NOTE

INSURER INSOLVENCY: PROBLEMS & SOLUTIONS

I. INTRODUCTION

When disaster strikes, modern America turns to insurance companies for shelter and compensation. Without insurance, everyday tragedies would be exacerbated by an inability to muster the funds necessary to start anew. Legal judgments would often be unenforceable leaving the culpable party ruined and the injured party without effective recompense. Insurance has become a common remedy for the uncommon occurrence, and often is crucial for those who can afford it, transforming a bleak situation into one of hope and possibility.

Unfortunately, some persons who have put their faith into large insurance companies have seen their dreams of security shattered. In 1990, forty-three nationwide insurers were declared insolvent by state regulators. The fifty states, as regulators of the nation’s insurance companies, have found themselves with a burgeoning nightmare: due to a combination of factors ranging from the real estate “slump” to lower interest rates, multi-state insurers are no longer the stable economic powers they once were and are now struggling to survive. As


2. Insurance Information Institute, Insolvencies/Guaranty Funds, DATA BASE REP., Sept. 1991 (Ruth Gastel ed.), at 1 [hereinafter Insolvencies/Guaranty Funds]; see also Earl R. Pomeroy, Slowing the Slide Toward Insolvency, 90 BEST'S REV. 16 (Jan. 1990) (stating that the “[s]tate insurance regulators are observing ominous signs of emerging insolvency”).

3. Other factors contributing to the insolvency of insurance companies are: the “spiral-
a result, a critical issue in the American insurance business has become the method of rehabilitating insurance companies on the brink of insolvency. Proponents of the present system contend that the complexity and importance of the problems inherent in insurance company insolvencies are the very reason that 11 U.S.C. § 109(b)(2) exempts domestic insurance companies from the purview of the Bankruptcy Code and relegates the rehabilitation and liquidation of domestic insurance companies to the states. However, the inadequacies of state regulation have caused Congress to consider eliminating the insurance company exemption and to vest control over the regulation, rehabilitation, and liquidation of insolvent insurers with the federal government. This Note addresses the policies underlying the current exemption of insolvent insurers from federal regulation and the prevailing practices of state regulatory agencies in rehabilitating and liquidating insolvent insurers.

II. THE POLICIES

The Senate Judiciary Committee has justified the exclusion of domestic insurance companies from the Bankruptcy Code by stating that “[i]nsurance companies engaged in business in the United States..." A General Accounting Office Study has determined that the following factors contributed to the failure of several large property/casualty insurers in the last few years: (1) multiple regulators; (2) expanding markets; (3) excessive underpricing and minimal or poor underwriting of insurance; (4) imprudent management; (5) infrequent fiscal examinations; (6) inadequate internal controls; (7) insufficient loss reserves; (8) the adoption of precarious investment strategies; (9) obsolete audit guidelines; and (10) an inability on the part of regulators to identify and respond to insurers’ financial problems. See U.S. GEN. ACCT. OFF., Property and Casualty Insurance: Thrift Failures Provide Valuable Lessons, GAO/T-AFMD-89-7 (April 19, 1989) [hereinafter Property and Casualty Insurance] (statement of Frederick D. Wolf, Assistant Comptroller General, Testimony Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives); see also Insurance Industry, supra note 1; SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION, HOUSE COMMITTEE ON ENERGY AND COMMERCE, 101ST CONG., 2D SESS., FAILED PROMISES: INSURANCE COMPANY INSOLVENCIES 70 (Comm. Print 1990).

4. Section 109(b)(2) of the Bankruptcy Code provides that “[a] person may be a debtor under chapter 7 of this title only if such person is not... a domestic insurance company...” 11 U.S.C. § 109(b)(2) (1991).

Section 109(d) provides that “[o]nly a person that may be a debtor under chapter 7 of this title... may be a debtor under chapter 11 of this title.” 11 U.S.C. § 109(d) (1991). Therefore, the liquidation and rehabilitation of domestic insurance companies is beyond the scope of the Bankruptcy Code.

5. See infra notes 6-24 and accompanying text.

are excluded from liquidation under the bankruptcy laws because they are bodies for which alternate provision is made for their liquidation under various State or Federal regulatory laws.\textsuperscript{7} Although conclusory, this rationale has been adopted by many authorities, primarily because it is the only statement of congressional intent in this area.\textsuperscript{8} However, it does not explain the disparate treatment of domestic insurance companies and other debtors who are also regulated by the states but whose liquidation and rehabilitation is now executed within the confines of the Federal Bankruptcy Code.

The Fourth Circuit Court of Appeals set forth a more satisfying rationale in \textit{Sims v. Fidelity Assurance Ass'n}.\textsuperscript{9} Fidelity, a multi-state investment company incorporated in 1911, sold annuities throughout its corporate life until 1940.\textsuperscript{10} At that time, Fidelity revised its corporate charter in order to enter the life insurance business.\textsuperscript{11} Fidelity sold insurance for four months after the charter revision, but was then ordered to cease selling its policies by the State Insurance Commissioner.\textsuperscript{12} Fidelity subsequently filed a petition alleging insolvency and sought to reorganize as a debtor under the Bankruptcy Act.\textsuperscript{13}

\begin{itemize}
\item The Supreme Court has held that Congressional power to regulate the insurance industry stems from the Commerce Clause of the Federal Constitution. United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944).
\item \textsuperscript{9} 129 F.2d 442 (4th Cir. 1942), aff'd, 318 U.S. 608 (1943).
\item \textsuperscript{10} Id. at 445.
\item \textsuperscript{11} Id. at 446-47.
\item \textsuperscript{12} Id. at 447.
\item \textsuperscript{13} Id. The applicable provision of the Bankruptcy Act which prevented domestic insurance companies from filing for bankruptcy was 11 U.S.C. § 22 (1910) (repealed 1978). That provision read:

\begin{quote}
Section 4. Who May Become Bankrupts.
(a) Any person, except [an] ... insurance ... corporation ... shall be entitled to the benefits of this Act as a voluntary bankrupt.
(b) ... and any moneyed, business, or commercial corporation except [an] ... insurance ... corporation ... may be adjudged an involuntary bankrupt.
\end{quote}

\textit{Id.}
The district court approved the petition and enjoined the state officials who were otherwise to preside over the liquidation from disposing of the insurer's property and ordered the state to deposit with the bankruptcy trustee all assets that were under the state's control.14

In finding that Fidelity was a "domestic insurance company" within the meaning of the Bankruptcy Act, the court provided a detailed analysis of the policies underlying § 109(b)(2). The broad purpose of the exclusion, the court stated, "may be surmised to lie in the public or quasi public nature of the business, involving other interests than those of creditors, in the desirability of unarrested operation, the completeness of state regulation, including provisions for insolvency, and the inappropriateness of the bankruptcy machinery to their affairs."15 Moreover, the following specific policies were said to support the exclusion:

(1) Judicial Economy. The court noted that insurance companies are likely to have "a variety of insurance obligations" and that many, if not all, of the policy holders and creditors would seek to be represented during the pendency of the bankruptcy.16 Furthermore, the various claims would have to be examined for authenticity and accuracy, a problem "requiring much time and elaborate accounting for its solution" and perhaps, depending upon the size of the case, drawing out the proceedings for years.17 While a similar situation might arise whenever a large corporation declares bankruptcy, it is a certainty in the case of insurance companies. Therefore, rather than burdening federal courts with protracted cases, Congress believed that justice and the interests of creditors would be best served by allowing the states to administer insurer insolvencies.

(2) Ease of Administration. In addition to having to contend with a large class of potential creditors, insurance companies are subject to numerous laws and regulations. All fifty states, as well as several territories, have statutes that govern the insurance companies within

16. Sims, 129 F.2d at 449; see also Buchbinder, supra note 8, at 89 ("There are a myriad of issues arising [in the case of insolvent insurance companies] that are too complex and unusual to be considered within the purview of the bankruptcy system. For example, there are the rights of the policy holders; the rights of the claim holders, and the rights of the shareholders and other general creditors. Separate regulation pays more careful attention to these precise relationships.").
17. Sims, 129 F.2d at 449.
their respective boundaries. The states also provide for guaranty funds whereby solvent insurers pay the claims of insolvent or rehabilitating insurers. Thus, states have a vested interest in an insurer's solvency and in ensuring that the integrity and technical accuracy of insolvency proceedings are protected. If a domestic insurance company is declared insolvent, every state whose guaranty fund is threatened is likely to seek representation in the bankruptcy proceedings, lengthening the case and perhaps confusing the issues. Permitting the states to oversee their own portion of insolvency proceedings prevents bankruptcy courts from having to learn the precise and technical laws of several states simultaneously. As the Sims court noted, "it would be a ruinous thing to the state, to the depositors, and to the creditors to have the elaborate [regulatory and insolvency schemes] which the state provides broken into and nullified by bankruptcy proceedings . . . ."

(3) The States' Interest in Protecting the Public Interest. Insurance companies are "affected with a public interest" because individuals who deal with them are generally at an economic disadvantage. Therefore, the courts have concluded that "since the states commonly kept supervision over [the insurance companies] during their lives, it [is] reasonable that they should take charge on their demise." Thus, it is clear that when Congress enacted § 109(b)(2), there were many apparently sound reasons for doing so. Nevertheless, in order to obtain the protection of the Federal Bankruptcy Code, entities that appeared to fit under the § 109(b)(2) insurance company exclusion argued that they were not the type of entity that § 109(b)(2) was

18. See infra note 78. The list found therein is representative, not exhaustive.
19. See, e.g., Insolvencies/Guaranty Funds, supra note 2 and infra notes 91-98 and accompanying text.
20. See Sims, 129 F.2d at 449. The court specifically stated that "it was intended by [Congress that by] withdrawing jurisdiction over these corporations from the bankruptcy court . . . that this would not occur." Id.
21. "The affairs of an embarrassed or insolvent insurance company often require much technical skill and judgment and time for their adjustment and a carrying forward of the business, to prevent lapses and to permit reinsurance to simplify them." Id.
22. Sims, 129 F.2d at 449; see also Grand Lodge, Knights of Pythias v. O'Connor, 95 F.2d 477 (5th Cir. 1938); Woolsey v. Security Trust Co., 74 F.2d 334, 337 (5th Cir. 1934).
meant to encompass. In other words, they argued that they were not domestic insurance companies.

III. WHAT IS A DOMESTIC INSURANCE COMPANY?

At its most fundamental level, an insurance company "is a company or corporation engaged in making contracts" by which it "assumes particular risks of the other party and promises to pay . . . a sum of money on a specified contingency."25 Engaging in such a business—also defined as the "spreading and underwriting of a policyholder's risk"26—for any length of time may place an entity within the scope of section 109(b)(2).27 However, even if an entity has engaged in the business of insurance, if "the element of insurance is but incidental" to the business predominantly engaged in, the entity may not be "an 'insurance company' within the meaning of that phrase as it is commonly used and understood."28

Furthermore, "insurance companies" are not the only entities engaged in the type of business defined above. For example, health maintenance organizations have been a frequent subject of litigation centering on the issue of what constitutes a domestic insurance company. In order to effectively deal with this issue, courts have formulated three additional tests which determine whether an entity is a domestic insurance company. These are: (1) the "state-classification" test; (2) the "independent classification" test; and (3) the "alternative

25. 44 C.J.S. Insurance §§ 1, 91 (1988); see also Portland Metro, 15 B.R. at 104 ("[an insurer evaluates] and spread[] . . . an individual's risk of incurring . . . expenses among a large group." Its rates are determined by projecting a subscriber's "risk factor" with the goal of reducing the company's risk factor).

The United States Supreme Court has defined insurance as "the act of insuring, or assuring, against loss or damage by a contingent event; a contract whereby, for a stipulated consideration . . . one party undertakes to indemnify or guarantee another against loss by a certain specified contingency or peril, called a risk, the contract being set forth in a document called the policy." Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211, reh'g denied, 441 U.S. 917 (1979); and cert. denied, 469 U.S. 1160 (1985) (quoting WEBSTER'S NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE UNABRIDGED (2d ed. 1958)); see also Jordan v. Group Health Ass'n, 107 F.2d 239, 245 (D.C. Cir. 1939).


27. See Sims, 129 F.2d at 442. As indicated above, even a company which engaged in the business of insurance for a mere 4 months was determined to fall within the scope of § 109(b)(2). See supra notes 9-24 and accompanying text.

28. In re Prudence Co., 79 F.2d 77, 90 (2d Cir.), cert. denied, 56 S. Ct. 248 (1935) (The debtor's principal business was making and selling mortgages. The debtor guaranteed the payment of the mortgages sold to third parties, and was therefore held not to be an insurance company within the meaning of § 22 of the Bankruptcy Act).
relief" test.

A. The State Classification Test

The state classification test allows courts to characterize debtors as insurance companies if the state of the debtor's incorporation so views the debtor.29 The state's classification is considered important because "[w]hen Congress excepted not all companies affected with a public interest, but specified kinds of such companies, presumably it intended the states to define the kinds."30 If a state's statutory scheme classifies a debtor as an insurance company, the debtor may be deemed excluded from the Bankruptcy Code by § 109(b)(2).31 If the statute is ambiguous,32

the court will more closely examine the substance of the statute, especially the powers given [the entity] under the statutory scheme. In some instances, a comprehensive statutory liquidation scheme may indicate that the corporation is to be excluded from the reach of the Bankruptcy Code, although statutory provision for state supervised liquidation does not necessarily bring a corporation within the exclusionary language of § 109. If an examination of the state statute indicates that the state does not equate the [entity] in question with corporations in the excluded class, the [entity] is a proper debtor.33

In order to further clarify the issue, the test requires courts to take into consideration a number of factors, including: (1) The extent to which actions taken by the debtor in the due course of business


30. Prudence, 79 F.2d at 79 (quoting Union Guarantee & Mortgage Co., 75 F.2d 984 (2d Cir.), cert. denied, 296 U.S. 594 (1935)). Contra In re Colorado Indus. Bank of Fort Collins, 84 B.R. 735, 738 n.2 (Bankr. D. Colo. 1988) ("[T]he court is convinced that the 'state classification test' is inappropriate for determining jurisdiction because its utilization would result in an abdication of a federal court's responsibility to interpret federal law. No state scheme can override Congress's own intention as to who should be eligible for bankruptcy relief and the mere fact that a debtor is an [insurance company] as defined by state law is not dispositive of the issue of federal jurisdiction under the Bankruptcy Code.").


32. It is often the case with statutes concerning health maintenance organizations that their classification under state law is ambiguous. See infra notes 58-77 and accompanying text.

are similar to actions of entities which are "clearly exempted under § 109(b)(2);" 34 (2) The amount and quality of state regulation over the debtor, including the existence of statutory provisions concerning the liquidation of the debtor; 35 and (3) The "public or quasi-public" nature of the debtor's business. 36

The "state classification test" alone is not determinative of whether a debtor is an insurance company. Several courts have expressly disavowed the test as being dispositive of the issue, stating that the test should merely be a "predominating influence." 37 The primary reason seems to be that "the 'state classification test' [is] somewhat illusory, for no State scheme [can] override Congress' own intention as to who should be eligible for bankruptcy relief." 38 Therefore, the formulation of other tests has been necessary.


35. Southern Indus. Banking, 59 B.R. at 982. The court stated that "[a] significant factor . . . in applying the state classification test is whether the state provides a specific liquidation scheme. [citations omitted] The more comprehensive the liquidation scheme, the stronger the indication that the state sees a strong public interest in direct governmental supervision and control of the liquidation or dissolution of the institution." Id. at 984; see also Cash Currency, 37 B.R. at 621; Portland Metro Health, 15 B.R. at 104.


37. In fact, the Sims court stated that "[t]he scope of the provision by which . . . insurance . . . corporations are excepted from Bankruptcy proceedings is to be determined in any case by the classification of the corporation under the law of the state of its creation rather than by the character of its predominant business activity," Sims, 129 F.2d at 448, but that "the classification of a state statute [need not] be followed literally in every instance without any regard whatsoever to the real activity of the corporate body." Id. at 451; see also First American Bank & Trust, 540 F.2d at 346 ("The utilization of the incorporating state's classification of the corporation does not mean that state law will be followed literally without regard to an assessment of the actual operation of the petitioning corporation."); Cash Currency, 37 B.R. at 621 n.3; In re Morris Plan Co. of Iowa, 62 B.R. 348, 353 (Bankr. N.D. Iowa 1986).

Collier agrees with this view, stating that although the state classification test "is more favored by the courts, this does not mean that state law is followed literally without regard for the real activities of the corporation, particularly where the corporation has failed to utilize its charter or has developed into a different kind of corporation." 2 COLLIER ON BANKRUPTCY ¶ 109.02, at 109-14 (15th Ed. 1985).

38. In re Republic Trust & Savings Co., 59 B.R. 606, 614 (Bankr. N.D. Okla. 1986), appeal denied, 77 B.R. 282 (N.D. Okl. 1987); see also Colo. Indus. Bank of Fort Collins, 84 B.R. at 738-39 n.2 ("The creation of the bankruptcy court's jurisdiction is statutory and constitutional; as such jurisdiction does not depend on what a state court or a state legislative scheme might or might not do under certain circumstances.").
B. The Independent Classification Test

Under the "independent classification test," the language of the Bankruptcy Code must be construed in order to determine if the debtor falls within the scope of the statute.\textsuperscript{39} This rule was adopted by the Illinois bankruptcy court in \textit{Cash Currency Exchange, Inc. v. Shine}\textsuperscript{40} as the predominant rule in determining the scope of the §109(b)(2) exclusions, to the disavowal of the "state classification test"\textsuperscript{41} and the "alternative relief test."\textsuperscript{42}

In interpreting the language of §109(b)(2), the \textit{Cash Currency} court observed that aside from a limited number of specific exclusions, the Bankruptcy Code's inclusion of debtors is fairly broad.\textsuperscript{43} The general rule of statutory construction requires that where a statute delineates specific exclusions, the statute otherwise applies to all entities not specifically excluded.\textsuperscript{44} Thus, statutes that specifically exclude entities from their scope are considered exhaustive, not illustrative.\textsuperscript{45} Moreover, statutory provisions should be construed so as to give effect to their plain meaning.\textsuperscript{46} Therefore, under the "independent classification test," the court will merely look to whether the debtor in question fulfills the functions and has the powers understood to be those exercised by entities normally fitting the definition of insurance companies.\textsuperscript{47}

C. The Alternative Relief Test

The "alternative relief test," a relatively new test\textsuperscript{48} for determin-
ing whether a debtor is excluded from § 109(b)(2), is "a policy based analysis" which permits courts to exercise the broad discretion vested within them by Congress "to serve the purpose and intent of the Bankruptcy Code." The test enables courts to be flexible rather than compelling them to adhere to the comparatively rigid state and independent classification tests when evaluating the applicability of § 109(b)(2) to a debtor. "In general, 'courts should consider whether a bankruptcy proceeding is a satisfactory method, compared with available State and Federal non-bankruptcy methods, of reorganizing or liquidating a would-be debtor.'"

The alternative relief test obviously allows a court to be relatively subjective in its analysis of the applicability of § 109(b)(2). The test has been the subject of both praise and criticism, the latter most notable in In re Beacon Health Services. In Beacon, the court found that the alternative relief test was "irrelevant" when applied to a debtor that engages in business in only one state. Bankruptcy Judge James E. Yacos wrote:

[i]n legislating the exception to federal bankruptcy relief, Congress said in effect if an entity is an 'insurance company' there is no federal relief regardless of any considerations of comparable effectiveness of the state and federal procedures. A bankruptcy court is not authorized . . . to ignore the command of § 109(b) of the Bankruptcy Code just because it believes relief in its court will be more effective.

The court then expressed the belief that the alternative relief test might be appropriate where there are "numerous states involved, [and] classification and independent classification tests. See, e.g., Sims, 129 F.2d at 442. What is new is its classification as an independent test. In re Family Health Services, Inc., 101 B.R. 628 (Bankr. C.D. Cal. 1989) has expressly recognized this third category; see also In re Republic Trust & Savings Co., 59 B.R. 606, 611 (Bankr. N.D. Okla. 1986).

49. Family Health Services, 101 B.R. at 626.
50. Id.; see also 1 COLLIER ON BANKRUPTCY ¶ 4.05[2], at 593 (14th ed. 1975).
52. See, e.g., Republic Trust, 59 B.R. at 611; 1 COLLIER ON BANKRUPTCY ¶ 4.05[2], at 593 (14th ed. 1975). Though neither source labeled the test as one of "alternative relief," the court disparaged both the "state classification test" and the "independent classification test" and then cited Collier for the proposition that "courts [are] free to take a 'reasonable and flexible approach' to the matter of eligibility for bankruptcy relief and 'should be guided largely by the question of whether a bankruptcy proceeding is a satisfactory method of liquidating the [entity] under consideration.'" See also In re Guaranty Trust Company, No. BK-78-62019 (W.D. Okla. Filed March 6, 1979).
54. Id. at 183.
it arguably might be difficult for the entities to get effective, coordinated relief in the individual states." 55 The court added, however, that it did "not find the underlying rationale [for the alternative relief test] compelling in any event, i.e., the fact of numerous states involved as being determinative as to whether an entity is within the exclusions of section 109(b)." 56

Indeed, the bankruptcy of a multi-state debtor that could clearly be classified as an "insurance company" under § 109(b)(2) might be expedited if in federal bankruptcy court under the purview of the Bankruptcy Code. However, absent a statutory amendment such a result would be devoid of statutory or constitutional authority, would directly contradict a command of Congress, and therefore would be void. 57 Nevertheless, where there is some question as to whether an entity is an insurance company, the alternative relief test—if used in conjunction with the "state classification" and "independent classification" tests—may be helpful in resolving the question.

D. Applying the Tests

In In re Portland Metro, 58 the debtor, an Oregon "health maintenance organization," sought to reorganize under Chapter 11 of the Bankruptcy Code. The court, using the "state classification test," found that the debtor was an "insurance company" for the purposes of determining whether the debtor fell within the scope of § 109(b)(2). 59 Citing Sims, the court concluded that "state law classification of the debtor as an insurance company rather than the predominant or any single activity of the debtor, which may include non-insurance activities, is... the primary test of insurance." 60 The court also noted that entities which are classified as insurance companies always have several elements in common: (1) They are extensively regulated by well-organized departments of the State and of the United States; (2) they are subject to express statutory procedures for non-bankruptcy liquidation; (3) the nature of their business is public

55. Id.
56. Id. at 186.
57. See Vallely v. Northern Fire & Marine Ins. Co., 254 U.S. 348, 353 (1920) ("Courts are constituted by authority and they cannot go beyond the power delegated to them. If they act beyond that authority, and certainly in contravention of it, their judgments and orders are rendered as nullities.").
59. Id. at 104.
60. Id.
or quasi-public and involve interests other than those of creditors. The court observed that the Oregon State Insurance Commissioner was engaged in regulating the debtor on a daily basis, and had the power to supervise the liquidation of the company. Moreover, the debtor was subject to regulation "as a health maintenance organization by the Federal Department of Health and Human Services." The court did not recognize the apparent incongruity of that statement: the debtor was viewed and regulated by the Department of Health and Human Services as a "health maintenance organization," and yet the court cited that fact as indicative of the debtor's being an insurance company. The court focused on the fact that because "regulation" existed—regardless of the characterization of the regulation by the administering agency—the debtor fulfilled the requirement that it be of "public or quasi-public nature." However, the court acknowledged the federal regulation even though by doing so the court undermined its finding that the entity was subject to comprehensive regulation as an insurance company. The incompatibility of the two positions was never acknowledged by the Portland Metro Court, but may be indicative of why other courts have not adopted Portland Metro's conclusions.

The court provided several other reasons supporting its conclusion that Portland Metro was an insurance company. The court remarked that the organization's subscribers viewed it as an insurance company, and pointed out the parallels between Portland Metro's operation and other, more typical insurance companies. Also, Portland Metro's relationship with its survivors begins with the evaluation and spreading of an individual's risk of incurring medical expenses among a large group. The [plaintiff's] subscriber rates are determined based upon a projected risk factor . . . with the goal of minimizing [the plaintiff's] exposure to loss . . . [The plaintiff] reinsures its excess liability with another carrier.

Finally, the court concluded that "[t]he fact that the debtor arranges for medical services by contracting directly with providers rather than by indemnifying subscribers only focuses on the debtor's means of

61. Id.
62. Id.
63. Id. (citing 42 U.S.C. § 300e-11).
64. Id.
65. Id. at 104-05.
accomplishing its objectives but does not detract from its purpose and character as an insurance company."\textsuperscript{66}

Conversely, several courts have found that health maintenance organizations are not "domestic insurance companies." Foremost among them is the Central District of California Bankruptcy Court, which decided a series of cases in 1989 under the name \textit{In re Family Health Services, Inc.}\textsuperscript{67} The cases involved forty-eight related health maintenance organizations in seven different states, 100,000 creditors, and 600,000 plan members with claims against the organization.\textsuperscript{68}

The Family Health plan members paid a monthly fee allowing them to take advantage of hospitals and doctors, regardless of the medical situation, at a reduced cost.\textsuperscript{69} Although the debtor was regulated by the Texas State Board of Insurance, it was authorized by the Board to do business only as a health maintenance organization.\textsuperscript{70} Moreover, the debtor's articles of incorporation stated that the debtor's purpose was to "plan, develop and operate a health maintenance organization."\textsuperscript{71} Finally, the Texas statute drew a distinction between "insurance companies" and "health maintenance organizations." An insurance company was defined as "a corporation doing a business involving payment of money conditioned upon loss due to sickness or health."\textsuperscript{72} Health maintenance organizations are defined as "any person who arranges for or provides a health care plan... to enrollees on a prepaid basis."\textsuperscript{73}

The court also emphasized the difference between health maintenance organizations and insurance companies. The court observed that health maintenance companies \emph{provide} services, whereas insurance

\textsuperscript{66.} \textit{Id.} at 105.

\textsuperscript{67.} 101 B.R. 618 (Bankr. C.D. Cal. 1989). Related cases dealing with other aspects of the entity called "MaxiCare" may be found, under the identical name of \textit{In re Family Health Services, Inc.}, 101 B.R. 628 (Bankr. C.D. Cal. 1989); 101 B.R. 636 (Bankr. C.D. Cal. 1989); 104 B.R. 268 (Bankr. C.D. Cal. 1989); 104 B.R. 279 (Bankr. C.D. Cal. 1989); 105 B.R. 937 (Bankr. C.D. Cal. 1989), \textit{vacated on separate grounds}, 130 B.R. 314 (9th Cir. 1991). These cases all remain within the judicial system. The case at 101 B.R. 618 [hereinafter \textit{Family Health}] is considered representative, and will be used for this discussion.

\textsuperscript{68.} \textit{See Family Health}, 101 B.R. at 619; \textit{In re Family Health Services, Inc.}, 130 B.R. 314 (9th Cir. 1991). The corporation had approximately one million members prior to filing for reorganization under Chapter 11 of the Bankruptcy Code.

\textsuperscript{69.} \textit{See Family Health}, 101 B.R. at 619.

\textsuperscript{70.} \textit{Id.} at 623.

\textsuperscript{71.} \textit{Id.}

\textsuperscript{72.} \textbf{TEX. INS. CODE ANN.} \S 3.01(3) (West 1981).

\textsuperscript{73.} \textit{Family Health}, 101 B.R. at 623; \textit{see also TEX. INS. CODE ANN.} \S 20A.02(j) (West Supp. 1989).
companies reimburse for services previously or currently being rendered.74 A health maintenance organization, the court found, merely controlled costs, and did not act to reimburse costs, and thus was not an insurance company.75

Another prominent health maintenance organization case that conflicts with the Portland Metro holding is In re Michigan Master Health Plan, Inc.76 The state statute provided for regulation by the "insurance bureau" but, as was the case in Family Health Services, drew a distinction between health maintenance organizations and insurance companies. Relying upon this statutory scheme and the "independent classification test," the court found that health maintenance organizations are essentially "medical clinics," and not insurance companies within the meaning of § 109(b)(2).77

Portland Metro, Family Health Services and Michigan Master Health Plan all aptly illustrate one of the problems posed by the various tests and classifications of debtors used to determine the applicability of § 109(b). Under the current system, entities, policyholders and plan participants are not treated equally from state to state. This is true, of course, of many entities in many fields. Yet in this situation, it is not enough to allow an entity to live and die by the laws of the state in which it has knowingly incorporated, or does business, because there are innocent policyholders and creditors involved. More often than not, policyholders will not be well versed in the complexities of the law, or the significance of the insolvency laws of their state or of the state where the entity is incorporated. Conversely, policyholders could be said to have constructive knowledge of the laws of their jurisdiction and of the company they contract with for medical or insurance services. But the problem goes beyond that.

In re Family Health Services demonstrates the real difficulty with § 109(b) and the current system of testing entities for inclusion under § 109(b). The insolvency of a multi-state insurer is governed by the laws of the states in which its subdivisions are incorporated. Yet, if those states provide a different classification for entities that perform the same function—as was provided by Texas and Oregon for the

75. Id. at 624; accord Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S., 205 (1979).
77. Id. at 277.
health maintenance organizations in *In re Family Health Services* and *In re Portland Metro Health*—then policyholders in the same company, purchasing what is essentially the same product, may receive widely disparate remedies in the event of an insolvency. Such a result—perhaps a full reimbursement for policyholders in one state, and nothing for policyholders in another—is patently inequitable and should not be permitted.

At this level, the simplest solution would be for Congress either to define a "domestic insurance company," or to include questionable entities within the scope of § 109(b)(2). Yet the discrepancy amongst the states is only one of the problems facing the current rehabilitation and liquidation system. The real difficulties lie, not in the disparities, but in the inadequacies of the states as regulators.

IV. THE DEATH OF AN INSURER

The insolvency laws of the several states are designed to ensure that, upon dissolution, an insurer's policyholders will not be left without a remedy in the event of disaster. The process, replete with regulatory safeguards, is inundated with incompetency, inadequacy, and inequity. This section of the Note examines the process and problems of the current system.

A. Regulatory Agencies

The state regulatory agencies, which oversee domestic insurance companies, rely upon various monitoring tools in order to ensure that insurance companies under their supervision remain able to pay their claims. The National Association of Insurance Companies ("NAIC") has created the Insurance Regulatory Information System ("IRIS") in order to identify insurance companies experiencing financial difficul-


79. For purposes of this discussion, the insolvency laws of New York and Florida will be examined with particularity. The fact that both states have adopted the Uniform Insurers Liquidation Act, see supra note 78, will highlight the differences between their statutory schemes.
ty. The system requires insurers to file annual financial statements with state regulators and to allow regulators to conduct on-site examinations. The insurer's financial strength in thirty categories is measured solely by means of the information contained within the financial statement. If the test "indicates that a company's financial ratios are outside the normal range in more than four areas, its finances are reviewed in greater detail to determine whether it is in need of immediate regulatory attention."

The IRIS system has been criticized on several grounds. Insurer-prepared financial statements are often unverified and stale. The statements are not reviewed by state regulators until several months after the close of the insurer's fiscal year, and problems may not be discovered for up to eighteen months after their inception. The problem has been aggravated by inadequate funding and manpower, which prevents state regulators from discovering problems as quickly as possible. Moreover, many state insurance departments rely upon examiners who do not meet NAIC standards.

The NAIC has commanded state insurers to share information regarding the health of multi-state insurers during insolvencies and

80. See Insolvencies/Guaranty Funds, supra note 2, at 9-10.
81. Id. at 10; see also U.S. GEN. ACCT. OFFICE, INSURANCE REGULATION: PROBLEMS IN THE STATE MONITORING OF PROPERTY/CASUALTY INSURER SOLVENCY, GAO/GGD-89-129 (Sept. 29, 1989) [hereinafter INSURANCE REGULATION].
82. INSURANCE REGULATION, supra note 81.
83. Insolvencies/Guaranty Funds, supra note 2, at 10.
85. Id. at 24; see also U.S. GEN. ACCT. OFFICE, INSURANCE REGULATION: STATE HANDLING OF FINANCIALLY TROUBLED PROPERTY/CASUALTY INSURERS, GAO/GGD-91-92, at 3 (May 21, 1991) [hereinafter FINANCIALLY TROUBLED INSURERS] (resulting in "insurance regulators [being] typically late in taking formal action against financially troubled companies. State regulators did not take formal action in 71 percent of failed insurer cases . . . until the insurers became insolvent or later").
86. FINANCIALLY TROUBLED INSURERS, supra note 85, at 33 ("Since 1989, NAIC has increased both staff and computer facilities to improve collection and analysis of financial and other data on insurance companies.").
87. Id. Though examiners are supposed to be certified as an Accredited Financial Examiner or a Certified Financial Examiner by the National Society of Financial Examiners, some of the examiners in 35 states did not fulfill either requirement.

http://scholarlycommons.law.hofstra.edu/hlr/vol20/iss3/5 16
inform other states whenever an insurer appears to be encountering financial difficulty. However, the states are often slow to do so, if at all. The result is that regulators in one state may not be aware that a "branch" of a multi-state insurer is in danger of requiring rehabilitation or liquidation until insolvency has been declared. Upon discovering that an insurer is in danger of becoming insolvent, the various states generally follow the procedures outlined in Part C of this Note.  

B. Guaranty Funds

In order to protect policyholders, every state—as well as the District of Columbia and Puerto Rico—has a "guaranty fund" which is used to help solvent insurers absorb the losses caused to claimants by insolvent insurers. In 1990, state guaranty funds contained an excess of nearly $2 billion after paying all claims filed due to insol-


89. See id.

90. See infra notes 99-126 and accompanying text.

91. See Insolvencies/Guaranty Funds, supra note 2, at 12-14. In addition, many insurers acquire "excess" insurance from other carriers in order to protect the insurer from excessive liability. The liability of the excess insurer remains intact, despite the insolvency of the primary insurer. However, the excess insurer's liability remains secondary to the liability of the primary insurer. Accordingly, the excess insurer does not have to pay the full amount of a claim against an insolvent primary insurer, but remains responsible only for the amount of the claim in excess of the primary insurer's liability, regardless of the ability of the insured to gain compensation from the primary insurer.

For example, assume a disallowed claim against an insolvent primary insurer in the amount of $2,050,000, and an excess insurer which has contracted to pay claims against the primary insurer in excess of $2,000,000. Despite the insured's inability to recover against the primary insurer, the excess insurer remains responsible for paying the amount of the claim exceeding $2,000,000. Therefore, the insured has an enforceable claim for $50,000 against the excess insurer. See, e.g., Zurich Insurance Co. v. Heil Co., 815 F.2d 1122, 1126 (7th Cir. 1987); Pergament Distributors, Inc. v. Old Republic Insurance Co., 513 N.Y.S.2d 467 (App. Div.), appeal denied, 514 N.E.2d 389 (N.Y. 1987); American Re-Insurance Co. v. SGB Universal Builders Supply, Inc., 532 N.Y.S.2d 712 (Sup. Ct. 1988). Cf. Gulezian v. Lincoln Insurance Co., 506 N.E.2d 123 (Mass. 1987) (the excess insurer is considered to "drop down" to first dollar coverage for the primary insurer, and in the above hypothetical would be responsible for the full $2,050,000 claim against the primary insurer); see also Mass. Insurers Insolvency Fund v. Continental Casualty Co., 506 N.E.2d 118 (Mass. 1987) (holding that if the primary insurer's obligation is unenforceable by the insured, "the excess policy in effect provides first dollar coverage" to the insured); infra notes 127-36 and accompanying text.
vencies. With the exception of New York, all states require their insurers to contribute to the fund subsequent to an insolvency, at which time they are assessed a prorated portion of the amounts necessary to maintain the fund. New York has a "pre-insolvency" fund wherein all solvent insurers contribute to the fund so that it always maintains a balance between $150 million and $200 million. The New York system is being studied by several states, because it is more effective than most: the money is present prior to insolvency, thereby preventing the possibility that a fund would not receive an adequate amount of financing upon the occurrence of an insolvency.

Expectedly, the states do not employ the same guidelines in the management of their guaranty funds. In some states, assessments are recouped by applying a surcharge to policies, and in others, by raising the premium taxes paid by policy holders. In addition, the funds have limitations: not all states cover all types of insurance, and some states have ceilings limiting any single guaranty fund payout. The result is that the same insurer's policy holders, if located in different states, may be treated very differently in the event of an insolvency. One may receive the full amount, or at least a portion of the claim owed it through a guaranty fund allocation, while the other may get nothing.

C. State Statutes

New York has provided that any organization or individual that is subject to supervision under the New York Insurance law shall be classified as an "insurer." Organizations are subject to supervision under the insurance law if they engage in business where they may be "obligated to confer [a] benefit of pecuniary value upon another party... dependent upon the happening of a fortuitous event in which the... beneficiary has, or is expected to have... a material

92. See Insolvencies/Guaranty Funds, supra note 2, at 5-6. The actual figures were $454.5 million paid out of an aggregate $2.4 billion (down from nearly $716 million in 1989). The guaranty funds of Maine and Louisiana were exhausted. Id. at 6.
93. Id. at 7.
94. Id.
95. Id. This procedure is followed in New Jersey and California. Id.
96. Id.
97. For instance, Colorado, the District of Columbia, Louisiana, and New Jersey do not have life or health insurance guaranty funds. Id. at 8.
98. Id. Colorado and Indiana will pay no more than $50,000. Oklahoma will pay a maximum of $150,000. Rhode Island, on the other hand, will pay up to $1 million. Id.
interest which will be adversely affected by the happening of such event.”

Conversely, Florida defines an insurer as “every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.” Insurance itself is “a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies.”

The distinction here is critical, particularly with regard to the threshold question of what entities constitute insurers. Health maintenance organizations are insurance companies under New York law, but are considered as separate entities by Florida. Thus, the insolvency of a New York health maintenance organization is not governed by the Federal Bankruptcy Code, but the insolvency of a Florida health maintenance organization is.

Once a state has identified an insolvent insurer, the state has three options: (1) attempt to solve the problems through informal “work-out” techniques; (2) initiate formal regulatory actions; or (3) commence rehabilitation or liquidation. The New York Superintendent of Insurance may order the rehabilitation of an insurer if the insurer is insolvent, refuses to permit the Superintendent to investigate its financial records, is found to be in a condition which could “be hazardous to its policyholders, creditors, or the public,” or has engaged in illegal activities. After obtaining the order of insolvency, the Superintendent assumes possession of the insurer and its

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101. FLA. STAT. ANN. § 624.03 (West 1990).
102. Id. § 624.02.
103. See id. § 624.04. The statutory definition of “person” does not include “health maintenance organizations.”
104. See, e.g., N.Y. INS. LAW § 7401 (McKinney 1991); N.Y. PUB. HEALTH LAW §§ 4307(d), 4310(c) (McKinney 1991).
105. N.Y. INS. LAW § 7402(a) (McKinney 1991). Insolvency occurs when an insurer “is unable to pay its outstanding lawful obligations as they mature in the regular course of business, as shown by an excess of required reserves and other liabilities over admitted assets, or by its not having sufficient assets to reinsure all outstanding risks with other solvent authorized assuming insurers after paying all accrued claims owed . . . .” N.Y. INS. LAW § 1309(a) (McKinney 1989 & Supp. 1991).
106. N.Y. INS. LAW § 7402(b) (McKinney 1991).
107. Id. § 7402(e). The term “hazardous” has been construed to encompass even the regular rejection of claims and their subsequent settlement by an insurer for less than full value. See, e.g., Caminetti v. Guaranty Union Life Ins. Co., 126 P.2d 159 (Cal. Ct. App. 1942).
108. The insurance company may appeal the Superintendent’s order by filing, but the
assets—usually consenting to the appointment of a conservator or receiver until such time as the rehabilitation has been successfully completed—and continues the insurer’s business. Unlike the conservator of a trust, the Superintendent, conservator or receiver is clothed with great discretion in the handling of the insurer, and is not required to obtain the consent of the court prior to transacting business. However, the Superintendent’s duty is merely to preserve the status quo until the insurer is rehabilitated. Therefore, the Superintendent remains subject to the control of the court, and parties in interest can object to the Superintendent’s actions during the pendency of the rehabilitation. If the Superintendent’s actions are shown by the petitioner to have been arbitrary or capricious, the court will direct the Superintendent to cease and desist.

Rehabilitation may be ordered for a Florida insurer if the insurer is declared insolvent, has withheld records, is engaging in unlawful practices, has failed to pay a final judgment rendered against it, or is the victim of embezzlement, among other reasons. Liquidation may be ordered for the same reasons.

New York law provides that if the Superintendent is unsuccessful, or does not believe that a successful rehabilitation is possible, the burden of proof is upon the company. In other words, the Superintendent’s order bears a presumption of propriety. See Caminetti, 126 P.2d at 159.


110. See, e.g., Lucas v. Manufacturing Lumberman’s Underwriters, 163 S.W.2d 750 (Mo. 1942).


112. See, e.g., Lucas, 163 S.W.2d at 750.

113. See, e.g., In re National Surety Co., 288 N.Y.S. 1014 (App. Div.), aff’d, 5 N.E.2d 358 (N.Y. 1936) (holding that the court should accord the insurer the highest degree of discretion in carrying out its duty).

114. “Unable to pay its outstanding debts as they become due in the usual course of business.” FLA. STAT. ANN. § 631.011(9) (West 1990).

115. Id. § 631.051(5).

116. Id. § 631.051(3).

117. Id. § 631.051(12). New York has no comparable provision.

118. Id. § 631.051(13). The embezzlement must have been great enough to “threaten” the corporation’s solvency, but need not have actually caused an insolvency. The effect is that even though the insurer is still able to pay its debts as they become due, and may have purged the wrongdoer, it can be seized by the State.

119. See generally id. § 631.051.

120. See id. § 631.061.
Superintendent may apply for an order allowing the liquidation of the insurer (an attempt at rehabilitation is not a prerequisite to seeking an order for liquidation).\textsuperscript{121} The Superintendent must reinsure the insolvent company, and thereby safeguard its primary obligations with a solvent domestic insurer that can absorb the additional policies.\textsuperscript{122} In addition, the Superintendent may sell the property of the insolvent insured, subject to the approval of the court,\textsuperscript{123} and must continue or commence any litigation that the insolvent insured was or may have been involved in if the recovery of additional assets for distribution to creditors may be realized.\textsuperscript{124} The remainder of Florida’s rehabilitation and liquidation provisions are substantially similar to New York’s, though not identical.\textsuperscript{125} Each state differs widely on the threshold question which determines the applicability of the statutory schemes: what constitutes an insurer. Thus, though both states have adopted the Uniform Insurer’s Liquidation Act,\textsuperscript{126} an entity in Florida may be entitled to take advantage of the Federal Bankruptcy Code, while an identical entity in New York may be foreclosed from taking that advantage.

\textbf{D. Claim Disposition}

The insolvency of an insurer is considered to breach the insurer’s contracts of insurance,\textsuperscript{127} and the insured is deemed to be a creditor for the value of its policy on the date of the insurer’s dissolution.\textsuperscript{128} If the insured has experienced a loss covered by its insurance prior to the insolvency, the loss is still enforceable against a subsequently

\begin{footnotesize}
\begin{enumerate}
\item N.Y. INS. LAW § 7404 (McKinney 1991). In addition, the Superintendent is the only party who may act as the liquidator, as opposed to rehabilitation proceedings wherein the Superintendent may consent to the appointment of a third party as receiver; see also In re Lawyers Title & Guaranty Co., 5 N.Y.S.2d 484 (App. Div.), reh’g denied, 9 N.Y.S.2d 126 (App. Div. 1938).
\item N.Y. INS. LAW § 7405(c) (McKinney 1991). The insolvent insurer’s “premium reserve” is used to effectuate the reinsurance.
\item See In re Lawyers Mortgage Co., 56 N.E.2d 305 (N.Y. 1944).
\item See, e.g., FLA. STAT. ANN. § 631.281 (West 1990); N.Y. INS. LAW § 7427 (McKinney 1991) (offsets).
\item See supra note 78 and accompanying text.
\item See People v. Commercial Alliance Life Ins. Co., 47 N.E. 968 (N.Y. 1897); Security Life, 78 N.Y. at 114.
\end{enumerate}
\end{footnotesize}
insolvent insurer. However, the appointment of a receiver, or a formal pronouncement of insolvency by the Superintendent as a prelude to liquidation, voids an insured’s policy and negates claims made subsequent to such a pronouncement. Consequently, although an insured may have a breach of contract claim for the value of the policy on the date insolvency is declared, the insured does not have a claim for the damages incurred as the result of any subsequent loss. In other words, if an insurer is declared insolvent and an insured experiences a loss the next day, the insured may only recover the value of the policy as of the date of the insolvency, and not the amount of its claim.

Policyholders of the insurer may file proofs of claim at the commencement of the rehabilitation. In New York for example, claims are paid in the following order: (1) the actual costs incurred during the insolvency proceedings; (2) debts due to employees; (3) claims to creditors for goods or services contracted for within 90 days of the insolvency; (4) claims to policyholders guaranteed by the Life Insurance Company Guaranty Corporation of New York; (5) claims of the federal or state government; (6) claims of general creditors; (7) surplus or contribution notes or similar obligations; and finally, (8) claims of policyholders. The Superintendent may “compromise or compound” any claim owed by the insurer under twenty-five hundred dollars. In other words, the Superintendent may eliminate such claims or settle them for less than their full value. The court, however, not the Superintendent, determines whether a claim above that amount shall be allowed or disallowed. Nor is the Superintendent obligated to pay interest on any claim when it is settled, unless the original policy provided for the insolvency and the payment of interest.

133. See N.Y. INS. LAW § 7435 (McKinney 1991). Policyholders are considered unsecured creditors of the insurer.
134. N.Y. INS. LAW § 7428(b) (McKinney 1989).
V. THE FEDERAL PROPOSAL

In response to the various criticisms of the state regulatory system and General Accounting Office recommendations that insurer oversight be federalized, Senator Howard Metzenbaum introduced a bill, "To create the Insurance Regulatory Commission" on August 2, 1991. The bill is designed to provide for federal regulation of all interstate insurers. It would establish federal standards for insurance companies, as well as a national guaranty fund system, and would provide for the liquidation and insolvency of financially troubled insurers.

The Commission would consist of five commissioners, three from one party and two from the other, to be appointed by the President and confirmed by the Senate. The Commission would "promulgate rules and regulations necessary to carry out its responsibilities" under the Act. Such rules would, in addition to the specific powers set forth above, include the power to investigate any entity in the "business of insurance," levy assessments upon insurers to pay the Commission's expenses, certify and examine state insurance departments, and examine and perform audits of insurance companies holding interstate insurance licenses. In order to carry out these duties, the Commission would also be authorized to establish a central depository for all insurance data it collects, as well as a "Securities Valuation Office" to appraise the assets of state insurance

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138. "Insurer" is defined as "the party to an insurance arrangement who undertakes to indemnify for losses, provide pecuniary benefits or render services . . . ." Id. § 104(b). "Insurance" is defined as "a contract whereby a person undertakes to indemnify another person or to pay another person a specified amount upon determinable contingencies." Id. § 104(c).
139. Id. § 201-20. An insurer which does not comply with these standards may be faced with regulatory action. Id.
140. Id. § 401-13.
141. Id. § 501-24.
142. Id. § 101(a).
143. Id. § 106.
144. Id. § 107(a).
145. Id. § 108(a). Assessments would be levied in direct proportion to an insurer's premiums. Id.
146. Id. §§ 109(a), 110.
147. Id. § 111.
148. Id. § 112.
departments and interstate insurers.\(^{149}\)

### A. Federal Minimum Standards

The federal bill would require an insurer to maintain a capital reserve in order to ensure its stability based upon the specific nature of its insurance business.\(^{150}\) In addition, specific standards would be developed in order to enable state insurance departments to identify insurers who are in precarious financial positions.\(^{151}\)

The federalization of financial requirements\(^ {152}\) would ensure state uniformity in the investigation of multi-state insurers. Such uniformity should expedite regulatory examinations and help to alert regulators to insurers experiencing difficulties. Although the bill does not contain precise language indicating what the standards focus on, it is probable that the submission of monthly or quarterly financial statements to regulatory agencies would be required by the Commission.\(^ {153}\) Frequent on-site audits of insurance companies would be encouraged, and in order to ensure a higher degree of technical accuracy, state regulators would no doubt have to meet Commission standards and receive certification from the Commission.\(^ {154}\)

Certification of regulators and, more frequent audits of insurers cannot be accomplished without additional funds. One of the purposes of the assessments levied by the Commission upon insurers is to provide such funds and ensure a greater depth to the resources of state insurance departments.\(^ {155}\) In order to further ensure an insurer's financial well-being, financial investments considered dangerous by the Commission would be curtailed.\(^ {156}\) In addition, the bill requires an insurer's investments to be "diversified,"\(^ {157}\) and the amount of risk an insurer could assume would be limited.\(^ {158}\) To further the goal of ensuring financial safety, the amount of "re-insur-
ance" that may be assumed by an insurer would be carefully regulat-
ed.159

B. The National Insurance Guaranty Corporation

The National Insurance Guaranty Corporation ("NIGC") would be a federal entity that would provide a uniform national system for the payment and administration for the rehabilitation and liquidation of insolvent member insurers.160 The NIGC would establish national guaranty funds for the separate lines of insurance maintained by assessments contributed from member insurers.162 The fund would be used in order to pay the claims of any insolvent insurer.163

C. The Liquidation of Insolvent Insurers

The proposed bill expressly preempts the states from supervising the liquidation of NIGC member insurers and places that power solely within the NIGC.164 The state insurance department would file a petition seeking to appoint the NIGC as receiver of the insolvent corporation with any United States District Court.165 The NIGC would be empowered to accept the appointment or reject the appointment if the subject insurer were not a member of the NIGC at the time the petition was filed.166 The NIGC would then take possession of the insurer and its assets, and would thereby become subject to claims against the insurer from the date of the petition forward.167

The filing of a petition would "operate as a stay of the commencement or continuation of any action or proceeding, in any State or Federal court, or any administrative proceeding, against the insolvent insurer."168 The stay, in contrast to the provisions of the Bankruptcy Code, could be lifted by the court if such action was "consistent with the preservation of assets and the efficient administration of the estate of the insurer."169 Thus, the Insurance Rehabilitation Act

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159. See id. § 301-13.
160. See S. 1644, 102d Cong., 1st Sess. § 401 (1991). Member insurers would consist of any "insurer which has an interstate insurance license." Id. § 402(a).
161. Comprised of life, health, and property/casualty insurance. See id. § 404(b).
162. See id. § 405(a).
163. See id. § 405(c).
164. See id. § 501.
165. See id. § 503.
166. See id. § 503(d).
167. See id. § 505.
168. Id. § 507(a).
169. Id. § 507(b); see also 11 U.S.C. § 362(d) (1991), which provides that:
would protect policy holders at the expense of general creditors: the language of the statute provides that it is not the damage to the creditor which will determine whether relief from the stay is granted. Rather, the insured, and by extension the policyholders, take priority.\textsuperscript{170} Because of the slight risk of insolvency, even in these difficult times, and the existence of the national guaranty fund, this provision is not likely to have a strong impact upon insurers and general creditors in the normal course of business.

As liquidator, the NIGC would have the power to hire such personnel as is necessary to conduct the liquidation,\textsuperscript{171} to appoint a committee of creditors,\textsuperscript{172} and to audit the insurer.\textsuperscript{173} Moreover, the corporation would have the power to collect debts owed to the insurer,\textsuperscript{174} to sell the property of the insurer,\textsuperscript{175} to pursue claims against the insurer\textsuperscript{176} and to review, allow and disallow claims against the insurer.\textsuperscript{177} The corporation would promulgate rules providing for the submission and proofs of claim,\textsuperscript{178} and would pay claims against the insurer as soon as practicable.\textsuperscript{179}

The bill contains a three-year period in which transfers by the insurer may be considered fraudulent and can be avoided by the liquidator.\textsuperscript{180} The lengthy time period, far exceeding that of 11 U.S.C. § 548, is further evidence that the bill is designed, in large

\begin{itemize}
\item the court shall grant relief from the stay . . . (1) for cause, including the lack of adequate protection of an interest in property of such party in interest; or [if] . . . (a) the debtor does not have an equity in such property; and (b) such property is not necessary to an effective reorganization.
\end{itemize}

\textit{Id.}

\textsuperscript{170} The provision could be read as eliminating the first prong of 11 U.S.C § 362(d), providing that a creditor may gain relief if lacking "adequate protection." The new bill merely focuses on whether the insurer may need the property or the property would be necessary for distribution to creditors and policy holders as a whole, in contrast to distribution to one individual creditor.


\textsuperscript{172} See id. § 511(a)(2). \textit{Contra} 11 U.S.C. § 705 (1991) (providing that unsecured creditors may elect their own committees).


\textsuperscript{174} Id. § 511(a)(4).

\textsuperscript{175} Id. § 511(a)(5).

\textsuperscript{176} Id. § 511(a)(6).

\textsuperscript{177} Id. § 511(a)(8).

\textsuperscript{178} Id. § 513.

\textsuperscript{179} Id. § 514.

\textsuperscript{180} Defined as "[e]very transfer made and every obligation incurred by an insurer within three years prior to the filing of a successful petition for liquidation . . . is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors." \textit{Id.} § 516(a).
part, to provide policyholders with the extra protection necessary for people in their uniquely disadvantaged position.

Preferences are also construed broadly under the proposed act. The act permits the avoidance of any transfer made within one year of liquidation, unless the insurer was already subject to rehabilitation at the time the liquidation order was entered into, in which case transfers made within two years may be avoided.\(^\text{181}\)

The proposed bill does not address the question of whether payments to an insured could be considered preferential in the event the insurer is subsequently adjudicated insolvent. However, it is not likely that the bill will exit the committee hearings without addressing the preference provision, or that the courts would construe the statute in such a way as to find that payments to an insured prior to an insolvency should be voided as preferences. The basis for this conclusion is threefold:

(1) The bill prefers policyholders of the insured to general creditors.\(^\text{182}\) The preference provision is obviously directed at creditors, and to enforce it against \textit{bona fide} policyholders would undermine the greater purpose of the statute: to protect policyholders in the event of an insolvency. Therefore, even if the bill were not amended in committee, courts should construe the preference provision to permit payments to the policyholders.

(2) If courts uphold pre-insolvency payments to insured parties, insurers may discriminate amongst policyholders. These policyholders can be divided into three classes: (a) policyholders whose claims are judged as valid by the insurer, (b) policyholders whose claims are declined in good faith (the judgment of which is probably disputed by the policyholder and, presumably, will be judicially determined), and (c) policyholders who receive improper preferential treatment from the insurer.

The claims paid in good faith are presumptively valid. Those policyholders may require their insurance payments immediately, and may suffer further, irreparable harm if they are not compensated immediately. Payments to those policyholders cannot truly be characterized as preferential or harmful to the other policyholders: the insurer could not have been seeking to receive future benefits from the payment (other than possibly seeking to maintain public confidence in the event of a successful rehabilitation, but the claim probably would

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181. See id. § 517(a).
182. See supra notes 168-79 and accompanying text.
have been paid in that event anyway), and was, but for the insolvency, obligated to pay the policyholder. This is not true in the case of general creditors who may subsequently provide the insurer with special treatment. Thus, the essential purpose of the voidable preference rule is not present in the case of *bona fide* claims, whereas it would remain in the case of general creditors.

(3) Claims paid to policyholders in bad faith are really fraudulent transfers, not preferential payments. The payments generally do not bear the indicia of a preference: although the payment does prefer these policyholders to those whose claims are declined, the payment is not made in order to prefer the payee over other policyholders for future purposes. Rather, the payment would probably be for fraudulent purposes. Moreover, such a characterization is more advantageous to policyholders in general because of the longer period during which the NIGC can avoid fraudulent transfers. Finally, an equitable reason exists for seeking the return of bad faith payments which does not exist in the case of *bona fide* payments: the former policyholder should never have been paid, whereas the latter policyholder has suffered a real injury for which compensation is necessary.

The final difficulty in this area concerns *bona fide* claim holders whose pre-insolvency claims were disputed by the insurer and enter litigation or extra-judicial settlement proceedings. The present language of the automatic stay provision bars the continuation of such proceedings, and therefore disadvantages these policyholders *vis a vis* policyholders whose claims are expeditiously paid. The automatic stay provision of the bill should therefore be amended to permit any policyholder whose claim arose prior to the insolvency to either continue or commence litigation with the NIGC after an appropriate time period (long enough for the NIGC to take possession of the insurer).

The recommended adjustments to the bill would prevent policyholders who have suffered a *bona fide* injury from being further impaired by an avoidance of a subsequent payment on their claim. Policyholders whose claims arise within a period immediately following the insolvency (i.e., two to three weeks) could also be permitted to pursue their claims. Such a “grace period” would provide these policyholders with coverage, yet protect the insurer from continuing claims by compelling policyholders to obtain re-insurance elsewhere. Subsequent claims generally would not have received compensation until the liquidation or rehabilitation was concluded. By permitting the continuation of the suit, these policyholders will receive what amounts to a more advantageous claim distribution position, thereby limiting
the "preferential effect" of the payments.

The bill's current distribution scheme provides for seven classes of distribution, in the following order: (1) reimbursement to the corporation for expenses incurred during the liquidation; (2) reasonable compensation to employees of the insurer; (3) all claims to policyholders; (4) unearned premium refunds; (5) claims of general creditors; (6) claims of the federal or local governments; (7) late claims; (8) surplus or contribution notes; and (9) claims of stockholders.\(^{183}\) The federal bill is much more favorable to policyholders than, for example, the New York distribution scheme.\(^{184}\)

The liquidation procedures of the proposed bill, while favorable to policyholders, are not as important as the new regulatory procedures which the bill would establish for the supervision and administration of multi-state insurers. The bill eliminates many of the problems caused by state supervision, and its passage would eliminate the uncertainties concerning which entities are insurance companies. In short, passage of the bill would strengthen the insurance regulation industry as well as expedite insolvency proceedings should an insurer fail.

The bill has been criticized on the grounds that it will prove to be no better than federal provisions for the supervision of the savings and loan industry.\(^{185}\) However, the insurance regulatory bill provides for much greater federal regulation than the Federal Deposit Insurance Act or the Financial Institutions Reform and Recovery Enforcement Act.\(^{186}\) An accompanying House of Representatives bill, "The Insurance Fraud Prevention Act of 1991," seeks to eliminate much of the fraud and corruption that existed in the savings and loan industry and in the state insurance regulatory industry.\(^{187}\)

VI. CONCLUSION

The current system of federal deference to state insurance regulation, created by the § 109(b)(2) exclusion of insurance companies from the purview of the Bankruptcy Code, is largely ineffective in

\(^{183}\) See id. § 520.

\(^{184}\) See supra notes 132-36 and accompanying text.


\(^{186}\) See 12 U.S.C.A. §§ 1441a(b)(1)(C), 1441a(b)(4), 1441a(b)(6), et. seq. (West Supp. 1991) (also known as "FIRREA").

the case of multi-state insurers and is detrimental to policyholders. The threshold question of what constitutes an insurance company, necessary for determining the applicability of the § 109(b)(2) exclusion, is difficult and has led to mercurial results in the resolution of proceedings involving substantially similar entities. This disparity of treatment is also present in the actual liquidation and regulation of multi-state insurers.

The proposed federal system would remove many problems inherent within the state regulatory system. Inclusion of multi-state insurers within a federal rehabilitation and liquidation scheme would eliminate the confusion over what entities are considered to be insurance companies, and eliminate the inequitable treatment currently afforded to policyholders in similar and often related entities. The inclusion of multi-state insurers into federal law should be promoted and supported in order to extend the protection and consistency of federal bankruptcy law to insurance companies.

'Adam Hodkin