insurers. In the case of life and health insurance, the guaranty fund mechanism also provides for the continuation of eligible policies and contracts that would otherwise terminate because of the insolvency. Funds to handle and pay claims come from premium-based assessments on solvent admitted insurers doing business in the particular state. Unauthorized insurers, surplus lines insurers, and professional reinsurers (reinsurers that do not write direct business) are not member insurers and therefore are not subject to such assessments. After an insolvency, the solvent authorized insurers are assessed based on premium volume written in the state. These funds are used to pay the covered claims of the insolvent insurer.

Forty-nine of the fifty states, Puerto Rico, and the District of Columbia have enacted property/casualty guaranty fund systems that are generally modeled after the NAIC Property & Liability Post Assessment Model Act, adopted in 1969.[12] The exception is New York, which is the only state with a pre-assessment fund.[13] Life and Health Insurance Guaranty Association Acts, based on the 1970 NAIC Model Act, have been adopted in all states, including New York.[14]

Before the creation of guaranty funds, claimants often had to wait years to receive payment, and then only received a portion of their claimed amount. Today, however, most guaranty funds are able to readily assess and pay policyholders and claimants that have covered claims that fall within prescribed statutory limits for member companies.

Before a guaranty fund can handle a covered claim, the guaranty fund must be "activated" or "triggered" with respect to a particular insolvency. A guaranty fund is generally triggered if (i) the insurer was licensed to transact insurance in the state, either when the policy was issued or when the insured event occurred, and (ii) a court of competent jurisdiction has entered a final order of liquidation, usually with a finding of insolvency against the insurer.

A few state guaranty funds are triggered only upon an order with a finding of insolvency, even if in an order of rehabilitation rather than in an order of liquidation. These states include Arizona, Arkansas, Connecticut, Kansas, Massachusetts, Montana, New Hampshire, New Jersey, New York, Rhode Island, Texas, Vermont and the Virgin Islands. This is why many orders of rehabilitation clearly state that there is not a finding of insolvency and that the state guaranty funds are not triggered, which, of course, has a major impact on the rehabilitation process. An example is the recent rehabilitation order for The Home Insurance Company in New Hampshire, which included the following provision:

> "(l) This Order shall not be deemed a finding or declaration of insolvency such as would activate the provisions of the New Hampshire Guaranty Association, RSA 404-B, or the provisions of similar acts of any other state or territory; . . ."[15]

Once triggered, both the expenses incurred in the claims process and the actual loss payments, up to a statutory maximum "cap", are paid by the funds. Statutory caps range from a low of $50,000 to a high of $1,000,000, with the average and most common ranging from $300,000-$500,000. Guaranty funds, in many ways, act as a substitute for the now insolvent insurer's claims department. Today, claims may be paid as early as 90 days after an order of liquidation is issued.

But not all claims are handled by guaranty funds. For example, most property/casualty guaranty funds exclude coverage for certain lines of business, such as financial guaranty,

disability, fidelity and surety, residual value, credit insurance and assumed reinsurance. In addition, approximately one-third of the guaranty funds statutes include a "net worth" threshold, whereby, otherwise covered claims will be denied coverage based on the net worth of the policyholder. The expansion of excluded coverages and criteria for covered claims encourages policyholders, particularly large commercial insureds, to forum shop in order to find a guaranty fund to handle their claims. Guaranty funds initially determine what is and what is not a "covered claim" under the state's Guaranty Association Act. When a claim is not handled by a guaranty fund the receiver must advise the policyholder that he/she now has the ultimate responsibility for handling the claim and then filing a claim for reimbursement in the insolvency proceeding.

Guaranty fund coverage is not always the only available avenue for recovery of claims against an insolvent insurer. Challenges to guaranty fund determinations and interpretations of the role of guaranty funds are on the rise. In a 2001 New Jersey case, for example, the court ruled that where the same claim is covered by both a solvent insurer and an insolvent insurer, the Guaranty Association has no obligation until the limits under the solvent insurer's policy is exhausted.[16] Likewise, the Court of Appeals in Ohio held that a party must exhaust all rights of recovery against solvent insurers of all tortfeasors before the Ohio Insurance Guaranty Association will be responsible for damages.[17]

When an insured or third-party claim exceeds the guaranty fund's statutory cap, the claimant retains a claim for the excess due under the policy directly against the estate. An individual claimant may also settle with the guaranty fund for the statutory cap less the statutory deductible, if any. Most guaranty funds will attempt to settle a claim, however, with a full release.

After the receiver approves and "allows" the excess claim, it will be paid as a distribution along with other "allowed" claims. To the extent that guaranty funds pay claims, they become subrogated to the claimant's rights against the insolvent insurer's estate. They occupy the same statutory priority as policyholders and third-party claimants. Unlike these other claimants, however, the guaranty funds are entitled, by statute, to periodic early access from the estate's assets, plus reimbursement for their cost of administration.

The Life Guaranty Associations handle the claims of insolvent life insurers, although it is typical that the receiver will continue the blocks of business and may pay claims for a period of time. Life guaranty association laws focus on the continuation of coverage, unlike the property/casualty laws, which generally terminate coverage 30 days following an order of liquidation. Commonly, the statutory obligation of life guaranty associations is to "assume, reinsure or guaranty…the contractual obligations of the insolvent insurer."

Although both guaranty funds and receivers have a duty to protect the policyholders of insolvent insurers, their roles are different. The guaranty fund is concerned with the determination and payment of "covered" claims, while the receiver is concerned with the "allowance" of the entire claim, that portion covered by the guaranty fund and the excess, if any. Therefore, it is imperative that the receiver and guaranty funds not only maintain open communication, but also must continue to cooperate to achieve their common goal- the payment of claims.

An example of the need for communication among guaranty funds and receivers was underscored in an interesting and unusual "conflict" between the Liquidator of Reliance Insurance Company in Pennsylvania and the guaranty funds concerning the "ownership" of large deductible payments. Most recently the Reliance liquidation has presented a unique "conflict"

between the Liquidator and the guaranty funds concerning the "ownership" of large deductible payments.

Reliance issued many policies to commercial insureds with a large deductible of at least $100,000. Many of these insureds had established funding mechanisms for the payment of these deductibles and provided significant collateral to Reliance to secure the payment of the deductibles. Some of these same policies are entitled to guaranty fund coverage. Both the Liquidator and the guaranty funds claim ownership to the deductibles once the claim has been paid, even if the claim has only been paid in part by a guaranty fund. In order to permit the orderly administration of these policies, the Liquidator and the guaranty funds reached an agreement for the handling of these large deductibles,[18] which covers Workers' Compensation, Auto and General Liability policies.

Under the agreement large deductible policies are being handled in two ways: (i) 'self-funded large deductible policies' where the policyholder funded the claims directly with a Third Party Administrator ("TPA") under contract with Reliance (and often selected and controlled by the policyholder), and (ii) "Reliance-funded large deductible policies", where either Reliance or a TPA paid the claims on behalf of Reliance and the deductibles were then collected from the policyholder.

Under the Agreement between Reliance and the guaranty funds, the claims handling for self-funded large deductible policies would remain in place, unless a policyholder fails to pay, then the policy will be treated as a Reliance-funded large deductible. Reliance will be responsible to handle the billing and collection of policyholder reimbursements under the large deductible policies, and enforce the prefunding of deductible escrow of deposit funds. Only the

amount actually paid by a guaranty fund will be collected from the policyholder. Reliance will continue to make collateral drawdowns as required pursuant to the policies.

The deductible amounts recovered by Reliance will not become assets of the estate, but will be held in a separate account and on a quarterly basis, 80% of such funds will be paid to the guaranty funds to reimburse them for claim payments and related expenses for the large deductible policies. The remaining 20% will be kept in a separate account until ownership of the deductibles is determined.

A separate mechanism is in place to cover "large net worth policyholders" whereby the guaranty funds will either exclude from coverage such claims or seek reimbursement from the large deductible net worth policyholders but only for the actual amount paid plus related expenses. This will thus protect against the policyholder paying twice – the policyholder will either pay the deductible reimbursement or the statutory net worth reimbursements, but not both.

The Agreement is valid for 18 months, with a 90 day moratorium on litigation to determine the ownership of the deductible.

G. The Impact of an Insurance Insolvency

When a final order of liquidation, with a finding of insolvency, is issued, all the rights and liabilities of the insurer, its policyholders and other creditors, are fixed as of the date of the entry of the order of liquidation. Property and casualty policies are generally cancelled within 30 days of the order of liquidation, whereas in a rehabilitation, the policies may be continued, transferred to and assumed by reinsurers, or sold to other insurers.

Depending on the insurer's cash flow and ability to pay all policyholder claims in full, a rehabilitator may need to impose a temporary moratorium on the continued payment of claims and/or defense of insureds on cash surrenders/policy loans/dividends, with consideration given to

hardship exceptions. Whether or not an insurer can be successfully rehabilitated or placed into liquidation often depends on cash flow considerations. In fact, it was the inability of the rehabilitator in Reliance to infuse cash through settlements with reinsurers following 9/11 that contributed to the decision to terminate the rehabilitation of Reliance and seek a final order of liquidation, which was granted by the court in Pennsylvania on October 3, 2001.[19]

In a liquidation of a property/casualty insurer, the cancellation of insurance policy obligations raises several legal issues with respect to such obligations. Not only does the order of liquidation effectively cancel in-force policies, but it also fixes the date for ascertaining debts and claims against the insolvent insurer.

The insolvency of a life and annuity insurer presents a different situation. Generally, life, health and annuity policies are not cancelled, and through the coordination of NOLHGA and the state life and health guaranty associations, these policies are either sold or assumed by the reinsurer on the book of business.

Policyholders, third party claimants, and ceding insurers have the most to lose when an insurer is placed into receivership. However, other significant players, especially producers, intermediaries and reinsurers, can also be significantly affected.

Agents, brokers and MGAs are required to account for all premiums and commissions, whether earned or unearned, to the receiver and to pay over immediately all funds, whether earned or unearned. Set offs by agents are no longer permitted. A receiver may cancel contracts with general agents, agents and MGAs. Intermediaries, however, are often instructed to continue to perform all contractual duties and responsibilities, although some of their duties may well be changed. Receivers will often direct the intermediaries to:

(i) Turn over original LOCs

(ii) Continue to render accounts

(iii) Assist in the collection of funds from reinsurers

(iv) Cease netting of accounts

H. Collection of Reinsurance Receivables

As previously stated, reinsurance plays a significant role in a receivership proceeding. The most significant asset of a property/casualty insurer is often its reinsurance receivables. Reinsurance is a contract of indemnity and the cedant may only collect the amount paid in losses and related expenses form its reinsurers. But when a cedant is declared insolvent the statutorily mandated "insolvency clause" is invoked, thereby providing an exception to the indemnity rule. Following is a discussion of how underlying policyholder claims alter the relationship between a now insolvent insurer and its reinsurers.

1. The Insolvency Clause

The "insolvency clause" in a reinsurance agreement governs the rights and obligations of the parties once one of the parties is placed in receivership. A typical clause provides:

> In the event of the company's insolvency, the reinsurance is payable on the basis of the company's liability…without diminution because of the company's insolvency or because its liquidator, receiver or statutory successor has failed to pay all or a portion of the claim.[20]

Very simply, the reinsurer is obligated to pay the Receiver its full liability, notwithstanding whether the Receiver pays less than the full amount of the claim. It does not mean, "Pay as paid."

The insolvency clause is best understood by reviewing its origins. In 1932, Southern Surety Company of New York was declared insolvent and Superintendent Pink was appointed Liquidator. Pink "allowed" a claim for payment, but did not actually pay it. He then sought indemnity from the reinsurer, who refused to pay because it was only required to indemnify after payment of an actual loss. Pink sued the reinsurer and the case went all the way to the United States Supreme Court, which held in favor of the reinsurer in Fidelity & Deposit Co. v. Pink.[21]

Pink sought revenge by introducing legislation, which is now Section 1308(a)(2)(A) of the New York Insurance Law. Under this provision, a reinsurance agreement must include the "without diminution" provision of the insolvency clause or the ceding insurer cannot take credit for its reinsurance receivables on its financial statement. As the New York Court of Appeals noted in Kemper Reinsurance Co. v. Corcoran,[22] the "loss of those rights is substantial because if the primary insurer must maintain reserves in the full amount of reinsurance ceded, one of the primary reasons for obtaining reinsurance is defeated." Thus, by requiring reinsurance agreements to contain the clause before an insurer can claim a deduction for the amount ceded or treat the reinsurance receivable as an asset, this reinsurance regulatory credit requirement provides needed protection to ceding insurers.

Today virtually every state has legislation based on the New York statute, and almost all reinsurance agreements contain an insolvency clause. Also, there has been significant case law that reaffirms the principle that the reinsurer's liability remains unaltered by the reinsured's insolvency.

Reinsurance proceeds often attract the attention of not only the receiver, but also policyholders and state guaranty funds, claiming that they are third-party beneficiaries to the reinsurance contract. Courts have generally not permitted recovery from reinsurers to other than the statutory successor, in the absence of specific language in the reinsurance agreement permitting such direct payments.

Guaranty funds have attempted to claim the right to reinsurance recoveries as a right of subrogation, but the courts have not generally accepted this reasoning.

2. Notice and Defense Provision

In addition to the "without diminution" provision, the insolvency clause contains another provision that has not attracted much attention in the past, but which may prove to be of equal importance: the "notice and defense" provision. This provision requires receivers to provide notice of claims to reinsurers, and to allow reinsurers at their own expense to become associated with the investigation and defense of claims. The inclusion of the "notice and defense" provision in the insolvency clause is permissive rather than statutorily mandated.

Although the effect of the receiver's failure to strictly comply with the notice provision has not yet been subject to litigation, reinsurers are raising late notice and lack of notice defenses in disputes and settlement discussions with receivers. Decisions outside of insolvency cases, however, have generally held that a reinsurer must show prejudice by a cedant's late notice before coverage can be avoided, and insolvency cases will likely follow suit. But more importantly, the "notice clause" is also now being used to challenge receivers' authority to estimate contingent claims in order to accelerate reinsurance receivables and effectuate final Liquidation Distribution Plans.

Over the years there have been an increasing number of arbitrations and litigations in response to receivers' attempts to collect receivables from reinsurers of insolvent ceding insurers. Some of the more contentious issues involve enforcement of cut-throughs and honoring the set-off provisions found in most reinsurance agreements.

3. Cut-Throughs

Creating direct liability from a reinsurer to the original insured through a cut-through clause or cut-through endorsement has, historically, not been well-received among regulators and has been the subject of some debate, litigation and even lobbying before state legislators.

It is a well-settled principle that reinsurance proceeds are general assets of the estate and these proceeds are distributed by the receiver to all creditors. Policyholders, particularly large commercial insureds with significant potential claims, may look to circumvent the liquidation process and enforce a cut-through clause or endorsement when their insolvent insurer fails to pay claims. Where there is a clear cut-through arrangement, these policyholders would likely fare better than if they waited for a distribution from the estate, and the reinsurer would probably realize a substantial savings on its liabilities.

But it is also well accepted that a reinsurance agreement is a contract of indemnity between the cedant and its reinsurer, and does not exist for the benefit of the original insured. Generally, there is no privity between the reinsurer and the insured. Nevertheless, it is possible to create contractual liability between the reinsurer and the original insured by the use of the "cut-through" clause or a "cut-through" endorsement. The cut-through is designed to change the route of payment only, and not to increase the intended risk to the reinsurer. The cut-through clause or endorsement is the reinsurer's promise to pay reinsurance proceeds to a named party, usually the insured or a lending institution, after the direct insurer is declared insolvent. The cut-

through does not enlarge or diminish the reinsurer's obligations, it only reroutes the payment, unlike an assumption of liability endorsement (A.L.E.), where the reinsurer agrees to assume not just the amount due under the reinsurance contract, but the entire liability of the insolvent insurer to its insured or third party. Thus, the reinsurer undertakes to assume and carry out the financial obligation of the insurer regardless of any reinsurance retention or limits.

Cut-throughs and A.L.E.'s are usually asked for to provide greater financial strength or a higher credit rating than the direct insurer can provide. Cut-throughs and A.L.E.'s enable the insurer to retain its valued business, while the reinsurer retains its client (the insurer) and premium flow.

Even with a properly worded cut-through, the reinsurer assumes risks -- particularly that of double payment: if the reinsurer honors the cut-through and pays the loss, a liquidator may still demand full payment for the same loss under the insolvency clause in the reinsurance agreement. Generally, the courts have favored the liquidator by finding that the cut-through is a preference.

Several states have amended their statutes to allow for cut-throughs that are specifically provided for in the reinsurance agreement. Illinois and Wisconsin have a favorable statutory framework, but actual enforcement has not yet been tested. In addition, a number of states have either amended their credit for reinsurance or insolvency provisions to permit cut-throughs under certain circumstances, including Arizona, California, Connecticut, Florida, Idaho, Indiana, Iowa, Kansas, Minnesota, Nevada, New Jersey, New York, South Carolina, Texas and Washington.

Other states may consider amending their statutes, but only a challenge to the enforcement will tell whether these are friendly amendments. For example, although Section 1308 of the New York Insurance Law provides for cut-throughs, Circular Letter 1998-5 raises

interpretation issues. And in June 2000, the New York Insurance Department issued an informal opinion in response to an inquiry on whether a cut-through endorsement would be effective in the event of the insolvency of a ceding insurer. The opinion stated that the right of an insured to collect from the reinsurer can be preserved by the provisions of the reinsurance contract; however, the cut-through arrangement would be subject to the rules governing voidable transfers.[23] Therefore, if the cut-through was entered into within 12 months prior to the insurer's receivership and with the intent that the insured receive preferential treatment, the cut-through would be set aside. To prevent such a result, it is recommended that the insurer/reinsurer seek approval from the Department before the cut-through is issued.

Yet consider the decision In Re Liquidation of Galaxy Ins. Co.,[24] where the New York Liquidation Bureau sought enforcement of certificates of suretyship (endorsements) issued by an affiliate of Galaxy which provided a promise to defend and indemnity insureds in the event that Galaxy became insolvent. Although the New York Insurance Department had not and most likely, would not have approved such an endorsement, the Appellate Court found that the affiliate was required to honor its contractual obligation.

The leading case dealing with the viability of cut-throughs in the insolvency area is Warranty Association v. Commonwealth Insurance Co.[25] In this 1983 case, the Supreme Court of Puerto Rico held that the enforcement of cut-throughs in an insolvency proceeding would amount to an unauthorized preference in a liquidation, and be unfair to other policyholders and creditors of the estate.

Attempts to recover reinsurance proceeds directly have been made by policyholders and state guaranty funds, and most recently in connection with Equitas' liability in connection with Lloyd's reinsurance run-off business, whereby insureds are claiming that they are third-party

beneficiaries to the reinsurance contract. Courts generally do not permit recovery from reinsurers in the absence of specific language in the reinsurance agreement permitting such direct payments. In a very recent case (Gannon Trucking v. Aon Corp.),[26] a California court held that a policyholder that was unable to recover an adverse judgment from its insolvent insurer (American Eagle) had no standing to sue the insolvent carrier's reinsurers because the insured was not listed in the reinsurance agreement as a third-party beneficiary.

But compare with Klockner Stadler Hunter, Ltd. v. Insurance Co. of the State of Pa.,[27] where a New York federal district court clearly recognized that "an insured ordinarily does not have a direct right of action against a reinsurer, since the reinsurance contract is only one of indemnity to the original insurer." The Court, nevertheless, rejected the argument that the insured could not bring claims against the reinsurer, because of the nature of the relationship among the parties. In Klockner, the insured alleged and the court found that the reinsurer not only was directly responsible for premium and claim handling, but also dealt directly with the insured.

Other examples come from the New Jersey courts, which appear to enforce cut-throughs when it finds that the reinsurer has assumed underwriting, financial or claim responsibility. In Venetsanos v. Zucker, Facher & Zucker,[28] a New Jersey Appellate Court held that a reinsurer was directly liable to the third-party beneficiary of the underlying policy where the unauthorized reinsurer was determined to "control" the underlying policy for the authorized "fronting" insurer. Here, the reinsurer underwrote the policy, assumed 100% of the risk, negotiated and settled claims and reimbursed the insurer for all payments under the policy. Similarly, in Employers Mutual Cas. Co. v. Owens Ins. Ltd.,[29] a New Jersey state court refused to dismiss an action against Equitas, because Equitas had assumed financial and claims handling responsibility.

4. Setoffs

Most reinsurance agreements contain a setoff clause that permits either party to net credits against debits and pay the balance. Some "setoff" clauses permit the parties to off set any balances due from one party to the other under a particular agreement only or under any other reinsurance agreement entered into by and between them.

The right to set off has been and continues to be challenged. Various jurisdictions have allowed reinsurers to off set monies owed to an insolvent ceding company, while others have ruled against setoff. The courts in New York and California, for example have upheld the right to offset under reinsurance agreements.

In Kemper,[30] the New York Court of Appeals upheld a reinsurer's right to setoff monies due to and from an insolvent insurer under separate and distinct reinsurance agreements. The Court reinforced the judgment of the Appellate Division, which stated that "it is black letter law in New York that the Liquidator steps into the shoes of the insolvent insurer assuming all of the rights and subject to all of the defenses and setoffs the insurer was subject to at the time of the insolvency."

In addition, the Supreme Court of California, in Prudential Re,[31] ruled that Mission's reinsurers had the right to setoff amounts they owed to the insolvent insurer by amounts owed to them. In so finding, the Court held that a reinsurer's right to setoff should not be conditioned upon the insolvent insurer's ability to pay in full the claims of those in higher priority classes.

More recently, the Supreme Court of Massachusetts, in Commissioner v. Munich America,[32] held that setoff is generally appropriate between mutual debtors-creditors, even if one

is insolvent. The court found that there was nothing explicit or implicit in the statutory scheme for this legislation that rendered the common-law principles of setoff inapplicable.

Contrary positions on the setoff issue, however, have been taken in other jurisdictions. For example, in Swiss Re Life Co. of America v. Gross,[33] the Virginia Supreme Court held that Swiss Re could not set off sums it owed to an insolvent insurer under certain reinsurance treaties (the "Integrated treaties") against amounts due to Swiss Re under separate reinsurance treaties with the insolvent (the "Fidelity treaties"). Because Fidelity was in receivership when Swiss Re acquired the Integrated treaties, the rights Swiss Re acquired under those treaties were different than the obligations owed by Swiss Re under the Fidelity treaties. Thus, there was no mutuality of debts and credits.

A cedant's petition to setoff premiums it owed to an insolvent reinsurer against losses owed it by the reinsurer's estate, was denied in Albany Insurance Co. v. Stephens[34] based on a Kentucky statute providing that: "No setoff or counterclaim shall be allowed in favor of any person where . . . the obligation of the person is to pay premiums, whether earned or unearned, to the insurer." The cedant had argued — unsuccessfully — that the statute did not apply to reinsurance transactions. The Kentucky court rejected this argument, noting that it would contravene both the "letter and spirit" of the Kentucky Insurance Code to allow parties to setoff their losses to the exclusion of other creditors.

I. Claims Estimation and Closure of Estates

One of the most important issues today, and the one with the greatest impact on reinsurers, is receivers' attempts to close long-tail liability estates. Rehabilitations do not

actually "close", but are ordered into liquidation or control of the insurer is returned to the original owners or to new owners.

The best time to start planning for closure is at the start of the liquidation proceeding. There are three general types of final liquidation plans: the "run-off plan", the "cut-off plan", and the "final liquidation dividend plan" (or "FLDP"). Under a run-off plan the liquidator administers the estate and keeps the estate open until all allowed claims are fully liquidated. In contrast, an arbitrary point in time is set as the date after which all claims will be "cut-off" under a cut-off plan. An FLDP, on the other hand, tries to balance the various interests by setting a final bar date before which the holders of filed contingent claims must amend the claims to state absolute claims. Non-complying claims are then rejected.

Receivers in several jurisdictions have adopted, or have attempted to adopt, a claims estimation approach in connection with a FLDP. Under this approach the receiver estimates contingent and unliquidated claims to trigger the collection of reinsurance receivables so that the final liquidating dividends can be distributed and the estate closed.

1. Competing Interests: Cedants and Reinsurers

Cedants want claims estimation because it allows the estate to close earlier and reduces administrative costs. It also accelerates the recovery of reinsurance proceeds under the contracts, which increases the amount of assets in the estate for distribution to guaranty funds. Larger distributions to guaranty funds translate to lower assessments against insurers to fund the guaranty funds.

Reinsurers oppose claims estimation because it accelerates reinsurance recoverables and a reinsurer's liability does not mature until claims are liquidated. Claims estimation would

substantially impair the contractual relationship between a cedant and its reinsurers, first, by requiring reinsurers to pay claims that may never materialize --or may not materialize to the extent estimated; second, by eliminating reinsurers' right to arbitrate disputes under the reinsurance agreement; and third, by eliminating reinsurers' contractual rights under the notice and defense provision found in the insolvency clause.

As noted earlier, a typical notice provision not only requires the liquidator to give reinsurers notice of claims received against the estate, but also permits the reinsurers to investigate such claims and interpose, at their own expense, any defenses available to the now insolvent insurer or its liquidator. If contingent claims are allowed, reinsurers claim that they will be forced to waive their contractual right to raise coverage defenses that are available to the liquidator under the underlying policies and to the reinsurers under the reinsurance agreements.

2. Alternatives to Claims Estimation

Several alternatives to claims estimation have been suggested in an effort to balance the competing interests of cedants and reinsurers. One alternative is to modify the process by placing a cap on IBNR estimates, allowing reinsurers to pay recoverables in periodic installments, or appointing an arbitration panel to estimate claims instead of the receiver or the guaranty funds. The problem with this alternative is the difficulty in devising a process that will please all parties involved.

Another alternative is to develop a claims estimation process that would pay distributions to the guaranty funds but would not trigger acceleration of reinsurance recoverables. This approach would please reinsurers but would keep the estate open indefinitely.

A third alternative is to allow the guaranty funds to handle the runoff of an estate. A fourth alternative is to allow private vendors to submit bids to handle the runoff business. The private vendor would pay part of the final liquidating dividend to the estate immediately. While this approach may result in earlier distributions, it may not work for all estates because private vendors may only seek to bid on profitable insolvencies.

Although these approaches would technically close the estate insurance commissioners and receivers would likely oppose them on the grounds that they cannot delegate their statutory authority regarding insolvent insurers to third parties.

Yet another alternative is to establish a cutoff date for contingent and unliquidated claims. This approach would save administrative costs but it would also cut off the rights of third party claimants (the class that the guaranty funds and the state liquidation laws were designed to protect).

III. DEALING WITH THE INSOLVENCY PROCESS

In May 2000, the Task Force on Insurer Insolvency of the Tort and Insurance Practice Section of the American Bar Association issued its Final Report on the Receivership of Insolvent Insurance Companies. In its Report the Task Force reviewed the current state insurance receivership system and identified three significant problems: (a) the selection of qualified receivers; (b) the accountability for and an oversight over their performance; and (c) The lack of incentives in statutory authority and procedures to bring estates to closure.[35]

The report concluded that any significant weaknesses in the system relate back to one or more of these three issues. The report summarizes these three issues as follows:

> Under most state laws, the insurance commissioner, who is the statutory receiver of an insolvent insurer, appoints a special deputy receiver to administer the estate. While some individual deputy receivers have been well qualified to do the job, the Task Force believes that the current appointment process generally does not provide adequate assurances that qualified persons will be administering insurance receiverships.
>
> There is also inadequate oversight over receivers in many states. Insurance departments have limited resources for such functions. State receivership courts routinely approve the actions of receivers because there is no adverse party before the court to challenge a receiver's activities. Because there are few insurer insolvencies, judges may be assigned an insurer insolvency only once in their careers. Receivership courts do not generally gain the insolvency expertise needed to effectively oversee an insolvent insurer's estate.
>
> Appointed deputy receivers often have little incentive to bring an estate to prompt closure as, by doing so, they would render themselves unemployed. Even where some receivers want to bring estates to closure, they sometimes lack the statutory authority and procedures. The current state insurance receivership system has a virtual built in incentive to prolong the administration and early closure of estates.[36]

The treatise on Managing the Cost of Property-Casualty Insurer Insolvencies in the U.S. issued last fall by the Center for Risk Management and Insurance Research at Georgia State University concluded:

> "Our examination reveals several aspects of the U.S. insurer receivership system that contribute to higher insolvency costs. Fundamentally, there are incentive conflicts between regulators, receivers and other stakeholders that the system fails to control. Receivers have incentives to prolong receiverships and inflate costs (to increase their compensation) as these costs are passed on to parties that have little ability to influence the receivers' performance. <u>There is little transparency and accountability, and regulators and the courts do not exercise adequate oversight of receivers and receiverships</u>." [Emphasis added].[37]

These basic criticisms – lack of transparency, lack of accountability and lack of adequate oversight – should be kept in mind by any entity involved with or affected by an insolvent or

potentially insolvent insurer or reinsurer, and they should underscore the importance of being alert to potential early warning signs. Early warning signs may allow alert producers, insureds, insurers and reinsurers to consider protective actions before the commencement of formal proceedings by the regulators.

Armed with knowledge of the insolvency process, including its inherent weaknesses, it is important for participants in the insurance marketplace, whether an insurer, a reinsurer, an insured or a producer, to be constantly on guard for signs of concern or potential problems in the marketplace.

The following are a few common sense "Golden Rules" for anticipating and dealing with potential insolvency problems:

Rule #1. Before entering a significant insurance/reinsurance transaction, know where the exits are. In addition to analyzing the benefits of an insurance/reinsurance transaction, the participants should also analyze the transaction from a worse-case scenario. What happens if the other party or parties become insolvent?

Rule #2. Follow the money. Every party to the transaction should trace the flow of funds throughout the entire transaction, particularly if there are multiple participants, such as a TPA, MGA, or other intermediary involved with the handling of funds. Like musical chairs, consider what happens if the music stops at various points in the process.

Rule #3. Keep the funding current. If you are a cedant, make sure your reinsurers keep current on their contractual funding requirements. If you are a reinsurer, make sure you are not overfunded. If you are a self-insured with an excess insurer administering claims, make sure you can access the funds to pay claims if the administrator is insolvent.

Rule #4. Remember that receivers love to hold on to funds. Do not assume that simply because you have a contractual right to receive back funds from an insolvent insurer or reinsurer, that the receiver will relinquish the funds voluntarily or quickly. They won't!

Rule #5. There is no such thing as too much information. Published financial statements of insurers and reinsurers, and rating service reports are an essential step in knowing your partners in a transaction. In addition, your should be diligent in pursuing all sources of information, not just at the beginning of the transaction, but throughout the life of the relationship. Among the other sources to pursue are the following:

(a) Constantly update financial information. A.M. Best and other rating agencies periodically issue updates of their ratings of insurance and reinsurance companies. Although these updates are often behind the events that result in the ratings adjustments, over a period of time they can provide insight into trends within a company.

(b) Listen to the rumors. One interesting fact about rumors: they are often true. Also, rumors tend to run ahead of public disclosure of significant problems. It is important to pay attention to what is being said in the street about particular companies. It is also important to consider such information carefully so that false rumors are not perpetuated.

(c) Follow a company's response to questions and concerns. Shakespeare was on target in advising that protesting particular disclosures too much can be a sign that there may be some validity to the criticism. If the responding company addresses problems with emotional denials rather than by providing explanations and facts, this should give some pause to investigate further.

(d) Consider the source of information. If a producer, for instance, attempts to reassure you about the financial integrity about the company that it placed you with, consider whether or not that producer has an incentive to keep you with that carrier. For instance, does the producer have financial ties to the carrier?

After all is said and done, there is one final "Golden Rule":

Rule #6. Follow your instincts. It is important that you assess the status of your partners in the business with as much information and study as possible. Although you should obtain the opinions others, particularly from brokers and others, in the end, it should be your assessment that counts. Once you have made your mind to take a course of action, such as to change carriers or to seek a cut-through endorsement, proceed with diligence and determination. Even if you ultimately wrong about the financial condition of your carrier or reinsurer, you will have strengthened your position with respect to that carrier or reinsurer for the future. If you were right, you may have provided yourself with the opportunity to avoid significant financial impact on your business, and that should be your primary concern.

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ENDNOTES:

[1] 15 U.S.C. §§1011-1015.

[2] The term "receiver" is used in this article as a broad term intended to include a conservator, rehabilitator or liquidator.

[3] Texas Insurance Code Article 21.28, Section 2 (a). See also Section 12 (b), which states that "In making an appointment under this section, the commissioner shall attempt to reflect the ethnic, racial, and geographic diversity of the state."

[4] *Annual Report of the Liquidation Bureau to the Superintendent of Insurance of the State of New York on Year 2001 Activities of Insurance Corporations Subject to Rehabilitation or Liquidation*, Issued April 26, 2002.

[5] "*Managing the Cost of Property-Casualty Insurer Insolvencies in the U.S.*", Martin F. Grace. Robert W. Klein and Richard D. Phillips, Center for Risk Management and Insurance Research, Georgia State University, November 2002, Table III.1 at p.48.

[6] New York Supreme Court, Order appointing Superintendent of Insurance as Ancillary Receiver of Reliance Insurance Company entered December 14, 2001.

[7] See, for instance, the Rehabilitation Order recently entered In the Matter of the Rehabilitation of The Home Insurance Company, New Hampshire Superior Court, March 5, 2003.

[8] Insurers Rehabilitation and Liquidation Model Act §16, reprinted in III NAIC MODEL LAWS, REGULATIONS AND GUIDELINES, AT 555-20 (October. 2000).

[9] "*Managing the Cost of Property-Casualty Insurer Insolvencies in the U.S.*", *supra*, at pages 52-53.

[10] Pennsylvania Insurance Code, § 40-11-426

[11] Covington v. Ohio General Insurance Co., No. 01AP-213, 2001 WL 1013126 (Ohio App. Sept. 6, 2001) appeal allowed, 44 Ohio St. 3d 1451, 762 N.E. 2d 369 (Ohio 2002).

[12] Post-Assessment Property & Liability Insurance Guaranty Association Model Act, reprinted in III NAIC MODEL LAWS, REGULATIONS AND GUIDELINES at 540-1 (July 1996).

[13] N.Y. Insurance Law §§7601-7614. The New York property/casualty fund is also distinguishable in that it is not a separate entity from the Liquidation Bureau. In essence, it is a checking account that can be drawn against by the rehabilitator or liquidator directly.

[14] Life and Health Insurance Guaranty Association Model Act reprinted in III NAIC MODEL LAWS, REGULATIONS AND GUIDELINES at 520-1 (October 1999).

[15] The Home Insurance Company Order of Rehabilitation, *supra*, at p. 3.

[16] Jendrzejewski v. New Jersey Property Liability Ins. Guaranty Assoc., No. A-3939-99T1, 2001 WL 717062 (N.J. Super. June 26, 2001).

[17] Sutton v. Scheidt, No. 11-2000-12 WL 88797 (Ohio App. Feb. 2, 2001).

[18] Order of the Commonwealth Court of Pennsylvania entered April 26, 2002, approving the "Agreement Handling Reliance Large Deductible Policies."

[19] Koken v. Reliance Insurance Company, Pa. Court of Common Pleas, October 3, 2001. See also the News Release of the Pennsylvania Commissioner of Insurance of the same date.

[20] See N.Y. Insurance Law, §1308(a)(2), (3)

[21] 302 U.S. 224 (1937).

[22] 79 N.Y. 2d 253, 582 N.Y.S. 2d 58, 590 N.E. 2d 1186 (1992).

[23] Office of General Counsel, Informal Opinion, June 14, 2000.

[24] 274 A.D. 2d 320, 710 N.Y.S. 2d 72 (App. Div. 1st Dept. 2000).

[25] 1983 WL 204211 (P.R.)

[26] No. BC-199481 (Cal. Super. Los Angeles Cty. April 4, 2000).

[27] 785 F. Supp. 1130 (S.D.N.Y. 1990).

[28] 271 N.J. Super. 459, 638 A.2d 1333 (N.J. Super. Ct. App. Div.), cert. denied, 137 N.J. 166, 644 A.2d 614 (1994).

[29] No. MRS-C-51-96 (N.J. Super. Jan. 28, 2000).

[30] 79 N.Y. 2d 253, 582 N.Y.S. 2d 58, 590 N.E. 2d 1186 (1992).

[31] 3 Cal. 4th 1118, 842 P.2d 48, 14 Cal. Rptr.2d 749 (1992).

[32] 429 Mass. 140, 706 N.E. 694 (1999).

[33] 253 Va. 139, 479 S.E.2d 857 (1997).

[34] 926 S.W.2d 460 (Ky. App. 1995), rev. denied, Aug. 21, 1996.

[35] Receivership and Insolvent Insurance Companies, Final Report of the Tort and Insurance Practice Section, Task Force on Insurer Insolvency, American Bar Association, May, 2000 at p. 5.

[36] Ibid.

[37] "*Managing the Cost of Property-Casualty Insurer Insolvencies in the U.S.*", *supra*, at p. 1.