Published on *III* (http://www.iii.org)

Insolvencies/Guaranty Funds

THE TOPIC

AUGUST 2016

The regulation of insurance company solvency is a function of the state. State regulators monitor the financial health of companies licensed to provide insurance in their state through analysis of the detailed annual financial statements that insurers are required to file and periodic on-site examinations. When a company is found to be in poor financial condition, regulators can take various actions to try to save it. Insolvencies do occur, however, despite the best efforts of regulators.

All states have procedures through which the property/casualty insurance industry covers claims against insolvent insurers. New York has a pre-assessment system, which requires insurers to contribute to a permanent insolvency fund, while the other states have established insurance guaranty associations (known as guaranty funds) which, for the most part, assess insurers after an insolvency occurs for amounts needed to pay claims. Insurers are required to be members of guaranty associations as a condition of licensing. When there is an insolvency, they are assessed based on business they do in that state.

The National Association of Insurance Commissioners (NAIC) moved to strengthen solvency regulation in the 1980s. It developed an accreditation program that requires state insurance departments to meet certain prescribed standards. It also established minimum capital requirements for insurers, known as risk-based capital (RBC) calculated according to riskiness of the insurer?s business activities. The NAIC continues to refine regulations.

RECENT DEVELOPMENTS

- **Financial Impairments and Insolvencies:** According to A.M. Best, there were 14 known impairments in 2013, compared with 25 in 2012, with most being the result of several years of volatile and generally unprofitable underwriting results. This is little more than half the average for the property/casualty insurance segment of the industry. Risk retention groups, a form of alternative risk transfer entities, see report on Captives, accounted for half of the impairments. An impairment is not the same as an insolvency. A.M. Best defines an impairment as any official action by a state regulator that restricts the business activity of an operating insurance company.
- Ten insolvencies occurred in 2013. Five of the 10 sold workers compensation among other coverages. Only one was a single state insurer. Three were domiciled in Illinois and were licensed all states. From 2011 to the end of 2013, 28 property/casualty companies went into liquidation, according to the National Conference of Insurance Guaranty Funds (NCIGF), compared with 46 in 1992 and 33 in 1993. Since 1994, when there were 21 insolvencies, the total has moved back and forth with seven years in which the number was below 10. The NCIGF reported five insolvencies in the first six months of 2014.
- **Modernization Initiatives:** In its long-awaited report, the Federal Insurance Office (FIO), a unit of the U.S. Department of the Treasury that was created by the 2010 Dodd-Frank Act, says that insurance regulation should continue to be a hybrid system with both the states and the federal government playing complementary roles. But, it says, the federal government may need to

ensure that regulations are more uniform. In terms of the guaranty fund system, Congress might establish uniform caps on coverage to ensure that when an insurance company becomes insolvent, all claimants, regardless of where they live, receive the same benefits from the state guaranty fund. Currently, the maximum amount anyone making a claim against a bankrupt insurer can receive varies by state. The National Association of Insurance Commissioners has been encouraging states to raise their coverage cap to $500,000.

- The FIO also suggests that states should develop regulations to make sure the receivership process is more transparent. The public needs access to more information about an insolvent insurer?s estate as well as the administrative costs of the receivership.

Property/Casualty Guaranty Fund Net Assessments, 2006-2015

Year	Net assessments (1)
2006	$1,344,487,899
2007	943,164,094
2008	368,451,899
2009	522,881,688
2010	171,159,059
2011	138,652,497
2012	450,415,322
2013	456,953,717
2014	481,082,306
2015	458,510,638
Total, inception-2015 (2)	**$16,702,976,899**

(1) Assessments less refunds and abatements (cancellations of uncalled portions of assessments when funds on hand are sufficient to pay claims).
(2) Includes pre-1978 net assessments.

Source: National Conference of Insurance Guaranty Funds.

View Archived Tables [1]

Property/Casualty Guaranty Fund Net Assessments By State, 2015

State	Net assessments (1)	State	Net assessments (1)
Alabama	$7,117,657	Montana	0
Alaska	5,050,002	Nebraska	$3,200,000
Arizona	0	Nevada	7,485,495
Arkansas	0	New Hampshire	0
California	228,506,804	New Jersey	128,576,628
Colorado	0	New Mexico	0
Connecticut	973,820	New York	0
Delaware	0	North Carolina	5,625,000
D.C.	3,915,999	North Dakota	0
Florida	0	Ohio	0
Georgia	0	Oklahoma	-7,800,000
Hawaii	38,847,339	Oregon	0
Idaho	0	Pennsylvania	19,265,000
Illinois	5,147,731	Rhode Island	-1,815,432
Indiana	0	South Carolina	14,249,530
Iowa	0	South Dakota	831,387
Kansas	0	Tennessee	0
Kentucky	0	Texas	0
Louisiana	0	Utah	0
Maine	-1,125,799	Vermont	0
Maryland	0	Virginia	0
Massachusetts	0	Washington	459,477
Michigan	0	West Virginia	0
Minnesota	0	Wisconsin	0
Mississippi	0	Wyoming	0
Missouri	0	**United States**	**$458,510,638**

(1) Assessments less refunds and abatements (cancellations of uncalled portions of assessments when funds on hand are sufficient to pay claims). Negative numbers represent net refunds.

Source: National Conference of Insurance Guaranty Funds.

View Archived Tables [2]

Chart Notes: The two charts above are the yearly totals for insurance company payments to state post-assessment guaranty funds and a state-by-state chart showing assessment amounts. (The figures do not include assessments made under New York's pre-assessment insolvency fund nor payments made by individual companies under the insolvency provision of the uninsured motorist endorsement to auto insurance policies. They also do not take into consideration recoupments available through premium tax offsets and policyholder surcharges.) Net assessments in 2008 represented only 0.2 percent of the property/casualty insurance industry's net premiums written. Assessments include monies needed to pay claims against companies that became insolvent in the past as well as current insolvencies.

BACKGROUND

Regulation for Solvency: State insurance departments [3] monitor the financial health of insurance

companies through regular in-depth financial analyses and periodic on-site examinations. The National Association of Insurance Commissioner?s (NAIC) uses a series of tests?the Insurance Regulatory Information System (IRIS)?to help identify companies in trouble. All insurers are required to file annual financial statements with regulators in all states in which they are licensed to do business. Statistical data taken from these statements are run through IRIS tests. If the tests indicate 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.

State insurance departments must meet certain standards to ensure they have the capacity to oversee the financial condition of the insurers they regulate. Under state accreditation program rules, accredited states are subject to a full review every five years and a lesser audit every year. However, accreditation may be suspended at any time, after notice to the state and a hearing, if regulators become aware that a state is no longer in compliance with certification standards.

Risk-Based Capital Standards: The NAIC has been strengthening solvency regulation since the early 1990s. Among other things, it adopted risk-based capital (RBC) standards for the property/casualty industry, which took effect for the 1994 annual financial reports filed with regulators in March 1995. RBC standards replaced individual state surplus and capital requirements, which varied widely from state to state and had been criticized as being too low and too simplistic to be meaningful thresholds for capital adequacy. In some states, a large insurer could have been insolvent while still meeting the minimum requirements.

The old blanket minimum requirements were replaced with standards geared to the specific characteristics of the company and its business, a move designed to improve solvency regulation. With formulas that reflect individual capital needs, examiners can more quickly identify insurers that are under financial pressure and take action earlier to avert insolvency.

Capital adequacy is linked to the riskiness of an insurer's business activities. An insurance company that insures medical device manufacturers or high-rise buildings along California's earthquake faults needs a larger cushion of capital than a company specializing in Main Street businesses. A company that is heavily reinsured may have more security than a similar one that is not, but what happens if its reinsurer is in poor financial health when it comes time to honor the reinsurance contract?

RBC formulas therefore set out minimum levels of capital that will help maintain solvency in the event of a serious miscalculation. The likelihood and extent of these errors are built into the formulas for various elements of an insurer's business. These include the risk that loss reserves set aside for future claims will be inadequate. (Loss reserve risk is tied to the kind of business the company underwrites. There is more uncertainty in liability than property lines of insurance because of the long-tail nature of claims, where it may take years to arrive at a settlement for injuries.) In addition there is credit risk?the chance that an insurance agent or reinsurer will default on monies owed under contracts. Premium risk assesses the degree to which insurance policy prices may inadequately reflect the cost of claims. Capital levels are also established for investment and off-balance sheet risks. An allowance is made in the calculations for the fact that everything is unlikely to go wrong at the same time.

The adequacy of a company's capital is assessed by comparing its total adjusted capital, which is basically its net worth, with its RBC?an amount of capital that reflects the level of risk the company has assumed. The greater the total riskiness, the greater the minimum financial cushion must be. The result is expressed as the company's RBC ratio. Ratios are categorized in six levels, or zones, that run from adequate (125 percent and higher) to mandatory control or below 35 percent, at which point the insurance commissioner is authorized to seize the company, unless there is some reasonable expectation that the circumstances that caused the depletion of capital will be remedied within 90 days.

Insurance companies are required to disclose in financial statements filed with regulators their total adjusted capital and their ?authorized control level? of risk-based capital. This is one level above mandatory control, the point at which a regulator may take control of the company if it is deemed to be in the best interests of the policyholders, creditors and the general public. However, when RBC ratios are published outside of the annual statement, they usually refer to the "company action level," (75-99 percent), where a company is required to file a plan with regulators to correct its capital deficiencies.

RBC data are not a measure of financial performance. They are designed to help identify companies whose capital has fallen below regulatory-determined minimums rather than assess the financial strength of adequately capitalized insurers as rating agencies do from reviews of both financial data and discussion with company management. A company that fails the RBC tests may not be on the brink of insolvency and it is possible for a company in poor financial shape to pass the tests.

The United States is currently updating its solvency regulations, including its RBC formulas as a result of the financial crisis and the European Union?s Solvency II directive, see U.S. Solvency Regulation and Solvency II. The result can be seen in the NAIC?s Solvency Modernization Initiative. The NAIC sees the initiative as ?a critical self-examination to update the United States? insurance solvency regulation framework.,? It includes a review of international standards and regulatory developments and an evaluation of how the U.S should address them.

Solvency Modernization, States: The NAIC began work on its SMI in September 2008, the aim of which is to determine whether current U.S. solvency requirements need to be modified in light of regulations in other countries and the changes that will take place in the European Union under Solvency ll. The analysis?which will focus particularly on capital requirements, international accounting, insurance valuation and group solvency?will include the solvency work of the International Association of Insurance Supervisors, of which NAIC is a member, as well as Solvency II, see also U.S. Solvency Regulation and Solvency II.

Solvency II includes a requirement that insurers embed risk-management considerations in decision making throughout the company, a provision known as Own Risk Solvency Assessment (ORSA). The NAIC has developed its own ORSA project which will take effect in 2015. Rather than implement it through regulation, it has created an ORSA model law that each state will adopt. Legislative authority is necessary for state insurance regulators to implement the NAIC?s ORSA Guidance Manual and to better protect the confidentiality of the information provided. In addition, the model act will enable regulators to assess capital adequacy at the group level, one of the regulatory goals of the NAIC?s Solvency Modernization Initiative, and also to implement a recommendation that emerged from the International Monetary Fund?s assessment of the U.S. regulatory system. A number of states have already adopted the model act, which has an effective date of January 1, 2015.

Insolvencies: A 1987 General Accountability Office (GAO) report on insolvencies noted that insolvencies generally follow the property/casualty insurance company profitability cycle. The GAO report also pointed out that the profile of insolvent companies has changed over the years. In the late 1960s and 1970s, insolvencies occurred mainly among small auto insurers with a limited geographical span. Since that period, the characteristics of insolvent insurers has become more diverse and has included some large multistate companies. The incidence of large company insolvencies has raised concerns over the ability of the guaranty fund system to pay all covered claims.

The insolvencies of four large insurers and the fallout from the savings and loan crisis in the 1980s prompted a Congressional study, which culminated in the February 1990 report "Failed Promises: Insurance Company Insolvencies." Known as the Dingell report, after the chairman of the committee that investigated the insolvency cases, Rep. John Dingell (D-MI), the study looked at the insolvencies

of four companies: Mission Insurance Co. and Transit Casualty Co., both with headquarters in California, although Transit Casualty was chartered in Missouri; Integrity Insurance Co. of New Jersey; and Anglo-American Insurance Co. of Texas. The report found what it called "disturbing" parallels between the mismanagement and fraudulent activity that led to the four insurer insolvencies and the factors that precipitated the savings and loan crisis. Specifically, it attributed the insurance company failures to rapid expansion, unsupervised delegation of authority, extensive and complex reinsurance arrangements, underpricing, reserve problems, false reports, reckless management, incompetence, fraud, greed and self-dealing.

According to a November 2005 A.M. Best study of insolvencies from 1969 to 2005, the leading cause of collapse was inadequate reserves for claims, which accounted for more than 38 percent of impairments among the 984 insolvencies studied. Rapid growth also played a major role, accounting for 16.5 percent of failures over the period studied, particularly during soft markets. Most insolvencies, Best says, were related to some form of mismanagement. Data for the period 2003-2005, which was also analyzed separately, shows that fraud can play a substantial role.

Solvency Oversight Process: Regulators monitor the financial condition of all insurance companies. If a company appears to be in poor financial health, regulators are empowered to take certain steps to strengthen the insurer's position and, if all else fails, to liquidate it.

The first indication of a possible problem frequently is a company's failure to pass four or more of the 11 financial tests that regulators administer as part of the normal monitoring process. Failure may trigger special audits or a requirement that the company begin to report its financial data on a quarterly basis instead of annually. These initial steps are precautionary in nature and serve as a warning to the company to put its financial affairs in order.

If there is no improvement, more formal steps may be taken to bolster the company's financial condition. The regulator may order the company to raise its rates, increase its capital, restructure its investments or take other corrective measures, depending on the nature and severity of the problem. To protect the company from "run-on-the-bank" type reactions, these remedial actions are not made public except at the company's request. If the deterioration continues, the next step is rehabilitation, a move that becomes part of the public record. The insurance department in the company's domiciliary state, the state in which the insurer is incorporated or organized, obtains a court order allowing it to take more specific steps to shore up the troubled company. These may include suspending claim payments, placing a stay on lawsuits against the company and searching for additional sources of capital?a merger prospect, for example.

When the commissioner of insurance determines a company is in financial trouble, he or she is empowered by law to take appropriate steps to protect the company?s policyholders and claimants. Depending on the severity of the problem, the commissioner can take a variety of actions to correct the situation. These may include an Order of Supervision, an Order of Suspension, an Order of Rehabilitation or an Order of Liquidation.

In an Order of Supervision, the commissioner can require the company to take specific steps or require it to obtain the commissioner?s approval before it undertakes certain transactions. Usually, an Order of Supervision alone does not result in changes to insurance policies the company issues or to the payment of claims. Under an Order of Suspension, however, the commissioner can order the company to stop all or a portion of its business in the state.

The commissioner may request a state court to issue an Order of Rehabilitation when the problems are more severe or where the commissioner believes it appropriate in order to protect policyholders and creditors. In such situations, the commissioner is appointed rehabilitator and has the authority to

manage the company until the problems are corrected. In his capacity as rehabilitator, the commissioner takes ownership and control of the company?s books, records and assets, and assumes all powers of the company?s directors, officers and managers. He also has broad discretion to take whatever corrective actions he believes appropriate, subject to oversight by the court. Once the problems are resolved, the company resumes control.

If the commissioner does not believe the problems can be corrected and that continuing to operate the company would be harmful to its policyholders and creditors, he can seek an Order of Liquidation from a state court. Under an Order of Liquidation, the commissioner is appointed liquidator. The liquidator then appoints a receiver to manage the liquidation process.

The Liquidation Process:

After the court issues the Order of Liquidation, the receiver and his or her staff take possession of the company?s offices, records, equipment and assets. A notice is sent to all policyholders and claimants informing them of the company?s liquidation and the steps they must take in order to file a claim against the company?s estate. The policyholders and claimants will also be informed that a guaranty association may handle the future processing of claims and that their insurance policy will be cancelled at a specified date.

Insolvency Data: The National Association of Insurance Commissioners (NAIC) considers a company insolvent when the state insurance commissioner has taken legal action against a company to place it in conservatorship, rehabilitation or liquidation. (The difference between conservatorship and rehabilitation is one of degree. According to the NAIC, the state insurance department guides the operations of a company in conservatorship but directs the operations of one in rehabilitation.) Each state has laws that govern what triggers the guaranty funds, generally a final order of liquidation and/or a finding of insolvency.

There is a wide variation among states as to what is included in their list of insolvencies. Some states count ancillary receiverships, for example. Ancillaries are set up because when an insurer domiciled in another state becomes insolvent an ancillary receivership order is needed to release guaranty funds. Some states charge insurance departments with the task of liquidating insurance-related entities such as insurance agencies and home and auto warranty firms. These, too, may be included in the state?s list of insurer insolvencies. In addition, due to the complexity of the issues involved, litigation and other problems, some companies remain on a state?s receivership list for many years.

Guaranty Funds, Property/Casualty Insurance: The first guaranty funds were narrow in focus and covered a particular line or area of insurance such as workers compensation, which was the first coverage to be made compulsory. In the 1940s and 1950s a few states created auto insurance guaranty funds. Among them was New York, whose Motor Vehicle Liability Security Fund, created in 1947, was expanded to cover other areas of insurance in 1969 when the NAIC proposed its model guaranty fund program. The guaranty fund concept was gradually adopted and by the end of 1982, all 50 states, the District of Columbia and Puerto Rico had established procedures under which solvent property/casualty insurance companies absorb losses of claimants against insolvent insurers. The life/health insurance industry also established guaranty funds, see end of this section.

The NAIC's Model Property/Casualty Guaranty Association Act recommended that states adopt a post-assessment, or post-insolvency, approach to financing the program, under which assessments are made only after an insurer?s assets have been valued and found to be insufficient to pay all claims and it has been declared insolvent. When a company becomes insolvent, other insurers doing business in the state are assessed the amount needed to pay policyholders and claimants of the insolvent company.

New York is the only state that does not use the post-assessment system for any line of insurance. New

York has a "pre-assessment" arrangement. Insurance companies are assessed in advance, according to a percentage of net direct premiums written, and contributions are held against future claims on insolvent companies. The fund halts contributions when the amount held exceeds $200 million and does not call for new payments until the balance falls below $150 million. (Some states, including New Jersey, New York and Pennsylvania, have pre-assessment funds for workers compensation and, in April 1989, Maine created a pre-insolvency fund to pay the claims of insolvent insurers for the first 60 days, by which time funds would have been collected through the regular post-assessment fund system.)

In most post-assessment states, companies can be assessed annually up to a maximum of 2 percent of net written premiums. A few states still have a limit of 1 percent. About one-third of guaranty funds have three accounts, although the number may vary from one to five. The three accounts are automobile, workers compensation and all other lines of insurance covered by the funds. In Florida, auto is separated into liability and physical damage. Assessments are made separately for each account. State legislation is generally required to impose higher assessments temporally if additional monies are needed to pay claims after a surge in insolvencies.

Insurers may recoup guaranty fund assessments. Nineteen states offset insolvency assessments through a reduction in premium taxes?a state tax levied on the amount of insurance premiums paid by the policyholders in the state. Some states raise money through an insurance policy surcharge. Others recoup insolvency assessments through changes in insurance premium rates.

While all state funds cover homeowners and auto insurance claims, some other types of insurance may not be covered. The life/health insurance industry has its own model law and guaranty funds. Some states that do not follow the guidelines of the model law in its entirety may include some of these types of insurance. There also may be other differences. For example, claims may be subject to a deductible, usually $100. Coverage limits exist in most states.

In 2009 the National Association of Insurance Commissioners adopted a new Property and Casualty Insurance Guaranty Association Model Act. At the same time, the National Conference of Insurance Legislators (NCOIL) promulgated its own model, based largely on provisions included in the NAIC one. Major changes include a revision in net worth provisions, see Background, and an increase in the coverage cap to $500,000 from $300,000. Most states have no limits on the amount paid to cover workers compensation claims.State guaranty funds do not generally cover groups that self-insure (assume the financial risk of loss instead of transferring it to an insurance company?see Captives report). Thus, participants in risk retention groups and purchasing groups, such as those established under an amendment to the Risk Retention Act of 1981, would not be able to call on state guaranty funds if their group became insolvent.

There has been discussion about the need or the advisability of establishing a guaranty fund for surplus lines insurers, whose claimants would not be covered by established guaranty funds in states where these companies are not licensed. Although lawmakers have considered such legislation, the only state so far to establish a special fund for surplus lines is New Jersey.

Another question is whether guaranty funds should cover "commercial lines" policyholders. Businesses generally are better equipped than individual consumers to evaluate the financial condition of insurance companies. They often have the in-house expertise to evaluate an insurer's financial data or they can ask a broker to assist them. Responding to the idea that the claims of large, sophisticated commercial policyholders should not be covered by state guaranty funds, in 1986 the NAIC adopted a model law that requires any corporation with a net worth of more than $50 million to reimburse state guaranty funds for liability claim payments made on its behalf. More than 30 states use net worth, though not necessarily as set out in the NAIC model act, to determine eligibility for guaranty fund coverage, and other states have been considering similar measures. In Missouri, for example, under a law that took

effect in August 1989, the guaranty fund will not pay the claims of corporate policyholders with a net worth in excess of $25 million.

Many states have incorporated "early-access" provisions into their insolvency fund laws. These statutes require state regulators to share the assets of an insolvent company with guaranty funds at an early stage in the liquidation process so that claimants do not have to "stand in line" with other creditors. Most states now have such provisions.

The size of insolvencies is increasing. In the 15 years from 1969 to 1984, the largest assessment was for an insolvency of $88 million for the Reserve Insurance Company, which became insolvent in 1979. Beginning in 1985, assessments for individual company insolvencies jumped into the $200 to $300 million range and rose higher each decade. By 2008, the insolvency of Reliance in 2001 had reached $2.9 billion, but recoveries were more than $1.7 billion. See chart on largest insolvencies below. The final figure may not be known for some time since much of the company?s business was workers compensation insurance and workers compensation claims can take years to settle as more becomes known about the injured workers? condition.

Life/Health Guaranty Funds: By the early 1970s, there was a general agreement that life, annuity and health insurance policyholders as well as property/casualty insurance customers should be protected against the insolvency of their insurance company through a guaranty fund system. (Today, life/health insurance guaranty funds also cover long-term care policyholders.) In 1971 the NAIC developed its Life and Health Insurance Guaranty Association Model Act, upon which all states have based their guaranty association statutes.

Life/health insurers tend to be among the most conservatively managed and regulated of all financial institutions. Over the past 20 years, only about 20 companies of significant size have been liquidated and, of those, only three had life insurance liabilities of more than $1 billion. Until the 1980s the insolvency of a major life insurer was a rare occurrence. But in 1983 Baldwin United failed, followed in the early 1990s by several other large companies and a succession of smaller ones. There have been no failures of nationally significant life insurers since 1994, when Confederation Life became insolvent.

The failure of a life insurance company has a different impact on its policyholders from the failure of a bank or even that of a property/casualty insurer. In contrast to banks, where a significant percentage of liabilities are ?demand? accounts that can be drawn down any time, and to property/casualty insurers that may owe payments on property, workers compensation or liability claims, liquidity is not generally a major issue. In general the liabilities of a life insurance company will not have come due and be owed to policyholders when liquidation proceedings begin. A large portion of liabilities are for future benefits?death benefits promised to people who might live another decade and annuities that have not begun to pay out?that will not be due for years.

According to the National Organization of Life/Health Guaranty Associations, guaranty funds in most states cover at least $300,000 in death benefits if the insurer becomes insolvent, with a number of states covering up to $500,000. There is a wide variation in the extent of coverage for health insurance, long-term care and annuities, with the lowest being $100,000 and the highest $500,000. With respect to annuities, some states pay more if the annuity is being paid out rather than in the so-called ?accumulation? period when the funds are being paid in.

The Claim Payment Process: When state guaranty fund associations are notified about an insolvency by the liquidator or their state insurance department, they must first determine whether the company was licensed to do business in their state for any of the lines of insurance covered by their guaranty fund. Then they must decide how much to assess other insurance companies doing business in the state to pay the outstanding claims against the insolvent insurer, or, in the case of New York State, whether a

new assessment must be made.

To come up with a figure, the association analyzes all available information on the insurer's business, including the financial data the company has submitted to the state's insurance department, claims files or a representative sample of claims, computer print-outs from the liquidator and any other material that would give some indication of outstanding claims and the amounts set aside by the company to pay them. After all the information has been factored in, each insurer is assessed its share of the total amount needed.

Claims are paid as information is received from the liquidator and as soon as each claim is resolved. Only hardship cases are given a priority. The time it takes to arrive at a settlement depends on the nature and complexity of the case, just as it does when a claim is filed with a solvent company. Liability claims tend to take longer to settle than first-party claims?those filed by the policyholder. Where necessary, the guaranty fund provides defense counsel to defendants.

In addition to providing information on the insolvent insurer to state insurance departments and guaranty fund associations, the liquidator is responsible for notifying all agents, policyholders and others who might have claims against the company of its insolvency. Policyholders are given an additional period of insurance coverage, typically 30 days from the date of liquidation, unless their policy would have expired prior to this. The policy period extension protects policyholders while they are shopping for a new insurance company. Policyholders also receive claim forms, known as proof of claim forms, and information on how to fill them out in the event that they have a claim against the insolvent company. (In states where the guaranty fund covers unearned premiums?premiums that the insurance company has collected from the policyholder but has yet to "earn" because the policy period has not yet expired?the majority of policyholders would have reason to file a claim.)

NATIONAL CONFERENCE OF INSURANCE GUARANTY FUNDS (NCIGF), INCEPTION-TO-DATE INSOLVENCY FINANCIAL INFORMATION BY COMPANY, TEN LARGEST INSOLVENCIES (1)

Year	Insolvent company	Payments	Recoveries	Net cost
2001	Reliance Insurance Company	$2,867,396,758	$1,751,608,142	$1,115,788,616
2002	Legion Insurance Company	1,481,687,959	453,266,892	1,028,421,067
2000	California Compensation Insurance Company	1,105,143,857	354,332,213	750,811,644
2000	Fremont Indemnity Insurance Company	1,045,377,198	723,963,519	321,413,679
2001	PHICO Insurance Company	776,821,738	247,393,029	529,428,708
2006	Southern Family Insurance Company	719,122,670	324,363,428	394,759,242
1988	American Mutual Liability Insurance Company	586,648,605	255,701,413	330,947,192
1985	Transit Casualty Insurance Company	567,967,111	388,722,447	179,244,664
1986	Midland Insurance Company	552,585,201	87,693,851	464,891,350
1987	Mission Insurance Company	507,133,775	589,318,750	-82,184,975

(1) Ranked by payments, from year of insolvency to 2008.

NCIGF Disclaimer: This is not a complete picture. The numbers may be understated as some states have not reported in certain years.

Source: The National Conference of Insurance Guaranty Funds.

View Archived Tables [4]

KEY SOURCES OF ADDITIONAL INFORMATION

National Conference of Insurance Guaranty Funds (http://www.ncigf.org [5])

"Failed Promises: Insurance Company Insolvencies," Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, U.S. House of Representatives, February 1990.;

"Insurance Failures," General Accounting Office, 1987 (GAO/GGD-87-100).

The National Organization of Life and Health Insurance Guaranty Associations (NOLHGA)(http://www.nolhga.com/ [6])

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