IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

IN THE MATTER OF THE REHABILITATION OF SCOTTISH RE (U.S.), INC.	)	C.A. No. 2019-0175-JTL

OPINION

Date Submitted: January 28, 2022
Date Decided: March 31, 2022

Peter B. Ladig, GianClaudio Finizio, BAYARD, P.A., Wilmington, Delaware; Diane J. Bartels, Wilmington, Delaware; James J. Black, III, Jeffrey B. Miceli, Mark W. Drasnin, BLACK & GERNGROSS, P.C., Philadelphia, Pennsylvania, *Counsel for The Honorable Trinidad Navarro, Receiver for Scottish RE (U.S.), Inc.*

Michael Busenkell, GELLERT SCALI BUSENKELL & BROWN, LLC, Wilmington, Delaware, *Counsel for Scottish RE (U.S.), Inc.*

Marisa R. DeFeo, Randall S. MacTough, SAUL EWING ARNSTEIN & LEHR LLP, Wilmington, Delaware, *Counsel for Lincoln National Life Insurance Company, Lincoln Life and Annuity Company of New York and First Penn Pacific Life Insurance Company*.

Christopher Viceconte, GIBBONS P.C., Wilmington, Delaware, *Attorney for AXA Equitable Life Insurance Company, MONY Life Insurance Company of America, MONY Life Insurance Company of the Americas, LTD., and U.S. Financial Life Insurance Company, Manhattan Life Insurance Company, Manhattan Life Assurance Company of America*.

Daniel Hargraves, FREEBORN & PETERS LLP, New York, New York, *Counsel for AXA Equitable Life Insurance Company*.

Randall S. MacTough, ZARWIN BAUM DEVITO KAPLAN SCHAER TODDY, PC, Wilmington, Delaware, *Counsel for First Penn Pacific Life Insurance Company*.

Joseph B. Cicero, Gregory Stuhlman, CHIPMAN BROWN CICERO & COLE, LLP, Wilmington, Delaware, *Counsel for Berkshire Hathaway Life Insurance Company of Nebraska, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, Allianz Life Insurance Company of North America, Ameritas Life Insurance Corp., Ameritas Life Insurance Corp. of New York, The Ohio National Life Insurance Company, Ohio National Life Assurance Corporation, Pacific Life Insurance Company, Pacific Life and Annuity Company, Columbus Life Insurance Company and Security Benefit Life Insurance Company*.

R. Stephen McNeill, D. Ryan Slaugh, POTTER ANDERSON & CORROON LLP, Wilmington, Delaware, *Counsel for Americo Financial Life and Annuity Insurance Company, Great Southern Life Insurance Company, National Farmers Union Life Insurance Company, and United Fidelity Life Insurance Company.*

William P. Bowden, Catherine A. Gaul, Ricardo Palacio, ASHBY & GEDDES, Wilmington, Delaware, *Counsel for PHL Variable Insurance Company, Nassau Life Insurance Company f/k/a Phoenix Life Insurance Company and Nassau Life and Annuity Company f/k/a Phoenix Life and Annuity Company, Protective Life Insurance Company, The U.S. Branch of Sun Life Assurance Company of Canada, Fidelity & Guaranty Life Insurance Company, Fidelity & Guaranty Life Insurance of New York.*

John C. Phillips, Jr., Paul S. Seward, PHILLIPS, GOLDMAN, MCLAUGHLIN & HALL, P.A., Wilmington, Delaware, *Counsel for Hannover Life Reassurance Company of America and Security Life of Denver Insurance Company.*

Joseph C. Schoell, FAEGRE DRINKER BIDDLE & REATH LLP, Wilmington, Delaware, *Counsel for The Canada Life Assurance Company; Homesteaders Life Company; Police and Firemen's Insurance Association.*

Kathleen M. Miller, SMITH, KATZENSTEIN & JENKINS, LLP, Wilmington, Delaware, *Counsel for The Prudential Insurance Company of America, Metropolitan Life Insurance Company, Employers Reassurance Corporation and Jackson National Life Insurance Company.*

David A. Felice, BAILEY & GLASSER, LLP, Wilmington, Delaware, *Counsel for Great American Life Insurance Company.*

John G. Harris, Peter C. McGivney, BERGER HARRIS LLP, Wilmington, Delaware, *Counsel for the Reinsurance Association of America.*

Garrett B. Moritz, Elizabeth M. Taylor, ROSS ARONSTAM & MORITZ LLP, Wilmington, Delaware; Matthew A. Clemente, R. Bradley Drake, John Grothaus, SIDLEY AUSTIN LLP, Chicago, Illinois, *Counsel for Merced Private Claims, LLC.*

Joelle E. Polesky, STRADLEY RONON STEVENS & YOUNG, Wilmington, Delaware, *Counsel for American Council of Life Insurers.*

Travis S. Hunter, Renee M. Mosley, RICHARDS, LAYTON & FINGER, P.A., Wilmington, Delaware, *Counsel for Transamerica Life Insurance Company, Allstate Life Insurance Company, State Mutual Insurance Company, American Home Life Insurance Company.*

Jarret P. Hitchings, DUANE MORRIS LLP, Wilmington, Delaware, *Counsel for NW Hall Building LP*.

Joseph Larkin, SKADDEN, ARPS, SLATE, MEAGHER & FLOM LLP, Wilmington, Delaware, *Counsel for John Hancock Life Insurance Company (U.S.A.).*

Barry M. Klayman, Simon Fraser, COZEN O'CONNOR, Wilmington, Delaware, *Counsel for Scottish Re (Dublin) dac.*

Kevin J. Mangan, Nicholas T. Verna, WOMBLE BOND DICKERSON (US) LLP, Wilmington, Delaware, *Counsel for Brighthouse Life Insurance Company and NonParty Brighthouse Life Insurance Company of NY, New York Life Insurance Company, New Your Life and Annuity Insurance Company, United Heritage Life Insurance Company, Shenandoah Life Insurance Company, USAA Life Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, SBLI USA Life Insurance Company, Inc., S. USA Life Insurance Company, Inc., Genworth Life Insurance Company, Genworth Life and Annuity Insurance Company , Genworth Life Insurance Company of New York, USAA Life Insurance Company of New York, The Guardian Life Insurance Company of America.*

Jody Barillare, MORGAN LEWIS & BOCKIUS LLP, Wilmington, Delaware, *Counsel for Assured Guaranty (Europe) plc.*

Peter H. Kyle, John L. Reed, DLA PIPER LLP (US), Wilmington, Delaware, *Counsel for Non-Party SCOR Global Life Americas Reinsurance Company, SCOR Reinsurance Germany, Branch of SCOR SE, TOA Reinsurance Company, Limited of Tokyo, Japan, SCOR SE, SCOR Global Life Reinsurance Company of Delaware, SCOR Global Life USA Reinsurance Company, Columbian Life Insurance Company, Columbian Mutual Life Insurance Company.*

LASTER, V.C.

Scottish Re (U.S.), Inc. ("SRUS" or the "Company") is a delinquent insurer. The Insurance Commissioner of the State of Delaware (the "Commissioner") successfully petitioned the court for an order that placed the Company in receivership and appointed the Commissioner as receiver for the purpose of rehabilitating the Company. The delinquency proceeding has now entered its third year. The Commissioner has proposed a rehabilitation plan, but has not yet sought to have the plan approved.

The Company acted solely as a reinsurer. In that capacity, the Company entered into reinsurance agreements with primary insurers in which the Company agreed to pay a portion of the losses that their insureds suffered. In the language of the insurance trade, the primary insurers are called cedents, because they cede a portion of the premium associated with their reinsured policies in exchange for the reinsurer's commitment to pay the ceding insurer for a portion of its losses. The cedent remains obligated to pay its insureds for their losses regardless of whether the reinsurer fulfills its obligations.

Upon entering receivership, the Company stopped making payments to its contractual counterparties so that it could marshal its assets for purposes of rehabilitation. The Company thus stopped paying its cedents for losses they incurred. The cedents' claims against the Company for those losses constitute general, unsecured claims.

Notably, the receivership did not affect the cedents' obligations to make premium payments to the Company. And it had no effect on the cedents' obligations to their own insureds. The cedents thus found themselves in the uncomfortable position of continuing

to pay premiums to the Company for reinsurance, continuing to pay their insureds for their losses, and yet not receiving any payments from the Company.

By statute, Delaware law recognizes the right of a delinquent insurer and a contractual counterparty to offset mutual debts or mutual credits, subject to certain exceptions. The court previously approved a plan under which parties who owed qualifying obligations to the Company could offset those obligations against any qualifying amounts that the Company owed (the "Offset Plan").

Through the Offset Plan, cedents who could claim offsets received significant value from the Company by using the amounts they owed the Company to net out their losses. Effectively, those cedents paid their own losses using the amounts they otherwise would have paid to the Company.

The ability of cedents to invoke the Offset Plan fell along a spectrum. Some cedents had large offsets that could satisfy all or a high percentage of their losses. Other cedents had much smaller offsets. Some had none at all. Those cedents had to bear their losses without receiving any value in return.

The Commissioner currently asks the court to permit the Company to make payments to a subset of the cedents for a portion of their losses, with those payments to be made before the approval of a rehabilitation plan ("Pre-Plan Payments").[1] The

[1] By longstanding custom, the Commissioner styled his request as a petition. Except in a delinquency proceeding, a petition is the equivalent of a complaint. It is a vehicle to initiate an action, not a means of seeking relief in an already-commenced action. The Commissioner is the only party in this court that follows a different practice. The petition

Commissioner contemplates that through the Pre-Plan Payments, the Company will pay amounts sufficient for each cedent to have received compensation for at least 43% of the cedent's undisputed losses on ceded policies. Cedents who already received value through offsets in excess of the 43% threshold will not receive any Pre-Plan Payments. General creditors who are not cedents will not receive any Pre-Plan Payments. The Pre-Plan Payments only will cover undisputed losses. No payment will be made on disputed claims.

The standard of review for the Motion is unsettled. The parties agree that some form of review for abuse of discretion applies. The open question is how to operationalize that standard. Delaware law has an established approach for applying the abuse of discretion standard when an aggrieved party challenges an administrative decision by the Commissioner. But Delaware law has not addressed how to apply the abuse of discretion standard in a context similar to this one, where the Commissioner seeks approval to take action as part of an ongoing effort to rehabilitate an insurer. Following the lead of other jurisdictions, this decision applies by analogy the same principles that govern when an aggrieved party challenges an administrative decision.

To establish a *prima facie* case sufficient for the court to grant the Motion, the Commissioner must make three showings. First, the Commissioner must show that he has authority to make the decision and that it complies with applicable law. Typically, the Commissioner will satisfy his burden by pointing to his authority under Title 18 of the

---

in question is, in substance, a motion. To avoid confusing readers not familiar with this procedural oddity, this decision refers to the petition as the "Motion."

Delaware Code (the "Insurance Code") or another statute. At that point, a dispute over the Commissioner's authority only will exist if an objecting party contends that the Commissioner's decision exceeds his authority or otherwise violates applicable law. The court uses a plenary standard to decide whether the Commissioner has sufficient authority and has acted in compliance with law. By adjudicating that issue, the court does not second guess the Commissioner's judgment. The court instead establishes the metes and bounds of the domain in which the Commissioner can exercise judgment.

Second, the Commissioner must provide a rationale for his decision and create a factual record that contains substantial evidence to support that rationale. If the Commissioner has not provided the necessary rationale or factual support, then the court must reject the decision as arbitrary and capricious. During this phase, the court only looks to see if the Commissioner's proffered rationale has substantial evidentiary support in the factual record that the Commissioner created.

Assuming the Commissioner has provided a rationale for his decision that has substantial evidentiary support, then the inquiry reaches the final phase. At this point, the court grants broad deference to the Commissioner's decision and will uphold it as long as it is rational. The court only will reject the Commissioner's decision if it was made in bad faith, is the product of fraud, or fails for some similarly extreme reason.

As noted, the Commissioner has asked the court to authorize the Company to make the Pre-Plan Payments to cedents who have not yet received value from the Company for at least 43% of their undisputed losses under ceded policies (the "Participating Cedents"). A group of cedents objected to the proposal (the "Objecting Cedents"), as did creditors

Merced Capital L.P. and its wholly owned subsidiary, Merced Private Claims, LLC (jointly, "Merced"). Neither objection took issue with the concept of the Pre-Plan Payments. The objectors merely complained about not receiving any portion of the Pre-Plan Payments. Through their objections, they sought to force the Commissioner to modify the Pre-Plan Payments so that they would receive some of the money.

The Objecting Cedents and Merced contend that by only making the Pre-Plan Payments to the Participating Cedents, the Pre-Plan Payments violate a provision of the Insurance Code that establishes a priority scheme for payments from a delinquent insurer and which forbids the creation of subclasses within any class of claims. 18 *Del. C.* § 5918(e) (the "Priority Provision"). It is undisputed that the claims of the Objecting Cedents, Merced, and the Participating Cedents fall within the same class under the Priority Provision. The Objecting Cedents and Merced assert that by making payments only to the Participating Cedents, and by not making similar payments to them, the Commissioner has created subclasses in violation of the Priority Provision.

The Commissioner responds that the Priority Provision only applies in a liquidation, not to a rehabilitation. The Delaware courts have not previously addressed this issue. Although the matter is not free from doubt, the better reading of the Priority Provision is that it can apply in any delinquency proceeding, including a rehabilitation. Precedent from other jurisdictions indicates that a priority statute applies to a rehabilitation plan that contemplates a claims process. The Priority Provision also logically applies if the Commissioner seeks to make a payment that would risk impairing the prospects for rehabilitation or operate as a *de facto* liquidation.

That said, the Priority Provision does not inevitably constrain every decision that the Commissioner makes when pursuing a rehabilitation. The purpose of a rehabilitation is to enable the delinquent insurer to emerge as a going concern that can pay its debts as they come due in the ordinary course of business. A company operating in the ordinary course of business can prioritize paying certain claimants over others. Indeed, under Delaware law, even an insolvent business can prioritize paying certain claimants over others, unless limited by statute or if the transaction benefits a self-interested fiduciary. The Priority Provision makes clear that in any liquidation or its functional equivalent, the Commissioner must satisfy claimants in their order of priority and treat each class of claimants ratably. In the interest of pursuing a rehabilitation, however, the Commissioner can prioritize paying certain claimants over others, as long as the Commissioner has made a judgment that the delinquent insurer can emerge from the proceeding as a going concern and will be able to pay its debts as they come due in the ordinary course of business, and as long as the Commissioner's judgment passes muster when reviewed for abuse of discretion.

Here, the aggregate amount of the Pre-Plan Payments is sufficiently small, relative to the assets of the Company, that the Commissioner properly concluded that the payments will not undermine the ongoing effort at rehabilitation or operate as a *de facto* liquidation. The Objecting Cedents agree that the payments will not have that effect. Merced did not argue to the contrary, but rather objected that the Commissioner had not created a sufficient factual record to demonstrate that the Pre-Plan Payments would not be problematic. Merced's criticism properly falls under the second stage of the abuse of discretion analysis.

In the second stage, the court asks whether the Commissioner has presented a rationale for his decision and created a factual record that contains substantial evidentiary support for that rationale. As Merced correctly pointed out, the Commissioner's initial submission did not meet that standard. The Motion contained lawyer's arguments, supported by a rote declaration that the contents of the Motion were true. The arguments seemed plausible, but the Motion lacked substantial evidentiary support, especially regarding the relative magnitude of the Pre-Plan Payments and their effect on the rehabilitation process.

During the hearing on the Motion, the Commissioner's counsel provided additional detail. The court invited the Commissioner to file a supplemental submission that supplied the missing facts. The Commissioner made that submission, and it provided the substantial evidentiary support necessary to satisfy the second step in the analysis. In the future, the Commissioner must establish the factual predicate up front. It is inefficient and potentially unfair to objecting parties for the Commissioner not to include sufficient information in the initial Motion to support a *prima facie* case for relief.

The analysis therefore reaches the third phase. At this stage, the court presumes that the Commissioner's decision was rational and made in good faith. There is no evidence to suggest otherwise. The proposal to make the Pre-Plan Payments falls within the broad discretion that the Commissioner enjoys when making decisions regarding the rehabilitation of a delinquent insurer.

The court accordingly approves the Commissioner's request to make the Pre-Plan Payments to the Participating Cedents. The Motion is granted.

I. FACTUAL BACKGROUND

The facts are drawn from the submissions in connection with the Motion and from other filings on the docket.

A. The Company

The Company is a Delaware corporation that the Commissioner has licensed to provide life and health insurance. The Company was incorporated in 1977 and is headquartered in Charlotte, North Carolina.

The Company is a wholly owned subsidiary of Scottish Holdings, Inc., also a Delaware corporation. That entity in turn is a wholly owned subsidiary of Scottish Annuity & Life Insurance Company (Cayman) Ltd. ("SALIC"), a Cayman Islands company. SALIC is a wholly owned subsidiary of Scottish Re Group Limited ("SR Parent"), also a Cayman Islands company. The Company thus serves as an operating entity within a corporate group headed by SR Parent.

The Company is licensed as a reinsurer in sixteen states and in the District of Columbia. At one point, the Company was qualified or accredited as a reinsurer in thirty-three states.

The Company operated strictly as a reinsurer. That means it did not write direct policies of insurance, and it does not have policyholders. Instead, the Company entered into reinsurance agreements with primary insurers, who provide insurance to policyholders. Under a reinsurance agreement, the reinsurer agrees to pay a portion of the losses suffered by the primary insurer on identified policies in return for a premium paid by the primary insurer. The primary insurer remains liable to its insureds for the losses they

suffer, regardless of whether the reinsurer pays the share of the losses that it committed contractually to pay.

Coinsurance is a form of reinsurance in which the reinsurer takes on a proportionate share of all risks and cash flows associated with the ceded policies, subject to limited exceptions. The reinsurer thus receives a share of the premium paid by the insured to the primary insurer, and the reinsurer uses the premium to establish reserves for its share of the losses. Typically, the primary insurer is entitled to deduct certain fees and expenses, and the reinsurer is obligated to pay an allowance to the primary insurer for a share of the expenses involved in acquiring and maintaining the policy. Dkt. 172 at 2.

The Company engaged in three lines of coinsurance business: Accident and Health, Annuity, and Life.

- The Accident and Health coinsurance business involved health insurance products, mostly long-term disability insurance.
- The Annuity coinsurance business involved life insurance products that pay periodic income benefits for a specified time period or over the course of the annuitant's lifetime.
- The Life coinsurance business involved traditional life insurance products.

In addition to these lines of coinsurance, the Company provided Yearly Renewable Term Reinsurance ("YRT Reinsurance"). That product is a form of reinsurance for term life insurance policies where the risk of loss, but not the permanent plan reserves, are transferred to the reinsurer along with an amount of premium that varies each year with the risk and the ages of the insureds. As a result, the premium that a cedent pays to the

Company for YRT Reinsurance is independent of the premium that the insured pays to the cedent. Dkt. 553.

In addition to its reinsurance relationships with cedents, the Company entered into retrocession agreements with other reinsurers, known as retrocessionaires. Each retrocession agreement is a further reinsurance agreement in which the retrocessionaire acts as reinsurer and the Company acts as a cedent, referred to in this context as a retrocedent. Under a retrocession agreement, the retrocessionaire agrees to pay a portion of the losses suffered by the Company on its reinsurance obligations to the cedents. In return, the retrocessionaire receives a premium from the Company, typically calculated as a portion of the premium that the Company received from the cedent. Dkt. 172 at 2.

B. The Company Suffers Financial Difficulties.

In 2008, the Company stopped writing new business. It notified its existing cedents that it would no longer accept additional reinsurance risks under its existing reinsurance agreements. At that point, the Company's business consisted of its then-existing rights and obligations under its reinsurance agreements and retrocession agreements. In the language of the insurance trade, the Company's business went into run-off. Dkt. 553 ¶ 4.

In 2018, the Company's parent companies filed for bankruptcy. Dkt. 668 at 11. SR Parent commenced voluntary winding-up proceedings in the Cayman Islands and Bermuda. Scottish Holdings and SALIC are the debtors in a jointly administered Chapter 11 proceeding in the United States Bankruptcy Court of the District of Delaware. Dkt. 1 ¶ 9 (the "Delinquency Petition" or "DP"). Before those filings, the parent companies had provided financial support to the Company, including another level of reinsurance. Dkt.

668 at 11–12. With that coverage no longer available, the Company's financial picture worsened. DP ¶ 13.

Delaware law requires that an insurer file financial statements with the Commissioner. After the Company failed to file its financial statement for 2018, the Company agreed to be placed under the Commissioner's regulatory supervision. DP ¶ 12; Dkt. 271. While under regulatory supervision, the Commissioner and the Company worked to assess the Company's financial condition and determine the steps necessary to "achieve and maintain solvency and otherwise conduct its business in accordance with the requirements of Delaware Insurance Law." DP ¶ 15.

C. The Delinquency Proceeding

By early 2019, the Commissioner had determined that the Company was in financial distress. The Company's financial records showed an emerging negative surplus with losses projected to grow. Dkt. 553 ¶ 7. The principal cause was losses associated with YRT Reinsurance, together with the inability of the Company's parent entities to meet their reinsurance obligations. Most notably, SALIC was obligated to make quarterly cash payments to the Company under various reinsurance agreements and was obligated to maintain a balance of funds to secure its obligations under those agreements. SALIC did not have the liquid assets to fulfill those obligations. DP ¶ 16. The Company also faced other adverse developments. *Id.* ¶¶ 17–18.

On March 1, 2019, the Commissioner commenced a delinquency proceeding against the Company. *See generally id.* In the Delinquency Petition, the Commissioner sought to have the court place the Company into receivership and appoint the Commissioner as

receiver for the purpose of rehabilitating the Company. The Commissioner asserted that the Company was impaired and in an unsound condition, and it detailed the adverse events that the Company had suffered. *Id.* ¶¶ 16–18. The Delinquency Petition also explained that the Company had advised the Commissioner that it would not be able to file the annual statement required by 18 *Del. C.* § 526 or the risk-based capital report required by 18 *Del. C.* § 5802(a). *Id.* ¶ 25.

The Delinquency Petition reported that the Company's management and its board of directors believed it was in the best interests of the Company and its cedents and creditors to be placed into rehabilitation. The Company and the Commissioner projected that a rehabilitation could be prepared and submitted for court approval within 120 days. *Id.* ¶¶ 29–31. At the same time, the Commissioner warned that if a viable plan for rehabilitation could not be achieved, then it would be in the best interests of the Company's creditors and cedents to convert the rehabilitation proceeding into a liquidation. *Id.* ¶ 33.

Because the Company consented to the rehabilitation proceeding, a hearing on the Delinquency Petition was unnecessary. By order dated March 6, 2019, this court placed the Company into receivership and appointed the Commissioner as the statutory receiver of the Company. Dkt. 18 (the "Receivership Order").

The Receivership Order determined that the Company was impaired and in an unsound condition. *Id.* ¶ 4. Among other things, the Receivership Order empowered the Commissioner to "forthwith conduct and continue the business of SRUS pursuant to the terms of this order. *Id.* ¶ 6. The Receivership Order instructed the Commissioner to "to take such steps to remove the causes of SRUS's impairment, unsound condition, or hazardous

condition pursuant to the provisions of 18 Del. C. ch. 59 as he deems necessary." *Id.* ¶ 8. The Receivership Order authorized the Commissioner "to take such actions as the nature of this cause and interests of the cedents, creditors, and stockholder of SRUS and the public may require, subject to Court approval as required by 18 Del. C. ch. 59." *Id.*

The Receivership Order contained injunctions designed to preserve the Company's business. Among other things, the Receivership Order prohibited the transfer or disposition of Company assets by persons other than the Commissioner. *Id.* ¶ 11. It also prohibited the commutation or termination of agreements with the Company or the assertion of a default against the Company. *Id.* ¶ 10.

As a result of those provisions, the Company stopped making payments to its contractual counterparties. The Company thus stopped paying its cedents for losses they incurred. The Company also stopped paying premiums to its retrocessionaires for reinsurance coverage.

The Company's cedents and retrocessionaires, however, were not permitted to terminate, modify, or declare a default under their contracts with the Company. The Company's cedents thus had to continue paying premiums to the Company for providing reinsurance coverage, even though the Company was not paying for any losses. And the Company's retrocessionaires had to continue covering the Company's losses under their retrocession agreements, even though the Company was no longer paying premiums.

D. The Offset Plan

On March 25, 2019, the Commissioner sought approval of the Offset Plan. Dkt. 42. By statute, parties can cancel or "offset" mutual debts to each other by identifying the

amounts owed, subtracting one from the other, and paying only the balance. *See* 18 *Del. C.* § 5927 (the "Offset Statute"). Offsets are used in the ordinary course of business to handle transactions between and among cedents, reinsurers and retrocessionaires (and where applicable their brokers or agents). *See* Stephen W. Schwab et al., *Onset of an Offset Revolution: The Application of Set-Offs in Insurance Insolvencies*, 95 Dick. L. Rev. 449, 454 (1991) [hereinafter *Offset Revolution*].

Initially, certain cedents and retrocessionaires objected to the Offset Plan. The parties eventually negotiated a revised Offset Plan, which the court approved on June 20, 2019. Dkt. 211. Through the Offset Plan, the Company has made loss payments to cedents by offsetting the premium payments that the cedent otherwise would owe to the Company.

E. The Proposed Rehabilitation Plan

On June 30, 2020, the Commissioner filed a proposed plan of rehabilitation. Dkt. 489 Ex. A (the "Rehabilitation Plan"). Certain cedents and retrocessionaires sought information from the Commissioner about the development of the Rehabilitation Plan, how it would operate, and potential amendments. Disputes emerged regarding the nature and types of information that the Commissioner will provide. Disputes also emerged regarding the standard that the Commissioner would have to satisfy to obtain court approval for the Rehabilitation Plan.

The Rehabilitation Plan rests on the Commissioner's assessment that the Company's financial difficulties arise principally from a few large cedents within the Company's YRT Reinsurance business (the "Loss Leader Cedents"). The Commissioner maintains that the losses from the Loss Leader Cedents dwarf gains associated with other

aspects of the YRT Reinsurance business, as well as gains associated with the three lines of coinsurance business.

As envisioned by the Commissioner, the Rehabilitation Plan would give cedents two options. The first option would be to continue their business relationships with the Company on modified terms, generally with the right to receive payment for 87.5% of their losses in cash and to have the balance paid in newly issued notes that would earn interest at 12% and could be converted to cash depending on the Company's future success.

In exchange for continuing coverage on these terms, cedents would have to pay increased premiums. Cedents in the YRT Reinsurance business would be subject to a surcharge to reflect higher mortality expectations resulting from the COVID-19 pandemic and other factors. The Loss Leader Cedents would be subject to additional surcharges based on the past experience with their polices. Cedents could receive credit against rate increases if the performance of their policies met certain benchmarks. Cedents in the Company's coinsurance business would give up their right to future commission and expense allowances.

Under the second option, a cedent could elect to terminate its business relationship with the Company. Cedents in the YRT Reinsurance business who elected to terminate their relationship would receive up to 70% of the unearned premium reserve and 70% of the unpaid losses. Cedents in the coinsurance business would receive up to 25% of the unearned premium reserve and 70% of the unpaid losses. Cedents with a fully funded dedicated trust fund would receive the value of their security adjusted for the time value of early payment.

The proposed Rehabilitation Plan contains a procedure for claimants to assert claims against the Company. The proposed Rehabilitation Plan defines a "Claim" as

> (i) any Reinsurance Claim, a claim for Paid Losses Due under this Rehab Plan, a claim for Future Losses under this Rehab Plan, a claim related to the valuation of Paid Losses Due, Future Losses, or Statutory Prescribed Reserves, a Non-Reinsurance Claim, or any other right to payment from SRUS, whether such right is known or unknown, reduced to judgment, liquidated, unliquidated, fixed, contingent or matured, 5 unmatured, disputed, undisputed, legal, equitable, secured or unsecured, and regardless of when such right arises;
>
> (ii) any right to an equitable remedy against SRUS for breach of performance if such breach gives rise to a right of payment, whether or not such right to an equitable remedy is known, reduced to judgment, fixed, contingent, matured, unmatured, disputed, undisputed, secured or unsecured, and regardless of when such right arises; or
>
> (iii) any claim arising out of the terms of the Rehab Plan or the Rehab Plan's implementation or application.

Rehabilitation Plan § 2.1.11 (formatting added).

Under the proposed Rehabilitation Plan, claimants must submit their claims to the Company in writing. The Commissioner will evaluate each claim. If the Commissioner determines that any portion of the claim is not disputed, the Company will pay that portion. The Commissioner may dispute a claim "on any reasonable ground." *Id.* § 8.9.1. The proposed Rehabilitation Plan contains a procedure for the resolving disputed claims.

After proposing the original Rehabilitation Plan, the Commissioner made a series of filings that proposed minor changes to the amended plan based on the Commissioner's interactions with cedents and retrocessionaires. *See, e.g.*, Dkt. 518, 527, 559. On March 16, 2021, the Commissioner filed an amended plan of rehabilitation with the court. Dkt. 555.

The amended Rehabilitation Plan retained the same basic framework as the original Rehabilitation Plan.

The court has not yet approved the Rehabilitation Plan. It is not presently clear when the Rehabilitation Plan might be presented for approval.

F. The Motion Seeking Approval Of The Pre-Plan Payments

As the delinquency proceeding stretched into its second year, the Offset Plan began to create significant disparities among cedents. Different cedents possessed varying degrees of offsets and hence received differing levels of value under the Offset Plan.

- Twenty-eight cedents received value through offsets equal to 100% of their undisputed and unpaid claims against the Company.
- Three cedents received value through offsets equal to at least 85% but less than 100% percent of their undisputed and unpaid claims against the Company.
- Fourteen cedents received value through offsets equal to at least 50% but less than 84% of their undisputed and unpaid claims against the Company.
- Fifty-five cedents received offset payments of 49% or less of their undisputed and unpaid claims against the Company.

Of the fifty-five cedents who have received the lowest levels of offsets, forty-five have received value equal to less than 35% of their undisputed and unpaid claims against the Company.

Through the Offset Plan, the Company provided significant value to the cedents who possessed offsets. Between March 6, 2019, and September 30, 2020, the cedents entitled to offsets used the Offset Plan to address losses totaling nearly $500 million. But a substantial amount of the undisputed losses remained unsatisfied. The Commissioner

estimated that through September 30, 2020, cedents had accrued nearly $300 million in undisputed and unpaid claims, net of offsets. In rough figures, therefore, the Offset Plan had addressed approximately 62.5% of the cedents' undisputed loses, leaving 37.5% of the undisputed losses unsatisfied.

Some cedents requested payment for undisputed losses that could not be addressed through the Offset Plan. The Commissioner considered those requests and concluded that it was inequitable for some cedents to receive substantially less value for their undisputed losses than others, simply based on the availability of offsets. The Commissioner noted that the cedents that did not qualify for offsets and that had not received any payments were often smaller insurers who could be burdened by not receiving any compensation for their losses. Dkt. 668.

Accordingly, on March 8, 2021, the Commissioner filed an initial version of the Motion that sought court approval to make Pre-Plan Payments to each cedent who had not received value for at least 35% of its undisputed and unpaid claims through offset. Dkt. 553 ¶ 41. The Commissioner envisioned that the aggregate amount of the Pre-Plan Payments would be capped at $33,781,534. *Id.* ¶ 42.

The Motion was nineteen pages long. The vast majority of its contents provided information about the Company and the history of the delinquency proceeding. The Motion said very little about the Pre-Plan Payments. In substance, the Commissioner's grounds for seeking relief boiled down to the following paragraph:

> After careful analysis and deliberation, the Receiver has determined that it would be equitable, fair, and in the best interests of the SRUS estate if SRUS was to make Pre-Plan Partial Loss Payments to those Cedents of SRUS that

> have not received loss payments from SRUS for claims paid by them through September 30, 2020 in an aggregate amount of at least thirty-five percent (35%) of their undisputed unpaid claims through statutory offset.

Id. ¶ 40.

The Commissioner did not provide any financial information beyond the total amount of the proposed Pre-Plan Payments and general figures about the magnitude of the offsets. The Motion simply asserted that

> [t]his payment amount is currently sustainable through SRUS' cash flow, will be coordinated with, and applied toward, payments later due from SRUS under Section 5 of the Rehab Plan, and will serve as a leveling mechanism to address the disproportionate impact experienced by nearly half of all Cedents that do not have the same ability as other Cedents to mitigate the impact to them of restrictions placed on non-offset loss payments that are necessary to the rehabilitation of SRUS.

Id. ¶ 40. The Commissioner also asserted that "[b]ased upon financial information that has been previously filed with the court, including the financial information that was filed as recently as March 2, 2021, the thirty-five percent (35%) payment should not constitute a preference." *Id.* The Commissioner did not provide any analysis or calculations to support that assertion. The Commissioner did not include any pinpoint citations to the "financial information that has been previously filed with the court." The Commissioner did not even provide a docket item number.

The Commissioner did not submit any supporting documents. No one provided a testimonial affidavit containing specific factual averments. The only effort that the Commissioner made to create a factual record was to have the individual serving as deputy receiver for the Company sign a verification in which he stated:

> I have reviewed the attached Receiver's Petition for Approval of Pre-Plan Partial Loss Payments from Scottish Re (U.S.), Inc. to Certain Cedents and hereby verify and declare that the factual responses and assertions therein are true and correct to the best of my knowledge and belief.

Dkt. 553. The Commissioner thus provided the court with nothing more than lawyer's argument.

The Commissioner subsequently withdrew the initial version of the Motion. On June 11, 2021, the Commissioner filed a revised version of the Motion which contemplated making Pre-Plan Payments to cedents who had received value through offsets for less than 43% of their undisputed and unpaid losses. Dkt. 590 ¶ 32. Although the qualifying percentage of unpaid losses increased from 35% to 43%, the aggregate cash outlay decreased marginally from $33,781,534 to $33,556,331. *Id.* ¶ 34.

The revised Motion did not expand on the original Motion's cursory description of the rationale for the Pre-Plan Payments. The revised version did not provide any factual basis for the Commissioner's decision beyond lawyer's argument. The Commissioner again did not provide any supporting documents or a testimonial affidavit containing specific factual averments. The only effort that the Commissioner made to create a factual record was to have the same individual serving as deputy receiver for the Company sign another verification containing the same recitation.

G. The Objections

The Motion drew two objections. Neither disagreed with the concept of the Company making the Pre-Plan Payments. The objectors rather sought to modify the Pre-Plan Payments so that they would be able to participate.

1. The Objecting Cedents

Forty cedents, comprising the Objecting Cedents, filed an omnibus objection to the Pre-Plan Payments. *See* Dkt. 573 (the "Omnibus Objection"). They made clear that they "do *not* object to [the Company] making partial payments at this time." *Id.* ¶ 2. They explained that a "[p]artial payment to stakeholders, even the very modest payment proposed by the Receiver, is welcome relief as this rehabilitation proceeding stretches into its third year." *Id.* Nevertheless, the Objecting Cedents advanced three objections.

First, they asserted that, as structured by the Commissioner, the Pre-Plan Payments impermissibly created a subclass in violation of the Priority Provision, 18 *Del. C.* § 5918. They correctly observed that their claims fell within the same category as the Participating Cedents and therefore had the same priority. They argued that by making a payment to the Participating Cedents and not to the Objecting Cedents, the Commissioner was treating claimants in the same category non-ratably and creating a subclass. The Objecting Cedents further argued that to the extent that the Commissioner claimed that they were differently situated because they had received offsets under the Offset Plan, a provision in the Insurance Code prohibited the Commissioner from treating offsets as payments. Instead, by statute, an offset was merely an adjustment to a claim that lowered the claim amount. The Objecting Cedents concluded that they, like the Participating Cedents, had not received any payments from the Company on their claims and therefore had a right to participate in the Pre-Plan Payments.

Second, the Objecting Cedents argued that the Commissioner had failed to include their claims for expense reimbursement and commissioner allowances when calculating

the amounts of the cedents' claims. The Objecting Cedents did not articulate this theory in any meaningful way.

Third, the Objecting Cedents argued that the accounting figures used by the Commissioner to calculate the payments to the cedents were "uncertain and likely materially wrong." *Id.* ¶ 3. The Objecting Cedents did not spell out this objection in detail either.

2. Merced

Merced advanced the second objection. Merced is a creditor of the Company that that filed two claims totaling $26 million. Like the Omnibus Objectors, Merced did not oppose the concept of the Pre-Plan Payments. *See* Dkt. 602 ¶ 1. Merced merely wanted to participate.

Like the Omnibus Objectors, Merced started from the premise that its claims were equal in priority to the claims of the Participating Cedents. Like the Omnibus Objectors, Merced argued that if the Commissioner made a payment to the Participating Cedents and not to Merced, then the Commissioner would be creating an impermissible subclass in violation of the Priority Provision. Merced's solution was for the Commissioner to pay 43% of Merced's claims, a percentage equal to the percentage of unpaid losses the Pre-Plan Payment contemplates paying to the Participating Cedents. Alternatively, Merced sought to have the Commissioner create a cash reserve for Merced's claim equal to 43% of the amount claimed. Dkt. 564 ¶ 17.

Unlike the Omnibus Objectors, Merced argued that the Commissioner had not provided sufficient information to demonstrate either (i) that the Pre-Plan Payments would

not jeopardize the Company's ability pay Merced's claim or (ii) that a rehabilitation plan would still be feasible. Merced nevertheless represented that it was "not generally opposed to the [Commissioner] making Pre-Plan Partial Loss Payments to Recipient Cedents, so long as Merced's ability to receive like treatment is ultimately preserved." Dkt. 564 ¶ 5. Accordingly, Merced requested that the court require that the Commissioner either pay or establish a cash reserve in an amount equal to a comparable percentage of Merced's claim.

H. The Supplemental Submission

On January 12, 2022, the court heard argument on the Motion. During the hearing, the Commissioner's counsel provided substantially more information about the rationale for the Pre-Plan Payments and the evidence that supported it.

The court noted that the Commissioner had not provided this information in his written submissions. Rather than denying the Motion on that basis, the court invited the Commissioner to make a supplemental submission to create the necessary factual record.

On January 28, 2022, the Commissioner filed the supplemental submission. Dkt. 669. Unlike the Commissioner's earlier submissions, the supplemental submission provided financial data points that supported the Commissioner's contention that the Pre-Plan Payments would not jeopardize the Company's prospects for rehabilitation. In support of the supplemental submission, the Commissioner submitted detailed factual affidavits from (i) Gregg I. Klingenberg, the Chief Executive Officer, General Counsel, and Corporate Secretary of the Company, and (ii) Randall Barber, the Senior Vice President—Head of Finance of the Company.

The supplemental submission established the following facts:

- For the periods ending December 31, 2020, and June 30, 2021, the actual amount of unrestricted Company assets was $519.4 million and $538 million respectively.

- The forecasted amount of unrestricted Company assets for the period ending December 31, 2021, was $528.1 million.

- The proposed payment of $33,556,331 constitutes just over six percent of the Company's unrestricted assets across all three periods.

- Even after the Company makes the Pre-Plan Payments to the Participating Cedents, the Company's total unrestricted cash and invested assets is projected to be $495.4 million.

At the same time, the supplemental submission undercut the Commissioner's previous assertion that the Company could support the Pre-Plan Payments with its operating cash flow. The submissions established that the Company incurred an operating loss of $32.3 million for 2020. While the Company was projecting an operating surplus for 2021, the amount of that surplus was only $4.4 million, far less than what would be required to fund the Pre-Plan Payments. *See id.* Ex. C.

II. LEGAL ANALYSIS

The Commissioner seeks court approval to cause the Company to make the Pre-Plan Payments. The Objecting Cedents and Merced have objected to the Motion. This decision grants the Motion and approves the Pre-Plan Payments.

A. The Standard Of Review

The parties broadly agree that an abuse of discretion standard governs the Commissioner's request. Black letter authorities generally state that an abuse of discretion standard applies when a court reviews the decision of an insurance commissioner acting as

a receiver for a delinquent insurer.[2] Cases from other jurisdictions regularly use an abuse of discretion standard when reviewing a rehabilitation plan that an insurance commissioner has proposed.[3] The parties have not cited, and research has not revealed, any case that

---

[2] *See, e.g.*, 43 Am. Jur. 2d *Insurance* § 89, Westlaw (database updated Feb. 2022) (citation omitted) ("Courts will generally defer to the business judgment of the rehabilitator and will disapprove the rehabilitator's actions only when they are shown to be arbitrary, capricious, or an abuse of discretion."); 44 C.J.S. *Insurance* § 271, Westlaw (database updated Mar. 2022) ("The conduct and disposition of proceedings for the conservation or rehabilitation of an insurance company are generally subject to judicial review under a deferential standard of abuse of discretion."); 1 Couch on Insurance § 5:22 (3d ed.), Westlaw (database updated Dec. 2021) ("The conservator has broad discretion to structure a plan of rehabilitation."); Kristen J. Brown & Stephen Pate, *Regulatory Framework*, *in* 9 New Appleman on Insurance Law § 98.01[6] (Library ed. 2021) ("Courts reviewing receivership orders and subsequent orders implementing the receivership order most often apply an abuse of discretion standard in reviewing the insurance commissioner's actions.").

[3] *See, e.g.*, *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d 453, 460 (Cal. Ct. App. 1995) (reviewing challenge to approval of rehabilitation plan and noting that "[t]he trial court reviews the Commissioner's actions under the abuse of discretion standard"); *Ky. Cent. Life Ins. Co. v. Stephens*, 897 S.W.2d 583, 588 (Ky. 1995) ("[T]he standard of the court's review of the rehabilitator's actions is one of abuse of discretion. Under the special statutory proceedings, the Commissioner is granted administrative discretion in the context of the insolvency/delinquency proceedings."); *Angoff v. Holland-Am. Ins. Co. Tr.*, 937 S.W.2d 213, 217 (Mo. Ct. App. 1996) (noting that "[a] receiver has broad discretion" in conducting and managing a liquidation" in review of a challenge to approval of liquidation plan (citing *Lucas v. Mfg. Lumbermen's Underwriters*, 163 S.W.2d 750, 757 (Mo. 1942))); *Mills v. Fla. Asset Fin. Corp.*, 818 N.Y.S.2d 333, 334 (N.Y. App. Div. 2006) ("The courts will generally defer to the rehabilitator's business judgment and disapprove the rehabilitator's actions only when they are shown to be arbitrary, capricious or an abuse of discretion"); *Foster v. Mut. Fire, Marine & Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) ("[T]he involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion."); *Kueckelhan v. Fed. Old Line Ins. Co. (Mut.)*, 444 P.2d 667, 674 (Wash. 1968) (reinstating an insurance commissioner as rehabilitator and noting that the commissioner is "required to follow the statutory mandates and to use reasonable discretion in the rehabilitation of a seized company, with abuse of discretion to be checked by the judiciary"); *In re Ambac Assurance Corp.*, 841 N.W.2d 482, 495 (Wis. Ct. App. 2013) ("When reviewing the circuit court's decision to

applies the abuse of discretion standard to a one-off issue like the request to make the Pre-Plan Payments that is not part of a broader rehabilitation plan.

Logically, the same standard should apply. Multiple factors warrant applying an abuse of discretion standard to an issue like the request to make the Pre-Plan Payments. They include (i) the Commissioner's status as an elected public official charged with exercising the authority conferred by the Insurance Code and other statues, (ii) the specialized nature of the insurance industry, (iii) the complexities of regulating insurers, (iv) the expertise that the Commissioner and the Department of Insurance develop over time, (v) the fact that the Commissioner assumes operational control of the business and affairs of the delinquent insurer and must make judgment-laden decisions regarding its operations, and (vi) the fact that in contrast to the Commissioner's direct involvement with the delinquent insurer, the court acts in an oversight role. *See Ambac*, 841 N.W.2d at 495 (citing similar factors in support of abuse of discretion standard).

The difficult problem is how to operationalize the abuse of discretion standard. In this proceeding, the Commissioner has come perilously close to contending that he can obtain court approval simply by informing the court in cursory fashion of his proposed decision, without providing a meaningful explanation of the rationale for the decision and without presenting a factual record to support that rationale. So construed, the court's role under the abuse of discretion standard would resemble a rubber stamp. When pressed at

---

approve the rehabilitation plan, we will uphold the determinations made by the rehabilitator unless the rehabilitator abused his or her discretion." (citations omitted)).

argument, the Commissioner disavowed such an extreme view, but his filings reflected that approach. In the Factual Background, this decision has discussed the cursory nature of the Commissioner's submissions.

When the Commissioner makes a decision in an administrative proceeding, the mechanism for applying the abuse of discretion standard is well-settled. In *BCBSD, Inc. v. Denn*, the Delaware Superior Court provided the following concise summary of the operative principles:

> When reviewing an appeal of a decision from an administrative agency, the Court must determine whether the ruling is supported by substantial evidence and free from legal error. The Court will affirm the agency's decision where there is no abuse of discretion. Only where the record clearly indicates that the agency's decision was based on improper or inadequate grounds has the agency abused its discretion. Where the agency's determination is supported by substantial evidence, however, the Court will affirm the ruling. Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. Substantial evidence is more than a scintilla but less than a preponderance.
>
> Where the issue presented is a question of law or the application of law to undisputed facts, the court's review is plenary. The court has discretion to give due weight to an agency's own interpretation of a statute it administers, but the Court may not defer to that interpretation. Where an agency interpretation is longstanding and widely enforced, that interpretation is entitled to greater weight.

2008 WL 1838462, at *4 (Del. Super. Apr. 22, 2008) (cleaned up); *accord Del. Comp. Rating Bureau, Inc. v. Ins. Comm'r*, 2009 WL 2366009, at *4 (Del. Ch. July 24, 2009). As this passage indicates, these standards do not apply uniquely to the Commissioner. They

are the general standards that a Delaware court uses when a party has challenged an agency determination.[4]

In this case, the Commissioner seeks court approval for his proposal to cause the Company to make the Pre-Plan Payments. The Commissioner has not made an administrative decision that would be subject to judicial review under the *BCBSD* standard, but a similar approach seems warranted. As a practical matter, the Commissioner has determined that making the Pre-Plan Payments is in the Company's best interest. Rather than implementing the decision and then having parties challenge it, the Commissioner is seeking approval upfront. Despite the timing difference, the issue is effectively the same—whether the Commissioner's decision will be upheld.

---

[4] *See Stoltz Mgmt. Co. v. Consumer Affs. Bd.*, 616 A.2d 1205, 1208 (Del. 1992) ("On appeal from a decision of an administrative agency the reviewing court must determine whether the agency ruling is supported by substantial evidence and free from legal error. Absent an abuse of discretion, the decision of the agency must be affirmed. However, where, as here, the issue is one of construction of statutory law and the application of the law to undisputed facts, the court's review is plenary" (citations omitted)); *accord Pub. Water Supply Co. v. DiPasquale*, 735 A.2d 378, 380–81 (Del. 1999) (quoting and applying the *Stoltz* test); *Olney v. Cooch*, 425 A.2d 610, 613 (Del. 1981) ("The standard for judicial review of a decision of an administrative body is well established. Reversal is warranted if the administrative agency exercised its power arbitrarily or committed an error of law, or made findings of fact unsupportable by substantial evidence." (cleaned up)); *Kreshtool v. Delmarva Power & Light Co.*, 310 A.2d 649, 652 (Del. 1973) ("The law in Delaware governing review of agency discretionary decisions is clear. An administrative agency with discretionary power cannot act arbitrarily or capriciously. The record must clearly show the basis on which the administrative agency acted in order that its exercise of discretion may be properly reviewed. Although the reviewing court's inquiry into the record is to be searching and careful, the ultimate standard that it must apply is a normal appellate one. . . . It is immaterial whether the reviewing court would have reached a contrary conclusion from the same evidence." (citations omitted)).

When operationalizing the abuse of discretion standard for purposes of reviewing a proposed rehabilitation plan, decisions from other jurisdictions use a framework similar to *BCBSD*. The intermediate court of appeals from Wisconsin has held explicitly that the principles governing review of an administrative ruling apply by analogy when a court reviews a proposed rehabilitation plan. *Ambac*, 841 N.W.2d at 494 (noting that the court was "reviewing the rehabilitation plan that the commissioner submitted for the circuit court's approval, and not a final agency decision made following an administrative proceeding," but holding that the same standard of review would apply). Research has not revealed any judicial decisions in which a court has reviewed a proposal by an insurance commissioner to take action separate from the approval of a rehabilitation plan, but logically the principles governing the review of an administrative ruling would apply by analogy there as well.

The analysis that other jurisdictions conduct proceeds in three steps. First, the commissioner's decision must comply with positive law.[5] Positive law includes the United

[5] *See Exec. Life*, 38 Cal. Rptr. 2d at 460 (noting that under the abuse of discretion standard, a court must evaluate whether the decision "is contrary to specific statute"); *Callon Petroleum Co. v. Superintendent of Ins. of State*, 863 N.Y.S.2d 92, 94 (N.Y. App. Div. 2008) (reversing decision of insurance commissioner under abuse of discretion statute where commissioner failed to comply with statutory requirement); *In re Frontier Ins. Co.*, 945 N.Y.S.2d 866, 870 (N.Y. Sup. Ct. 2012) (evaluating "the threshold question" of whether insurance commissioner's decision regarding classification of claims violated a state statute); *Foster*, 614 A.2d at 1092 (noting that the process of review starts with and includes "determining questions of law"); *Kueckelhan*, 444 P.2d at 675 (reversing trial court's rejection of plan where there was "nothing arbitrary, capricious, unreasonable *or unlawful* with the approach adopted by the [c]ommissioner" (emphasis added)); *Ambac*,

States Constitution, federal statutes, federal regulations, the state constitution, state statutes, state regulations, and common law. By determining whether the decision complies with positive law, the court does not second guess the commissioner's judgment. The court instead determines whether the commissioner's decision falls within the domain where he can exercise discretion.

Jurisdictions differ regarding the extent to which a court defers to the commissioner's interpretation of a governing statute or regulation. Under the federal concept of "*Chevron* deference," a court defers to an agency's interpretation of the statutes and regulations that it administers if the provision is ambiguous and as long as the interpretation is rational and not clearly erroneous. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council*, 467 U.S. 837, 842–43 (1984) ("[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute."). Some jurisdictions apply a similar concept; others do not.[6]

---

841 N.W.2d at 494 (analyzing whether commissioner actions were "arbitrary, capricious or an abuse of discretion" (quoting *Mills*, 31 A.D.3d at 850)).

[6] *Compare ABN AMRO Bank N.V. v. Dinallo*, 962 N.Y.S.2d 854, 866 (N.Y. Sup. Ct. 2013) (affording agencies "great weight and judicial deference" "in questions relating to its expertise," but declining to defer to the agency's determination "where the question is one of pure statutory reading and analysis, dependent only on accurate apprehension of legislative intent"), *In re Penn Treaty Network Am. Ins. Co.*, 119 A.3d 313, 321 (Pa. 2015) (reviewing cases and affirming the "deference due to the administrative agency" is great), *and Ambac*, 841 N.W.2d at 495 (treating questions of statutory interpretation as a question of law but concluding "that it is appropriate to afford great weight deference to the commissioner's interpretation and application of the statutes governing the rehabilitation of an insurer and other related statutes that the commissioner is charged with

The Delaware Supreme Court has declined to employ *Chevron* deference and held that the interpretation of applicable law is "ultimately the responsibility of the courts." *DiPasquale,* 735 A.2d at 383. That said, a court "may accord due weight, but not defer, to an agency interpretation of a statue administered by it." *Id.* (footnote omitted). A court also may give appropriate deference to an agency's interpretation of its own rules or regulations. *Id.* What a court applying Delaware law cannot do is defer to the agency's interpretation "merely because it is rational or not clearly erroneous." *Id.*

The decisions from other jurisdictions explain that the next step in the judicial process is to examine the rationale for the commissioner's decision to determine whether it has substantial support in the record that the commissioner submitted to justify his decision.[7] The court must consider the reasons provided by the commissioner and the

---

administering"; explaining that under "great weight deference" the court will "affirm an agency's interpretation of a statute if it is reasonable, even if we believe that another interpretation is more reasonable"), *with NIPSCO Indus. Gp. v. N. Ind. Pub. Serv. Co.,* 100 N.E.3d 234, 241 (Ind. 2018) (holding that questions of law are reviewed *de novo* and "accord[ing] the administrative tribunal below no deference"), *and In re Complaint of Rovas Against SBC Mich.*, 754 N.W.2d 259, 262 (Mich. 2008) ("[C]ourts may not abdicate their judicial responsibility by giving unfettered deference to an agency's interpretation.").

[7] *See Exec. Life,* 38 Cal. Rptr. 2d at 460 (noting that under the abuse of discretion standard, a court asks "was the action arbitrary, i.e. unsupported by a rational basis"); *Foster*, 614 A.2d at 1092 (noting that the process of review includes "determining . . . whether sufficient competent evidence exists to support the exercise of discretion"); *Koken v. Fid. Mut. Life Ins. Co.*, 803 A.2d 807, 812 (Pa. Commw. Ct. 2002) (noting that an administrative agency "abuses its discretion when its findings of fact are not supported by substantial evidence" (cleaned up)); *Kueckelhan*, 444 P.2d at 675 (reversing trial court's rejection of plan where commissioner provided expert testimony to support it); *Ambac*, 841 N.W.2d at 497 (affirming trial court's approval of insurance commissioner's decision

record that the commissioner created. The court looks narrowly for the existence of reasons, the existence of a supporting record, and the presence of substantial evidence to support the commissioner's reasons. *Cf. Tate v. Miles*, 503 A.2d 187, 191 (Del. 1986) (using similar approach when reviewing zoning decision). A lack of reasons, a lack of substantial evidence to support those reasons, or the absence of any correspondence between the two indicates an ill-considered, unsupported decision that is therefore arbitrary and capricious. *See id.*

If the commissioner has provided a rationale that has substantial support in the evidentiary record, then decisions from other jurisdictions grant broad deference to the commissioner's judgment. As the Supreme Court of Pennsylvania has explained, "it is not the function of the courts to reassess the determinations of fact and public policy made by the [commissioner]."[8]

Decisions from other jurisdictions place the burden of proof on the party opposing the commissioner's decision. *See Stephens*, 897 S.W.2d at 588 ("[T]he burden of proof is on those contesting the [c]ommissioner's actions."). Thus, "[a] party contesting the rehabilitator's actions bears the burden of showing arbitrary conduct by the rehabilitator."

---

where trial court received testimony which "established that the commissioner appropriately exercised its discretion").

[8] *Foster*, 614 A.2d at 1091; *see Mills*, 818 N.Y.S.2d at 334 (noting that courts will "disapprove the rehabilitator's actions only when they are shown to be arbitrary, capricious or an abuse of discretion"); *Kueckelhan*, 444 P.2d at 675 (reversing trial court's rejection of plan where there was "nothing arbitrary, capricious, unreasonable, or unlawful with the approach adopted by the [c]ommissioner").

Callon, 863 N.Y.S.2d at 94. That said, the commissioner must first make a record for review that includes a rationale for the decision and provides substantial evidentiary support for the rationale.

Based on these authorities, the abuse of discretion standard operates in the following manner for purpose of the Motion. The Commissioner has the initial burden of making out a *prima facie* case for the requested relief. If the Commissioner has identified a source of authority, articulated a rationale for the requested relief, and created a factual record to support the proffered rationale, then the burden shifts to the objecting party to show that (i) the Commissioner lacked authority to make the decision or that the decision does not otherwise comply with applicable law, (ii) the Commissioner's rationale does not have substantial evidentiary support, or (iii) that the decision is an abuse of discretion.

B. The Priority Provision

In this case, the Commissioner contends that his authority to make the Pre-Plan Payments derives from his charge to rehabilitate the Company, embodied in the Receivership Order. The principal challenge to that authority asserts that the Pre-Plan Payments conflict with the Priority Provision. That provision states, in pertinent part:

> The priority of distribution of claims from the insurer's general assets shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class shall receive any payment. No subclasses shall be established within any class. No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies.

18 *Del. C.* § 5918(e). The Priority Provision then establishes nine classes of claims against a delinquent insurer. Under the Priority Provision, the claims of each class must be satisfied

in order of priority. A lower class cannot receive any payment until the claims of the higher classes have been satisfied. Within each class, the Priority Provision requires ratable treatment. The Priority Provision forbids the creation of subclasses.

Class VI includes "[c]laims of general creditors including, but not limited to, claims of ceding and assuming insurers in their capacity as such, and claims of insurers, insurance pools or underwriting associations for contribution, indemnity or subrogation, equitable or otherwise." *Id.* § 5918(e)(6). The claims held by the Participating Cedents, the Objecting Cedents, and Merced all fall within Class VI and have the same priority. The Objecting Cedents and Merced assert that the Pre-Plan Payments violate the Priority Provision because, by making a payment to the Participating Cedents, the Company is treating claimants within the same class differently and effectively creating a subclass.

The Commissioner responds that the Priority Provision only applies in a liquidation and not to a rehabilitation.[9] The Insurance Code authorizes the Commissioner to file a delinquency proceeding against an insurer "for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer." 18 *Del. C.* § 5901(3). The statute does not define

---

[9] The Commissioner makes other arguments that this decision does not reach. In response to the Objecting Cedents, the Commissioner also argues that the Pre-Plan Payments do not create a subclass because under the Offset Plan, the Objecting Cedents already have received value for their undisputed and unpaid losses in excess of what the Participating Cedents will receive through the Pre-Plan Payments. Rather than creating disparity, therefore, the Commissioner interprets the Pre-Plan Payments as reducing disparity. In response to Merced, the Commissioner argues that Merced's claim is not undisputed and hence not subject to payment. Because of this decision's ruling on the Priority Provision, it is not necessary to consider the Commissioner's secondary arguments.

any of these terms, but three of the four have well understood meanings in the context of an insurance company receivership.[10]

- In a liquidation, the Commissioner winds up the business of the delinquent insurer, marshals its assets, and makes payments to its claimants, including a liquidating distribution to equity holders, if sufficient funds are available. The delinquent insurer does not continue as a going concern.[11]

- In a rehabilitation, the Commissioner seeks to remedy the problems that led to the delinquency proceeding so as to preserve the business of the delinquent insurer and allow it to emerge from receivership as a going concern.[12] In the language of the statue,

---

[10] The exception is a reorganization, which is a familiar term under Chapter 11 of the Bankruptcy Code. *See* 11 U.S.C. §§ 1121–1129. It is also a familiar term in corporate law. It does not seem to have a distinct meaning in the context of insurance receiverships, other than to connote a restructuring of the delinquent insurer. Given that a rehabilitation often includes some form of reorganization, there does not appear to be much of a role for the separate concept of a reorganization to play.

[11] *See* Michael F. Aylward & Paul M. Hummer, *When Insurers Go Belly Up: Implications for Insurers, Policyholders and Guaranty Funds*, 70 Def. Couns. J. 448, 450 (2003) ("Liquidation of a domestic insurer involves taking possession of the property of an insurer, being vested by operation of law with title to all property, contracts and rights of action of the insurer, and giving notice to all creditors to present their claims."); Howard M. Berg, *Fundamentals of Insurance Insolvency Laws*, 38 Prac. Law. 45, 46–47 (1992) ("In liquidation the commissioner takes title to the insurer's property and gathers the insurer's assets to liquidate them and pay the insurer's creditors."); Nat'l Ass'n of Ins. Comm'rs, *Receiver's Handbook for Insurance Company Insolvencies*, at iii (2021) [hereinafter *Receiver's Handbook*] ("In a liquidation, the receiver marshals the assets of the insurer, determines the liabilities of the insurer to policyholders and other creditors, and distributes the assets in satisfaction of such claims in accordance with a priority-of-distribution scheme prescribed by state law."); *Offset Revolution*, *supra*, at 451–52 n.3 ("'Liquidation' precludes the transaction of further business by the company and results in a final distribution of its assets."); Francine Semaya & William K. Broudy, *A Primer on Insurance Receiverships*, Brief, Fall 2010, at 22, 28 ("The liquidator's role is to wind up the insurer's affairs in a comprehensive and efficient manner.").

[12] *See* Berg, *supra*, at 47 ("In rehabilitation the aim is to restructure the insurer to make it a viable business entity. The rehabilitator's primary purpose is to determine whether the company is in a condition that makes rehabilitating or reorganizing the insurer a reality."); *Receiver's Handbook*, *supra*, at iii ("In rehabilitation, a plan is devised to

the Commissioner is charged with taking steps "towards removal of the causes and conditions which have made rehabilitation necessary." *Id.* § 5910(a).

- In a conservatorship, also called regulatory supervision, the Commissioner takes possession of the delinquent insurer to preserve the status quo while the receiver evaluates the Company's financial status.[13]

In the Delinquency Petition, the Commissioner sought authority to conduct a rehabilitation, and in the Receivership Order, the court empowered the Commissioner to carry out a

---

correct the difficulties that led to the insurer being placed in receivership and return it to the marketplace. The regulator must determine whether a rehabilitation of the company is likely to be successful, or if its problems are so severe that the appropriate course of action is to liquidate the insurer."); *id.* at 8 ("Rehabilitation can be used as a mechanism to remedy an insurer's problems, to run off its liabilities to avoid liquidation, or to prepare the insurer for liquidation."); *Offset Revolution, supra*, at 451 n.3 ("'Rehabilitation' has been defined as 'the preservation, whenever possible, of the business of an insurance company threatened with insolvency.'" (quoting *People ex rel. Schact v. Main Ins. Co.*, 448 N.E.2d 950, 952 (Ill. App. Div. 1983))); Semaya & Broudy, *supra*, at 28 ("The rehabilitator manages the insurer's affairs for an indefinite time period, until the company can be returned to its prior management, or perhaps new management, or it is placed in liquidation. The primary purpose of rehabilitation is the preservation of the insurer." (citations omitted)); David A. Skeel, Jr., *The Law and Finance of Bank and Insurance Insolvency Regulation*, 76 Tex. L. Rev. 723, 732 (1998) ("As the names suggest, rehabilitation proceedings are designed to stabilize and rehabilitate a troubled insurer.").

[13] *Offset Revolution*, *supra*, 451 n.3. *See* Couch on Insurance, *supra*, § 5:18) ("A conservatorship proceeding contemplates, not the liquidation of the company involved, but a conservation of the assets and business of the company over the period of stress by the commissioner who thereafter yields the control and direction to the regular officers of the company." (citing *Pac. Rim Mech. Contrs., Inc. v. Aon Risk Ins. Servs. W., Inc.*, 138 Cal. Rptr. 3d 294 (Cal. Ct. App. 2012)); *Receiver's Handbook*, *supra*, at 7 ("An order of conservation is designed to give the regulator an opportunity to determine the course of action that should be taken with respect to a financially impaired insurer."); Patrick H. Cantilo et al., *Purposes of Rehabilitation and Distinguishing It from Other Proceedings*, *in* New Appleman on Insurance Law, *supra*, § 100.01[4] [hereinafter *Purposes of Rehabilitation*] ("The conservator aims to effectively run the company and resolve the insurer's impairments, followed by a rehabilitation if conservatorship proves unsuccessful, and then liquidation if rehabilitation efforts fail.").

rehabilitation. The Commissioner maintains that because he is conducting a rehabilitation and not a liquidation, the Priority Provision does not apply.

The Priority Provision does not provide a clear answer to whether it applies outside of a liquidation, and the more persuasive authorities suggest that the Priority Provision would apply to certain activities in rehabilitation. This decision nevertheless agrees that the Priority Provision does not apply to the decision to make the Pre-Plan Payments.

1. Principles Of Statutory Construction

Whether the Priority Provision applies to a rehabilitation or only to a liquidation presents a question of statutory interpretation. "The goal of statutory construction is to determine and give effect to legislative intent." *Eliason v. Englehart*, 733 A.2d 944, 946 (Del. 1999). "[I]f a statute is clear and unambiguous, the plain meaning of the statutory language controls." *Shawe v. Elting*, 157 A.3d 152, 164 (Del. 2017) (cleaned up). "This is because an unambiguous statute precludes the need for judicial interpretation." *Id.* (cleaned up).

A statute is ambiguous "if it is susceptible of two reasonable interpretations." *CML V, LLC v. Bax*, 28 A.3d 1037, 1041 (Del. 2011). "If [a statute] is ambiguous, [Delaware courts] consider the statute as a whole, rather than in parts, and [they] read each section in light of all the others to produce a harmonious whole." *Doroshow, Pasquale, Krawitz & Bhaya v. Nanticoke Mem'l Hosp., Inc.*, 36 A.3d 336, 343 (Del. 2012) (cleaned up). Delaware courts "also ascribe a purpose to the General Assembly's use of statutory language, construing it against surplusage, if reasonably possible." *Taylor v. Diamond State Port Corp.*, 14 A.3d 536, 538 (Del. 2011); *see also Giuricich v. Emtrol Corp.*, 449

A.2d 232, 238 (Del. 1982) ("It is fundamental that the Courts ascertain and give effect to the intent of the General Assembly as clearly expressed in the language of a statute."). In construing an ambiguous statute, Delaware courts may look to the "relevant statutory history." *Gonzalez v. State*, 207 A.3d 147, 149–50 (Del. 2019). Additionally, Delaware courts have looked to other jurisdictions' interpretations of similar statutory provisions to interpret ambiguous Delaware statutes. *See Hudson Farms, Inc. v. McGrellis*, 620 A.2d 215, 218 (Del. 1993) ("[P]reexisting law and similar statutes from other jurisdictions which deal with comparable situations can be used as extrinsic aids in construing the legislature's intent.").

As noted previously, the court can take into account an agency's longstanding interpretation of a statute that the agency administers. *See DiPasquale*, 735 A.2d at 382–83. A longstanding interpretation is not binding, and it is not entitled to deference, but it ordinarily would receive weight. *Id.* Here, the Commissioner has not offered any evidence of a longstanding interpretation of the Priority Provision.

2. The Plain Meaning Of The Priority Provision

The Priority Provision does not expressly address whether it only applies in liquidation or extends beyond liquidation. The Priority Provision does not state that it only applies in liquidation. The Priority Provision also does not state that it applies in all delinquency proceedings. And the Priority Provision does not contain language stating that it applies to specific non-liquidation delinquency proceedings, such as rehabilitations.

There are states with statutes that include explicit language on the scope of their priority provisions. Insurance insolvency statutes in all fifty states contain a provision

establishing a priority for claims.[14] Only five address specifically whether the priority scheme applies only to a liquidation or also to a rehabilitation.

Virginia and Alabama have priority statutes that apply expressly to rehabilitation proceedings. In Virginia, the priority scheme applies "[w]henever the Commission is authorized . . . to rehabilitate or liquidate any domestic insurer . . . ." Va. Code Ann. § 38.2-1509(A). In Alabama, the priority scheme applies "[u]pon the issuance of a proper court order placing a domestic insurer in receivership or placing a foreign insurer in ancillary receivership for rehabilitation or liquidation." Ala. Code § 27-32-37.

Illinois also has a provision that causes its priority scheme, known as Section 205, to apply outside of a liquidation. The provision addressing the receiver's obligations in a rehabilitation states:

> Where in such [rehabilitation] proceedings the Court has entered an order for the filing of claims and it subsequently appears that the total amount of all allowable claims exceed the assets in the possession of the Rehabilitator, the Court may upon the application of the Director authorize a distribution of assets in accordance with the applicable provisions of Section 210.

215 Ill. Comp. Stat. § 5/192. The Supreme Court of Illinois has held that the plain language of this statute causes the priority scheme to apply to a rehabilitation. *In re Liquids. of Rsrv. Ins. Co.*, 524 N.E.2d 538, 543 (Ill. 1988); *accord In re Conservation of Alpine Ins. Co.*, 741 N.E.2d 663, 663 (Ill. App. Ct. 2000) ("Section 205 of the Code governs the priority of

---

[14] *See* Patrick H. Cantilo et al., *Powers and Duties of Rehabilitator*, *in* New Appleman on Insurance Law, *supra*, § 100.04; *see also* Bill Goddard, *The New World Order: Financial Guaranty Company Restructuring and Traditional Insurance Insolvency Principles*, 6 Brook. J. Corp. Fin. & Com. L. 137, 150 (2011).

distribution of an insolvent insurance company's assets. It applies in the context of either rehabilitation or liquidation . . . . (citations omitted)).

Massachusetts, Nevada, and New Mexico have statutes which state that their priority schemes apply in liquidation without mentioning other types of delinquency proceedings. The Massachusetts statute states, "The priority of distribution from the general assets of an insurer in a liquidation proceeding shall be in the order set forth below." Mass. Gen. Laws ch. 175, § 180F. The Nevada statute states, "The order of distribution of claims from the estate of the insurer on liquidation of the insurer must be as set forth in this section." Nev. Rev. Stat. § 696B.420(1). The New Mexico statute states, "The priority of claims and order of distribution of the insurer's assets on liquidation shall be as stated in this section." N.M. Stat. § 59A-41-44.

The evidence from the specific provisions in other state statues is unhelpful. If other states always stated when their priority schemes only applied in liquidation, then a court might draw an inference from the absence of that language and hold that a silent statue applied more broadly. If other states always stated when their priority schemes also applied in rehabilitation, then a court might draw an inference from the absence of that language and hold that a silent statute applied more narrowly. Instead, there are examples of each.

3. Snippets Of Language And Statutory Structure

Without plain language addressing the issue, the parties join issue over snippets of language and the placement of the Priority Provision in the structure of the statute. Those arguments are inconclusive.

The Commissioner argues that the Priority Provision is limited to a liquidation because it begins by stating that "[t]he priority of distribution of claims from the insurer's general assets shall be in accordance with the order in which each class of claims is herein set forth." 18 *Del. C.* § 5918(e). There is nothing special about this language; thirty-two states have priority statutes that contain a similarly generic introduction.[15]

---

[15] *See, e.g.*, Alaska Stat. § 21.78.260 ("The priority of distribution of claims from an insurer's estate is in accordance with the order in which each class of claims is set out in this section."); Ariz. Rev. Stat. § 20-629(A) ("In a delinquency proceeding against an insurer domiciled in this state, the priority of distribution of claims from the general assets of the insurer shall be determined pursuant to this section."); Colo. Rev. Stat. § 10-3-541(1) ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); Conn. Gen. Stat. § 38a-944(a) ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); Fla. Stat. § 631.271(1) ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this subsection."); Haw. Rev. Stat. § 431:15-332 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth."); Idaho Code § 41-3342 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth."); 215 Ill. Comp. Stat. 5/205(1) ("The priorities of distribution of general assets from the company's estate is to be as follows . . . ."); Ind. Code § 27-9-3-40(a) ("The priority of distribution of claims from the insurer's estate must be in accordance with the order in which each class of claims is set forth in this section."); Iowa Code § 507C.42 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth."); Kan. Stat. § 40-3641 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth."); Ky. Rev. Stat. § 304.33-430 ("The order of distribution of claims from the insurer's estate shall be as stated in this section."); Mich. Comp. Laws § 500.8142(1) ("[T]he priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); Miss. Code § 83-24-83 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth."); Mont. Code Ann. § 33-2-1371 ("The priority of distribution of claims from the insurer's estate is in accordance with the order in which each class of claims is set forth in this section."); Neb. Rev. Stat. § 44-4842 ("The priority of distribution of claims from the

Based on this standard phrasing, the Commissioner asserts that a distribution of claims from the insurer's general assets only happens during liquidation, so the Priority

---

insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); N.H. Rev. Stat. Ann. § 402-C:44 ("The order of distribution of claims from the insurer's estate shall be as stated in this section."); N.J. Stat. Ann. § 17B:32-71(a) ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); N.Y. Ins. Law § 7434(a)(1) ("The priority of distribution of claims from an insolvent property/casualty insurer in any proceeding subject to this article shall be in accordance with the order in which each class of claims is set forth in this paragraph and as provided in this paragraph."); N.C. Gen. Stat. § 58-30-220 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); N.D. Cent. Code § 26.1-06.1-41 ("The priority of distribution of claims from the insurer's estate must be in accordance with the order in which each class of claims is herein set forth."); Ohio Rev. Code Ann. § 3903.42 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); Okla. Stat. tit. 36 § 1927.1(A) ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); 40 Pa. Cons. Stat. § 221.44 ("The order of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth."); R.I. Gen. Laws § 27-14.3-46(a) ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); S.C. Code Ann. § 38-27-610 ("The priority of distribution of claims from the insurer's estate must be in accordance with the order in which each class of claims is set forth in this section."); S.D. Codified Laws § 58-29B-124 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth."); Tenn. Code Ann. § 56-9-330(a) ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); Tex. Ins. Code Ann. § 443.301 ("The priority of payment of distributions on unsecured claims must be in accordance with the order in which each class of claims is set forth in this section."); Vt. Stat. Ann. tit. 8, § 7081 ("The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section."); Wash. Rev. Code § 48.31.280 ("The priority of distribution of claims from the insurer's estate is as follows . . . ."); Wis. Stat. § 645.68 ("The order of distribution of claims from the insurer's estate shall be as stated in this section."); *see also* Cal. Ins. Code § 1033(a) ("Claims allowed in a proceeding under this article shall be given preference in the following order . . . .").

Provision must only apply in liquidation. The core premise of this argument is incorrect. Both a distribution of claims from the insurer's general assets and a claims process can be part of a rehabilitation plan.

Along similar lines, the Commissioner argues that the Priority Provision appears in the midst of statutory sections that address the process for making claims against a delinquent insurer. The Commissioner asserts that a claims process only happens during a liquidation proceeding, so the Priority Provision must only apply in liquidation. But a claims process can happen as part of a rehabilitation, and the Commissioner's proposed Rehabilitation Plan contemplates a claims process. *See* Rehabilitation Plan §§ 8–9.

The Commissioner also advances a series of arguments based on the definitions of the various classes of claims. The definition of Class I claims identifies that class as "including but limited to the following" three items:

> a. The receiver's actual and necessary costs of taking possession of the insurer, preserving or recovering the assets of the insurer, and otherwise complying with this chapter;
>
> b. Reasonable compensation for all services rendered at the request of and on behalf of the receiver, or that receiver's appointed deputy receiver or receivers, in the liquidation by the receivership's employees and its retained attorneys, accountants, actuaries, claims adjusters, expert witnesses and other consultants; and
>
> c. All expenses incurred by the Department in supervising the receivership proceedings of the insurer[.]

18 *Del. C.* § 5918(e)(1). The Commissioner points to the reference to "[r]easonable compensation for all services rendered . . . in the liquidation" and argues that the Priority Provision therefore applies in a liquidation. That is true, but that reasoning does not exclude

the possibility that the Priority Provision also applies to other types of delinquency proceedings. The three identified categories are explicitly non-exclusive, and the expenses that the Commissioner incurs in conducting a rehabilitation would easily fall within Class I.

The Commissioner also cites the definitions of Class II and Class III claims. Class II claims encompass "[t]he reasonable and necessary administrative expenses of the Delaware Insurance Guaranty Association or the Delaware Life and Health Insurance Guaranty Association or as the case may be, and any similar organization in another state." *Id.* § 5918(e)(2). Class III encompasses "claims of the Delaware Insurance Guaranty Association or the Delaware Life and Health Insurance Guaranty Association, as the case may be, and any similar organization in another state for coverage of policy benefits as required by statute." *Id.* § 5918(e)(3). The Commissioner observes that the guaranty associations only become pertinent in a liquidation, so these definitions show that the Priority Provision must apply to liquidations. As with the analysis of the definition of Class I claims, that proposition does not exclude the possibility that the Priority Provision also could apply in other types of delinquency proceedings. The Priority Provision does not suggest that every type of claim must exist in every type of proceeding. It rather provides that if a particular type of claim is made, then the claim has its designated statutory priority. The Priority Provision thus could apply to a rehabilitation proceeding. There simply would not be any claims related to guaranty associations.

A further textual argument compares the language of the Priority Provision, found in Section 5918(e), with the language of Sections 5918(a) and (b). Both Section 5918(a) and 5918(b) refer generally to "delinquency proceeding[s]."

- Section 5918(a) states: "In a delinquency proceeding against an insurer domiciled in this State, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of this State. All such claims owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where such assets are located." *Id.* § 5918(a).

- Section 5918(b) states: "In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this State shall be preferred if like claims are preferred by the laws of that state." *Id.* § 5918(b).

The statute defines a "delinquency proceeding" as "any proceeding commenced against an insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer." 18 *Del. C.* § 5901(3). Sections 5918(a) and 5918(b) thus expressly apply to all delinquency proceedings. The Priority Provision does not contain a similarly explicit reference.

The comparison of the Priority Provision with the first two subsections in Section 5918 supports competing inferences. One inference is that Section 5918 should be read as a whole, and that the references to "delinquency proceedings" in the first two subsections demonstrate that Section 5918 in its entirety, including the Priority Provision, applies to every subtype of delinquency proceedings: conservatorships, rehabilitations, reorganizations, and liquidations. Another inference is that the express references in the first two subsections, combined with the omission of any express reference in the Priority Provision, suggests that the Priority Provision does not apply to every subtype of delinquency proceedings.

The Commissioner seeks the latter inference, but the former seems more logical. Under the former and more logical reading, Section 5918 states that it applies to any delinquency proceeding—whether a "delinquency proceeding against an insurer domiciled in" Delaware or a "delinquency proceeding against an insurer domiciled in a reciprocal state"—and then says what the priority scheme will apply in any delinquency proceeding. The Priority Provision also has the general title, "Priority of Certain Claims," that does not contain a reference to any specific type of delinquency proceeding.

The various snippets of language in the Priority Provision and its location in the statute do not provide persuasive indications as to whether the Priority Provision applies only in liquidation or more broadly in rehabilitation. The stronger reading is that the Priority Provision could apply in any subtype of delinquency proceeding, but the statute does not plainly say that.

4. The History Of The Statute

Without a clear indication from the statutory text, the Commissioner turns to the history of the statute. The Commissioner observes that when the General Assembly initially adopted Section 5918 in 1968, the section did not contain the Priority Provision. When the General Assembly added the Priority Provision in 1983, the Priority Provision was much simpler and provided as follows:

> Claims by policyholders, beneficiaries, and insureds arising from and within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and liability claims against insureds which claims are within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and claims of the Delaware Insurance Guaranty Association, the Delaware Life and Health Insurance Guaranty Association, as the case may

> be, and any similar organization in another state *shall have priority in a liquidation proceeding* over all other claims except those for expenses of administration, wages covered by §5926 of this title and taxes.

64 Del. Laws ch. 193, § 1 (1983) (the "Original Priority Provision") (emphasis added). It was not until 2000 that the General Assembly enacted the current version of the Priority Provision. *See* 72 Del. Laws Ch. 400 (2000).

The Commissioner argues that the language in the Original Priority Provision, which states that the identified claims "shall have priority in a liquidation proceeding," shows that the priority scheme only applies in liquidation. That is what the Original Priority Provision stated, and if the Priority Provision currently contained comparable language, the inquiry would be at an end.

But the General Assembly removed the reference to a liquidation proceeding from the current Priority Provision, and that editorial move supports competing inferences. Its removal could suggest that the General Assembly regarded the reference as superfluous because, as the Commissioner argues, the Priority Provision could only apply to a liquidation. Its removal could suggest just as easily that the General Assembly intended to eliminate the limitation to a liquidation so that the Priority Provision would apply broadly to all delinquency proceedings. The history of the statute is therefore inconclusive.

5. Decisions From Other Jurisdictions

The meaning of the Priority Provision is ambiguous. It is not possible to reach a conclusion from the Priority Provision, snippets of language in Section 5918, or the structure of statute. The next step is to look to how other courts have interpreted similar provisions.

When looking to other statutes and decisions for guidance, it is important to have an understanding of the general statutory landscape for insurance company receiverships. In the McCarran-Ferguson Act, Congress provided that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several Sates which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a). As a result, the reorganization or liquidation of insurance companies does not take place under the federal bankruptcy code; it rather takes place almost entirely in state courts and as a matter of state law. *See Cohen v. State ex rel. Stewart*, 89 A.3d 65, 72 (Del. 2014); Skeel, *supra*, at 731.

Three generations of model legislation have sought to bring order to this important area. The first-generation statute is the Uniform Insurers Liquidation Act (the "Uniform Act"), promulgated in 1939 by the National Conference of Commissioners on Uniform State Laws ("NCCUSL") with the assistance of the American Bar Association, the National Association of Insurance Commissioners ("NAIC"), the insurance departments of several states, and other qualified experts. *See Commissioner's Prefatory Note, Uniform Insurers Liquidation Act*, 9B Unif. L. Annotated 284, 286 (1966). As many as thirty-two jurisdictions adopted the Uniform Act in some form.[16] NCCUSL withdrew the Uniform Act in 1981 due to its obsolescence.[17]

---

[16] *Lac D'Amiante du Quebec, Ltee. v. Am. Home Assurance Co.*, 864 F.2d 1033, 1039 (3d Cir. 1988).

[17] [13 Part II] Unif. L. Annotated 126 (2002) ("The Uniform Insurers Liquidation Act (1939) was withdrawn from recommendation for enactment by the National Conference of Commissioners on Uniform States Laws in 1981 due to it being obsolete."); *see* Am. Bankr. Inst., *State Insurance Company Insolvency Proceedings-Looks Like a*

Delaware adopted the Uniform Act in 1953. *See* 18 Del. C. § 5920 (1953) (declaring that the provisions being enacted "constitute and may be referred to as the Uniform Insurers Liquidation Act"). Judicial decisions sometimes refer to Delaware's version of the Uniform Act as the "DUILA." Today, Delaware is one of twenty-three jurisdictions that still use at least parts of the Uniform Act, notwithstanding its obsolescence.[18]

The second-generation statute is the Insurers Rehabilitation and Liquidation Model Act ("IRLA" or "Model Act"), promulgated in 1968 by the NAIC and based largely on the

---

Bankruptcy, Walks Like a Bankruptcy, at n.4 (July 13, 2006), *available at* Westlaw, 060713 ABI-CLE 129 ("The National Conference of Commissioners on Uniform State Laws withdrew the [Uniform Act] in 1981 due to its obsolescence."); *Receiver's Handbook*, *supra*, at 478 n.20 ("Note that the [Uniform Act] was withdrawn from recommendation for enactment by the National Conference of Commissioners on Uniform State Laws in 1981 due to it being obsolete."). At the time it was withdrawn, thirty states had insurance statutes that were substantially similar to the Uniform Act. Nat'l Conf. of Comm'rs on U.S. Laws, *Handbook of the National Conference of Commissioners on United States Laws and Proceedings of the Annual Conference Meeting in Its Eighty-Ninth Year* 481 (1982) (listing the states that had adopted the Uniform Act by 1980).

As a side note, the citation format for Volume 13, Part II, of the Uniform Laws Annotated is bizarre. This is one of the many times when a judge can be grateful for knowledgeable clerks, particularly those who have penetrated the recondite mysteries of the Blue Book. *See* The Bluebook: A Uniform System of Citation R. 3.1(a), at 72 (Columbia L. Rev. Ass'n et al. eds., 21st ed. 2020) ("If a volume designation includes words, use brackets to avoid confusion.").

[18] Nat'l Ass'n of Ins. Comm'rs, *Insurer Receivership Model Act State Page Key*, at ST-555-2 (2021), *available at* https://content.naic.org/sites/default/files/ST555_0.pdf [hereinafter *IRMA State Page Key*]. The court previously lamented its inability to locate a source that tracked the jurisdictions that had adopted the Uniform Act and its successors. *In re Liquid. of Freestone Ins. Co.*, 143 A.3d 1234, 1243 n.4 (Del. Ch. 2016) ("Research has not uncovered a source that tracks the number of jurisdictions that currently adhere to the Uniform Act."). Hope springs eternal, and a further trip to the research well uncovered the *IRMA State Page Key*, which performs that function.

Wisconsin Insurers Liquidation Act.[19] The Model Act carried over much of the terminology used in the Uniform Act,[20] but the Model Act also made changes intended to clarify and improve on the Uniform Act.[21] Thirty-one states plus the District of Columbia and Puerto Rico have enacted components of the Model Act.[22] Delaware has not.

---

[19] *See* Mary Cannon Veed, *Cutting the Gordian Knot: Long-Tail Claims in Insurance Insolvencies*, 34 Tort & Ins. L.J. 167, 174 (1998) (identifying the Wisconsin Insurer's Liquidation Act as the template for the IRLA); Skeel, *supra*, at 731 (same). The NAIC amended the IRLA several times over the years. *See Receiver's Handbook*, *supra*.

[20] *Receiver's Handbook*, *supra*, at 466–67 ("Ten sections (54–63) of the Model Act adopt much of the [Uniform Act], as well as its policy objective: centralization of delinquency proceedings in the domiciliary jurisdiction."); *accord* Stephen W. Schwab et al., *Cross-Border Insurance Insolvencies: The Search for a Forum Concursus*, 12 U. Pa. J. Int'l. Bus. L. 303, 325 (1991) [hereinafter *Cross-Border Insurance Insolvencies*] (explaining that the Model Act adopts "much of the basic terminology and procedure of the [Uniform Act], as well as the same universalist policy objective: centralization of delinquency proceedings in the domiciliary jurisdiction").

[21] *See Cross-Border Insurance Insolvencies*, *supra*, at 325 ("Differences between the two statutes derive from the NAIC's efforts to clarify and improve [Uniform Act] provisions."); Eric P. Berg, Note, *Injunctions Barring Suit Against Insolvent Insurance Companies: State Cooperation Through Tit-for-Tat Strategy*, 57 Rutgers L. Rev. 1377, 1379, 1384 (2005) (describing the Model Act as "more detailed" and "more comprehensive" than the Uniform Act but as providing "a framework supporting the same policies").

[22] *IRMA State Page Key*; *see* Alaska Stat. §§ 21.78.010–.330; Colo. Rev. Stat. §§ 10-3-401 to -559; Conn. Gen. Stat. §§ 38a-903 to -962j; D.C. Code §§ 31-1301 to -1357; Haw. Rev. Stat. §§ 431:15-101 to -411; Idaho Code §§ 41-3301 to -3360; Ind. Code §§ 27-9-1-1 to -4-10; Iowa Code §§ 507C.1–507C.60; Kan. Stat. Ann. §§ 40-3605 to -3659; Ky. Rev. Stat. Ann. §§ 304.33-010 to -600; Mich. Comp. Laws Ch. 500, §§ 8101–8159; Minn. Stat. §§ 60B.01–.61; Miss. Code Ann. §§ 83-24-1 to -117; Mont. Code Ann. §§ 33-2-1301 to -1394; Neb. Rev. Stat. §§ 44-4801 to -4862; Nev. Rev. Stat. §§ 696B.010–.570; N.H. Rev. Stat. Ann. §§ 402-C:1–61; N.J. Stat. Ann. §§ 17B:32-31 to -92; N.C. Gen. Stat. §§ 58-30-1 to -310; N.D. Cent. Code §§ 26.1-06.1-01 to -59; Ohio Rev. Code Ann. §§ 3903.01–.99; Okla. Stat. tit. 36, §§ 1901–1938; 40 Pa. Cons. Stat. §§ 221.1–.63; P.R. Laws Ann. tit. 26, §§ 4001–4054; R.I. Gen. Laws §§ 27-14.3-1 to -65; S.C. Code Ann. §§ 38-27-10 to -1000; S.D. Codified Laws §§ 58-29B-1 to -161; Vt. Stat. Ann. tit. 8, §§ 7031–7100;

The third-generation act is the Insurer Receivership Model Act ("IRMA"), promulgated in 2005 by the NAIC as an updated version of the Model Act. *Receiver's Handbook*, *supra*, at 463. As of summer 2021, only two states—Texas and Utah—have adopted the IRMA in its entirety. *IRMA State Page Key*, *supra*. Four other states—Maine, Missouri, Oklahoma, and Tennessee—have adopted portions of the IRMA. *Id.*

There are important distinctions between the three generations of statutes. *See Receiver's Handbook, supra*, at 468–73 (providing examples). Most notably for present purposes, the Uniform Act (represented in this case by the DUILA) envisions a single type of delinquency proceeding, defined in the Insurance Code as "any proceeding commenced against an insurer pursuant to this chapter of the purpose of liquidating, rehabilitating, reorganizing, or considering such insurer." 18 *Del. C.* § 5901(3). The Uniform Act (again represented by the DUILA) likewise provides that "[d]elinquency proceedings pursuant to this chapter shall constitute the sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer. 18 *Del. C.* § 5902(d).

By contrast, the IRLA abandoned the unitary delinquency proceeding by creating two sharp distinctions among proceedings. The IRLA first distinguishes between conservation proceedings and formal proceedings. The IRLA next distinguishes between two types of formal proceedings: rehabilitation proceedings and liquidation proceedings.[23]

Wash. Rev. Code §§ 48.31.010–.435; W. Va. Code §§ 33-10-1 to -41; Wis. Stat. §§ 645.01–.90.

[23] *See generally* Wis. Stat. §§ 645.01–.90 (distinguishing "summary proceedings" from "formal proceedings" in Sections 645.21 to 645.24 and Sections 645.31 to 645.77,

Like the IRLA, the IRMA continues to draw these sharp distinctions. *See* Nat'l Ass'n of Ins. Comm'rs, *Insurer Receivership Model Act* (Oct. 2007), *available at* https://content.naic.org/sites/default/files/inline-files/MDL-555.pdf.

Before proceeding further, it is worth emphasizing that by continuing to apply a version of the Uniform Act, Delaware has retained a statutory scheme that the promulgating authority withdrew as obsolete *more than forty years ago.* Delaware prides itself on having modern and efficient statutes, particularly for the governance of entities. Assisted by expert attorneys, the General Assembly regularly updates the statutory schemes for corporations, limited liability companies, limited partnerships, general partnerships, statutory trusts, and common law trusts. Yet for insurance companies, we have a statute that the promulgating authority deemed obsolete shortly after President Reagan took the oath of office, when I was still in middle school.

The absence of a current statute has consequences. When overseeing insurance company delinquency proceedings, this court must grapple all too often with questions that the DUILA either does not address or does not answer clearly. The parties and the court then must do what they have done here: search for hints in the statutory language, draw

---

respectively, and distinguishing rehabilitation proceedings from liquidation proceedings in Sections 645.31 to 645.35 and Sections 645.41 to 645.76, respectively); Nat'l Ass'n of Ins. Comm'rs, *Insurers Rehabilitation and Liquidation Model Act* (1994), *reprinted in* Nat'l Ass'n of Ins. Comm'rs, Fourth Quarter 1994 Proceedings of the National Association of Insurance Commissioners (1996), *available at* https://naic.soutronglobal.net/Portal/DownloadImageFile.ashx?fieldValueId=5695 (distinguishing rehabilitation proceedings from liquidation proceedings).

inferences from other statutory schemes, survey the law of other jurisdictions, consult articles and treatises, and consider overarching public policies, all in an effort to divine a rule that a modern statute could supply. If Delaware had a current statute, then those resources could be invested in other tasks, and delinquency proceedings would be more efficient and predictable for everyone involved.

In the absence of a current statute, it is somewhat tempting to interpret the DUILA to reach the result that the IRLA or the IRMA would specify. An admittedly non-exhaustive review of the IRLA, the IRMA, and applicable scholarship suggests, however, that in many situations, the later statutes include language designed to move away from the outcome that a court applying the Uniform Act would reach or to alter a common law rule that otherwise would govern. To play the judicial Procrustes and either stretch or shorten the DUILA as necessary to achieve the result provided for in a modern statute would be unprincipled and constitute judicial legislating.

Although it is difficult to perceive the value in retaining a statutory scheme that is four decades past its sell-by date, that is the choice that the General Assembly has made. The court must respect it. One might hope nevertheless that in the near future, we could have a Reaganesque morning in Delaware for insurance companies and update our statutory scheme for delinquency proceedings.

With that request for assistance made, the court returns to its search for insight. As its name implies, the DUILA is a uniform act that "shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it." 18

Del. C. § 5920(b). Decisions from other jurisdictions interpreting the Uniform Act can therefore provide assistance.

a. Decisions Applying A Priority Scheme To A Rehabilitation

Courts in California, New Jersey, and New York have interpreted the priority schemes in their state statutes to extend to rehabilitations. Generally speaking, each decision considered a request to approve a rehabilitation plan that included a claims procedure. Each decision concluded, explicitly or implicitly, that the priority scheme applied to the rehabilitation plan. These decisions are persuasive because each of the states employed a statutory scheme based on the Uniform Act, so each of the decisions interpreted a statutory framework comparable to Delaware's.

In 1995, California's intermediate appellate court addressed whether that state's priority scheme applied to a rehabilitation.[24] In a series of decisions involving the rehabilitation of the Executive Life Insurance Company, the California court rejected aspects of the receiver's proposed rehabilitation plans because they failed to comply with the priority scheme.[25] Most notably, in *Commercial National Bank*, the court considered a

---

[24] California adopted the Uniform Act in 1988. *See* Cal. Ins. Code §§ 1064.1–.13 (1988). California has never adopted the IRLA or the IRMA. *IRMA State Page Key, supra*. Before adopting the Uniform Act, California had its own insurance statute, enacted in 1935, that was based on New York's insurance law. *See Com. Nat. Bank v. Superior Court*, 17 Cal. Rptr. 2d 884, 889 (Ct. App. 1993).

[25] *See Exec. Life*, 38 Cal. Rptr. 2d at 468–70 (holding that priority statute governed claims in rehabilitation but that insurance commissioner had authority to settle dispute over priority, as long as there was no abuse of discretion); *Com. Nat'l Bank*, 17 Cal. Rptr. 2d at 887–88 (holding that holders of certain bonds received incorrect priority under statute);

proposed rehabilitation plan that called for (i) a transfer of essentially all of the assets and liabilities of the delinquent insurer to a new entity supported by a $300 million capital infusion, (ii) payments from the guarantee associations of forty-three states, (iii) restructured insurance contracts for policyholders who elected to participate in the plan, and (iv) a lump sum payment to contract holders that opted not to participate. 17 Cal. Rptr. 2d at 887–88. The court required that the rehabilitation plan be modified because the formulas for calculating the payments to the contract holders who opted not to participate did not comply with the priority scheme. The court held that the rehabilitation plan improperly treated certain bondholders as Class V policyholders rather than as general creditors. *Id.* at 892–94. There, as here, the receiver argued that he need not comply with the priority scheme because he possessed broad authority to rehabilitate an entity, but the court reasoned that the exercise of that power was "limited by the general principles explicitly set forth in the comprehensive statutory insurance insolvency scheme." *Id.* at 894.

New Jersey's intermediate appellate court has also addressed whether that state's priority scheme applied in a rehabilitation.[26] In a case arising out of the delinquency of the

---

Tex. Com. Bank v. Garamendi, 14 Cal. Rptr. 2d 854, 857 (Cal. Ct. App. 1992) (holding that a particular type of annuity qualified for including in the category of Class 5 claims for purposes of the rehabilitation).

[26] New Jersey adopted the Uniform Act in 1975. N.J. Stat. Ann. § 17:30C-1 (1975). New Jersey subsequently adopted parts of the Model Act in 1992 and has amended its insurance statutes periodically to reflect updates to the Model Act and the IRMA. N.J. Stat. Ann. §§ 17B:32-31 to -92; *see In re Rehab. of Mut. Benefit Life Ins. Co.*, 687 A.2d 1035, 1036 (N.J. Super. Ct. App. Div. 1997) (describing how certain provisions "supplanted the

Mutual Benefit Life Insurance Company, the receiver proposed a rehabilitation plan that transferred all of the assets and liabilities of the delinquent insurer to a new, wholly owned subsidiary and restructured various insurance contracts. *Benefit Life Ins.*, 687 A.2d at 1036. The plan placed a group annuity held by a university and a second annuity held by one of its professors into the category of restructured contracts. The university and the professor sought to be allowed to withdraw their funds, which would have resulted in their claims being treated differently than other claimants. The trial court rejected their request as contrary to the priority scheme, necessarily concluding that the scheme applied in a rehabilitation. The appellate court affirmed. *Id.* at 1038–39.

Finally, a trial court in New York has addressed whether that state's priority scheme applies equally to a rehabilitation.[27] After operating Frontier Insurance Company for more than a decade under a receivership order, the receiver proposed a plan of rehabilitation that contemplated an ongoing runoff of the insurer's liabilities and continued rehabilitation efforts for a period of five years to determine whether the insurer's "Claims under Policies" could be satisfied. *See Frontier Ins.*, 945 N.Y.S.2d at 867. The proposed plan defined "Claims under Policies" to exclude claims under surety bonds and similar instruments. *Id.*

Uniform Insurers Liquidation Act" in 1992). As a result, some sections of the current New Jersey insurance code remain drawn from the Uniform Act. *See* N.J. Stat. Ann. §§ 17:30C-1 to -31. Others are drawn from the Model Act and the IRMA. *See* N.J. Stat. Ann. §§ 17B:32-31 to -92.

[27] New York adopted the Uniform Act in 1984. N.Y. Ins. Law §§ 7401–7437. The New York legislature most recently amended the New York insurance code in 2013. *Id.* New York has never adopted the Model Act or the IRMA. *IRMA State Page Key*, *supra*.

at 868. The receiver took the position that claims under the surety contracts were entitled to a lower priority, and he therefore did not contemplate paying those claims without prior court approval and not at their full book value. Various parties raised objections, including a contention that the plan violated New York's priority statute and created impermissible subclasses. In a thorough and scholarly decision, the trial court held that the surety contracts qualified as policies of insurance that entitled them to equal treatment with other policies as Class II claims. *See id.* at 871–75. The court concluded that by proposing to afford junior status to the surety claimants, the rehabilitation plan was inconsistent with priority scheme. *Id.* at 875–76. To reach these results, the court necessarily concluded that the priority scheme applied in a rehabilitation.

b. Decisions Limiting A Priority Scheme To Liquidation

In contrast to the decisions in the preceding section that interpreted priority statutes based on the Uniform Act, Wisconsin's intermediate court has held that the state's priority scheme only applies in liquidation. Although that decision stands alone, a trial court in Pennsylvania used similar reasoning to hold that an offset statute only applies in liquidation, and an intermediate appellate court in South Carolina has distinguished between the jurisdictional provisions that apply in rehabilitation and liquidation. Notably, none of these states have statutes based on the Uniform Act. Each interpreted a statute modeled on the IRLA, or in Wisconsin's case the statute which formed the basis for the IRLA, and each statute drew a clear distinction between rehabilitation proceedings and liquidation proceedings. The Wisconsin, Pennsylvania, and South Carolina courts each relied heavily on that distinction, which does not exist in the Uniform Act.

The Wisconsin decision involved an appeal from the approval of a plan of rehabilitation for Ambac Assurance Corporation ("Ambac"). *Ambac*, 841 N.W.2d at 502. In presenting the plan, the commissioner demonstrated that 1,000 out of Ambac's 15,000 policies were imperiling its financial stability, and he placed those policies in a segregated account. The account was capitalized with a secured note and a reinsurance agreement. The segregated account could call upon the general account to pay claims, but only so long as the claims did not cause Ambac's assets to fall below a specified threshold. Under the rehabilitation plan, the holders of claims allocated to the segregated account would receive payment of 25% of their claims in cash and 75% in the form of surplus notes that might not be paid off until 2050, if not later. *Id.* at 492.

The trial court approved the plan, and various parties appealed. The claimants whose polices were assigned to the segregated account argued that the structure violated the priority scheme by creating a subclass that treated their claims differently, rather than paying their claims ratably with other policies. Although the commissioner viewed the priority scheme as applying to rehabilitation proceedings, the court disagreed, advancing an interpretation that seems to have inspired the Commissioner's arguments in this case.

The court started with the language of the statute, which it described as creating two broad sections: one section containing provisions governing rehabilitation, and a second section containing provisions governing liquidation. The priority scheme appeared in the latter section. *Id.* at 500–01. The court also observed that the priority scheme contained references to liquidation, noting that the definition of Class I claims included "compensation for all services rendered in the liquidation." *Id.* at 501. And the court looked

to surrounding statutory sections, where it found references to "the liquidator" and other language associated with liquidation. *Id.* The Commissioner made similar arguments in this case, but without taking into account the differences between the DUILA, which is based on the Uniform Act, and Wisconsin's statute, which was the precursor of the Model Act.

The Wisconsin court then looked to legislative commentary, which discussed the difference between liquidation and rehabilitation and reasoned that because of those differences, the statute appropriately provided separate procedures for the two types of proceedings. *Id.* at 502. Drawing on this commentary, the court concluded that to apply the statutory priority scheme in a rehabilitation would be inconsistent with the nature of the rehabilitation process:

> [T]he entire purpose of rehabilitation proceedings is to reform and revitalize the insurer. In light of that purpose, rehabilitation proceedings should emphasize flexibility and informality and should be provided without cumbersome procedures. The priority system set forth in § 645.68 provides inflexible and cumbersome rules concerning the order of distribution of claims, and therefore, requiring the application of § 645.68 to insurer rehabilitation would be contrary to the stated purpose of rehabilitation proceedings.

Id. (cleaned up). Having determined that the statutory priority scheme should not apply during rehabilitations, the court rejected the objection that proposed rehabilitation plan violated the scheme. *Id.*

A Pennsylvania trial court reasoned similarly in holding that Pennsylvania's offset provision only applied in a liquidation and not in rehabilitation. *See Muir v. Transp. Mut. Ins. Co.*, 523 A.2d 1190, 1192 (Pa. Commw. Ct. 1987). In *Muir*, the Pennsylvania

insurance commissioner proposed a rehabilitation plan that permitted some claimants to offset premiums owed to the insurer. The Pennsylvania statute, however, contained a specific prohibition against any offset where "the obligation of the person is to pay premiums, whether earned or unearned, to the insurer."[28] The court nevertheless held that the offset provision did not apply because "a clear reading of the Act, especially its breakdown into summary and formal proceedings, and the further subdivision of formal proceedings into rehabilitation and liquidation proceedings, evidence the clear intention of the General Assembly that rehabilitation and liquidation proceedings are to be treated separately." *Muir*, 523 A.2d at 1192. The court explained, "Section 532 of the Act is contained within the liquidation provisions of the Act, which encompass Sections 19 through 63 of the Act, 40 Pa. Cons. Stat. §§ 221.19–221.63. The rehabilitation provisions, Sections 14 through 18, 40 Pa. Cons. Stat. §§ 221.14–221.18, have no such prohibition." *Id.* at 1192. A leading treatise posits that a Pennsylvania court would apply the same analysis to the priority scheme. *Purposes of Rehabilitation*, *supra*, § 100.01[2].

The intermediate appellate court of South Carolina took a similar approach on a jurisdictional question. *See Smalls v. Weed*, 360 S.E.2d 531, 532 (S.C. Ct. App. 1987). The question presented was whether a resident of South Carolina could assert a claim for breach of contract and bad faith refusal to pay insurance benefits against an insurance company that was in rehabilitation in Tennessee. The Tennessee rehabilitator relied on a provision

[28] 40 Pa. Cons. Stat. § 221.32. Delaware's comparable statute does not contain an exception for this type of offset. 18 *Del. C.* § 5927.

in the South Carolina statute which provided that "[c]laimants residing in this State may file claims with the liquidator or ancillary receiver, if any, in this State or with the domiciliary liquidator." S.C. Code Ann. § 38-5-2470 (1976). The Tennessee rehabilitator argued that in the absence of an ancillary receiver in South Carolina, the plaintiff had to file his claims in Tennessee. *Smalls*, 360 S.E.2d at 533.

Applying the general principle that statutes divesting a court of jurisdiction are strictly construed, the South Carolina court interpreted that provision as limited to a liquidation. The court observed that rehabilitation is generally different from liquidation: "While 'liquidation' contemplates the end of corporate existence, 'rehabilitation' involves the continuance of corporate life and activities, and is an effort to restore and reinstate the corporation to its former condition of successful operation and solvency." *Id.* at 534. The court noted that South Carolina's insurance statute had a series of provisions that separately addressed rehabilitation and liquidation, demonstrating an intent to treat the two differently. *Id.* The court also observed that the statute contained a separate section addressing "Actions by and against a rehabilitator." *Id.* (cleaned up). The court concluded that no statutory provision deprived South Carolina of the power to hear the action. *Id.* at 535.

6. Whether The Priority Provision Applies To The Pre-Plan Payments

The array of inconclusive authorities makes it difficult to determine whether the Priority Provision only applies in liquidation or whether it applies more broadly to other delinquency proceedings. Because the Uniform Act envisions a single type of delinquency

proceeding, and because Delaware has adopted the Uniform Act, the better reading is that the Priority Provision could apply outside of a liquidation. The cases that have interpreted similar statutes reach that conclusion. By contrast, the cases that support limiting the Priority Provision to a liquidation invariably interpret the IRLA or its Wisconsin predecessor, which clearly distinguish between rehabilitation and liquidation.

Determining that the Priority Provision could apply outside of liquidation does not mean that the Priority Provision automatically applies to every decision that the Commissioner makes. The cases from other jurisdictions that have applied priority statutes based on the Uniform Act in the context of rehabilitations have involved the approval of a specific rehabilitation plan that included a claims procedure. It makes sense that a priority statute would apply in that setting.

The Pre-Plan Payments are not part of a rehabilitation plan. They are designed to provide a comparatively small payment to the Participating Cedents before the approval of a rehabilitation plan. Any eventual rehabilitation plan will have to take into account the amounts that the Participating Cedents received. Moreover, to the extent that the Commissioner's rehabilitation plan contemplates a claims process, as have the Commissioner's proposals to date, then that process will have to comply with the Priority Provision. The Pre-Plan Payments are not part of a claims process.

The Priority Provision also would apply if the record showed that the Pre-Plan Payments would jeopardize the Company's prospects for rehabilitation, or if the Pre-Plan Payments functioned as a *de facto* liquidation payment that could not be trued up later in the process. The Objecting Cedents have never argued that the magnitude of the Pre-Plan

Payments raised any issues. They view the Pre-Plan Payments as "very modest payment[s]" that would be "welcome relief as this rehabilitation proceeding stretches into its third year." Omnibus Objection ¶ 2.

Merced also has not argued that the magnitude of the Pre-Plan Payments would jeopardize the Company's prospects for rehabilitation or function as a *de facto* liquidation payment. Merced contended only that the Commissioner had not created a sufficient factual record to enable them to assess the issue. Dkt. 564 ¶¶ 5, 19. The Commissioner's pre-hearing submissions did not provide a sufficient factual record to support his assertion that the Company could make the Pre-Plan Payments without jeopardizing the rehabilitation process or functioning as a *de facto* liquidation payment. The Commissioner's supplemental submission remedied that issue.

But for the Priority Provision, there would not be any restriction on the Commissioner's ability to pay some creditors and not others. Under Delaware common law, a board of directors can decide to pay certain creditors but not others, and as long as the payment is not an interested transaction, then the court will review that decision under the deferential business judgment rule. That rule continues to apply even after insolvency.[29] Other doctrines, such as fraudulent conveyance law, may permit aggrieved creditors to recover certain types of payments, but there is nothing inherently problematic about the

[29] *See Quadrant Structured Prods. Co. v. Vertin*, 102 A.3d 155, 186 (Del. Ch. 2014) (collecting authorities for proposition that business judgment rule continues to apply in insolvency); *Asmussen v. Quaker City Corp.*, 156 A. 180, 181 (Del. Ch. 1931) (explaining that insolvent corporation can prefer some creditors over others, absent self-dealing).

fact that a company chooses to pay certain creditors and not others. Doing so may be necessary to preserve the value of the firm by maintaining relationships with critical counterparties. A company might keep paying its electric bill to keep the proverbial lights on and the computers running, while putting off the snack vendor.

Under the Receivership Order, the Commissioner took over the business and affairs of the Company and was charged with rehabilitating it. Under the authority granted in the Receivership Order, the Commissioner possesses the same authority that a board of directors has to pay certain creditors but not others. While seeking to rehabilitate the Company, the Commissioner can exercise a measure of discretion, particularly when the decision to pay certain creditors over others will confer benefits to the Company. The question of whether rehabilitation remains a viable option is itself a judgmental question where the abuse of discretion standard applies. No one has argued that rehabilitation is no longer viable. Merced argued that the Commissioner did not provide a factual record to support that determination, but the Commissioner addressed that issue through the supplemental submission.

The objections that the Pre-Plan Payments violate the Priority Provision therefore lack merit. The Commissioner's proposal complies with law, satisfying the first stage in the operationalization of the abuse of discretion standard.

C. The Offset Statute

In their objection to the Pre-Plan Payments, the Objecting Cedents also invoke the Offset Statute, 18 *Del. C.* § 5927. The operative language of the Offset Statute provides as follows:

> In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) of this section below.

18 *Del. C.* § 5927(a).[30] The operative language thus states that after the offset, "the balance only shall be allowed or paid." *Id.*

All of the Objecting Cedents have participated in the Offset Plan. All of the Objecting Cedents have used offsets to satisfy more than 43% of the losses that they have incurred. For purposes of their objection, the Objecting Cedents say that the Offset Statute requires that the Commissioner ignore that reality. As the Objecting Cedents see it, the directive that "such credits and debts shall be set off and the balance only shall be allowed to be paid" means an offset *cannot* be treated as a payment by the delinquent insurer or the receipt of consideration by the counterparty. Rather, the offset simply lowers the amount of the claim that the counterparty has against the delinquent insurer. The Objecting Cedents

---

[30] Section 5927(b) of the Offset Statute provides that an offset is not allowed if

> (1) The obligation of the insurer to such person would not at the date of the entry of any liquidation order or otherwise, as provided in § 5924 of this title, entitle such person to share as a claimant in the assets of the insurer; or
>
> (2) The obligation of the insurer to such person was purchased by or transferred to such person with a view of its being used as an offset; or
>
> (3) The obligation of such person is to pay an assessment levied against the members of a mutual insurer or against the subscribers of a reciprocal insurer or is to pay a balance upon the subscription to the capital stock of a stock insurer.

Id. § 5927(b). The exceptions to the Offset Statute are not at issue.

conclude that they have not received any legally cognizable value from the Company through their participation in the Offset Plan and therefore have not received any payment on their net claims.

Based on their interpretation of the Offset Statute, the Objecting Cedents contend that the Commissioner's plan to make the Pre-Plan Payments violates the Offset Statute because it treats the Participating Cedents as having received value for their claims through offsets. The Objecting Cedents maintain that the Commissioner cannot take that position because of the plain language of the Offset Statute.

To better understand the Objecting Cedents' position, it helps to have a simplified example. Assume that a delinquent reinsurer that is operating under a rehabilitation order has only two cedents. Both cedents suffered losses in the amount of $100 on policies ceded to the reinsurer, giving rise to claims against the reinsurer. One cedent ("Cedent A") also has an obligation to pay $43 in premium to the reinsurer. The other cedent ("Cedent B") does not have any obligation to pay premium to the reinsurer. The obligations between the reinsurer and Cedent A offset, with the result that Cedent A has a net unpaid claim against the reinsurer for $57. Cedent B does not have any right to an offset and therefore continues to have its original claim against the reinsurer for $100.

Now assume that the receiver proposes to make an equalizing payment to Cedent B equal to 43% of its losses. The receiver reasons that the rehabilitation process has dragged on for some time, that Cedent B has not received any consideration from the reinsurer during this period, and that it is beneficial to the reinsurer and its relationship with Cedent

B to make the payment. The receiver does not propose to make a payment to Cedent A, because Cedent A already has received $43 in value through the offset.

Under the argument advanced by the Objecting Cedents, the receiver's plan violates the Offset Statute by treating Cedent A as if it had received a payment. The Objecting Cedents contend that to comply with the Offset Statute, the Commissioner must treat Cedent A as having not received any legally cognizable form of payment through the offset. Citing the language in the Offset Statute providing that "such credits and debts shall be set off and the balance only shall be allowed to be paid," they argue that Cedent A simply had its claim reduced to $57. It did not receive any value for that claim. The Commissioner is failing to comply with the Offset Statute, they say, by contending otherwise.

The Objecting Cedents maintain that to comply with the Offset Statute, both Cedent A and Cedent B must receive a payment equal to 43% of their net claim, with Cedent A receiving $24.51 (0.43 * $57) and Cedent B receiving $43 (0.43 * $100). That result is obviously more favorable to Cedent A, which ends up receiving a total of $67.51 in value on its $100 claim ($43 through offset plus $24.51 through the pre-plan payment), than to Cedent B, which receives only $43 in value on its $100 claim. By contrast, under the Commissioner's proposal, the two cedents are treated equally: Cedent A received $43 through offset, and Cedent B receives $43 through the equalization payment. Rather than

equalizing the treatment of cedents, the Objecting Cedents' theory maintains a relative advantage for those who participated in the Offset Plan.[31]

Nothing in the plain language of the Offset Statute dictates the outcome that Objecting Cedents seek. The Offset Statute explains how mutual debts or mutual credits are handled by calling for them to be netted out. The Offset Statute then says that the only remaining claim is for a net amount due to or from the counterparty. That is all the Offset Statute says.

The Offset Statute does not contain language suggesting that the offset cannot be viewed as a source of value to the counterparty. The value that a counterparty receives through an offset obviously is a form of consideration: "[S]et-off operates as a payment or discharge of reciprocal claims: the debtor pays the creditor's claim *pro tanto* to the extent of his cross-claims against the creditor, thus using his own asses to pay his liability." *Offset Revolution, supra,* at 515. That is why the value of the counterparty's claim is reduced. As one treatise explains, an offset is a form of payment, "because debts are paid in that way, and the obligor may assert his set-off just as effectually as if he had tendered banknotes." Garrard Glenn, *The Law Governing Liquidation: As Pertaining to Corporations,*

---

[31] If the reinsurer has a fixed amount that it can use to make a payment, then the Objecting Cedents' argument would call for the aggregate amount to be allocated between Cedent A and Cedent B, not just paid to Cedent B. Assuming the reinsurer could afford a payment of $43 and that amount was distributed ratably across the aggregate $200 in claims, then Cedent A would receive one third, or $14.33, and Cedent B would receive two thirds, or $28.47. The same disparity persists. Cedent A ends up receiving a total of $57.33 in value on its $100 claim ($43 through offset plus $14.33 in the pre-plan payment), while Cedent B receives only $28.47 in value on its $100 claim.

Partnerships, Individuals, Decedents, Bankruptcy, Receivership, Reorganization § 544 (1935). Cases from multiple jurisdictions treat offset in this fashion.[32]

In response, the Objecting Cedents cite *In re Liquidation of the Realex Group, N.V.*, 620 N.Y.S.2d 37 (N.Y. App. Div. 1994). The *Realex* decision recognized the principal that "[a]lthough permitting offsets may conflict with the statutory purpose of providing for the pro rata distribution of the insolvent's estate to creditors, the Legislature has resolved the competing concerns and recognized offsets as a species of lawful preference." *Id.* at 39 (cleaned up). The court added that perhaps an offset should not be viewed as a preference at all. *Id.* The case does not suggest that receiving an offset is not a form of value. Nor does it suggest that an insurance commissioner should not be able to take into account the fact that some claimants have received offsets when determining whether to make a payment to certain claimants as part of an effort to rehabilitate the insurer.

The Objecting Cedents insist that the Offset Statute effectively treats a claimant with offset as a secured creditor to the extent of the offset, then allows the claimant to participate fully in any distribution with respect to its net claim. The Delaware courts have not yet had the opportunity to address whether the Offset Statute operates in this fashion, and the

---

[32] *See, e.g.*, *Harrington v. Berryhill*, 906 F.3d 561, 566 (7th Cir. 2018) (recognizing that economic value realized through debt reduction constitutes "payment"); *In re Cruz Rivera*, 600 B.R. 132, 151 (B.A.P. 1st Cir. 2019) ("Setoff is 'a form of payment [where] the medium of payment is a reduction or extinguishment of a separate claim.'" (alteration in original) (quoting William Hillman & Margaret Crouch, *Bankruptcy Deskbook* § 6:6.1 (4th ed. 2014))); *Gibson v. Harl*, 857 S.W.2d 260, 270 (Mo. Ct. App. 1993) (holding that a recission agreement "is the embodiment of an exercised right of setoff expressed as 'payment'").

parties did not provide adequate briefing for the court to assess that contention. There are statutory differences between a secured claim and an offset under the DUILA. The statute expressly contemplates the different treatment of the lender's secured claim by defining the concept of a "Secured claim" and excluding any specifically encumbered property from the definition of "General Assets," to the extent necessary to satisfy the secured creditors claim. 18 *Del. C.* § 5901(9), (12). Other than the phrase in the Offset Statute on which the Objecting Cedents rely ("such credits and debts shall be set off and the balance only shall be allowed or paid"), there is no comparable language addressing offsets. Nevertheless, there is authority from other jurisdictions that supports the Objecting Cedents' position. *See Offset Revolution*, *supra*, at 508–11 (collecting cases).

Assuming for the sake of argument that the Objecting Cedents are correct, the Offset Statute still only affects the amount of their claims. The Offset Statute does not determine whether the Commissioner can make a pre-loss payment to certain cedents and not others. The Priority Provision, not the Offset Statute, controls that issue. To illustrate, assume that none of the cedents had received any value from the Company, whether through offset or otherwise. In that situation, if the Commissioner determined to make a pre-plan payment to certain cedents but not others as part of the process of rehabilitating the Company, then the Offset Statute would not have any role to play.

This decision has held that under the circumstances presented by this case, the Priority Provision does not prevent the Commissioner from making the Pre-Plan Payments to the Participating Cedents. That result applies because (i) the Company is in rehabilitation, not in liquidation, (ii) the Pre-Plan Payments will not jeopardize the

Company's prospects for rehabilitation, and (iii) the Pre-Plan Payments will not operate as a *de facto* liquidation payment or affect the Company's ability to comply with the Priority Provision in the event of a liquidation.

The Offset Statute therefore does not limit the ability of the Commissioner to make the Pre-Plan Payments. When considering whether to make the Pre-Plan Payments and how to structure them, the Commissioner was entitled to consider the value that the Objecting Cedents had received under the Offset Plan.

D. A Rationale With Substantial Evidentiary Support

So far, this decision has concluded that the Commissioner's proposal complies with law. The second step in the abuse of discretion standard asks whether the Commissioner has provided a rationale for his proposal that has substantial evidentiary support in the factual record. In the context of an administrative decision, the Commissioner meets this standard by making "findings of fact that are supported by substantial evidence." *DiPasquale*, 735 A.2d at 383 n.9. A court cannot defer to a determination by the Commissioner that lacks factual support. *See Powell v. AmGuard Ins. Co.*, 2019 WL 2114083, at *2 (Del. Super. May 14, 2019) (stating that the court does not defer to the Commissioner's when there is no factual basis for the order). Put differently, a decision that lacks a sufficient factual basis is arbitrary and capricious, constituting an abuse of discretion. *See Exec. Life*, 38 Cal. Rptr. 2d 453.

As this decision has noted several times now, the Commissioner's Motion and reply did not provide a sufficient factual record to support his decision. The Commissioner grounded his decision on two premises. First, he thought it was inequitable that certain

cedents had received significant value under the Offset Plan and others had not. Second, he believed that the Company could address the inequity by making the Pre-Plan Payments to the Participating Cedents without jeopardizing the rehabilitation.

The Commissioner provided sufficient factual support for the first premise. He described how the Company had provided nearly $500 million in value to certain cedents through offsets, and he explained how certain cedents benefitted far more than others. He also explained that the cedents who had not received significant (or any) value through offsets asked for some form of financial relief and that those cedents were more likely to be small insurers whose operations could be placed at risk. That showing established a sufficient factual record to support the Commissioner's decision to make Pre-Plan Payments based on concerns about fairness and a desire to maintain good relationships with all of the Company's cedents.

The Commissioner did not provide any non-conclusory factual support for the second premise. Neither the original version of the Motion nor the revised version provided a calculation to establish that the payments would not jeopardize the rehabilitation. Neither version provided any financial information that could be the basis for such a calculation, except for the general figures about the total offset payments and the amount of the proposed Pre-Plan Payments. Both versions simply asserted that

> [t]his payment amount is currently sustainable through SRUS' cash flow, will be coordinated with, and applied toward, payments later due from SRUS under Section 5 of the Rehab Plan, and will serve as a leveling mechanism to address the disproportionate impact experienced by nearly half of all Cedents that do not have the same ability as other Cedents to mitigate the impact to them of restrictions placed on non-offset loss payments that are necessary to the rehabilitation of SRUS.

Dkt. 590 ¶ 35. The Commissioner alluded to "financial information that has been previously filed with the court, including the financial information that was filed as recently as March 2, 2021." *Id.* ¶ 36. The Commissioner's submissions did not provide pinpoint citations to any financial information or any further explanation about the financial justification for the Pre-Plan Payments.

Based on this inadequate record, the Commissioner asked the court to defer to his decision. Had the record remained in that state, the court would have denied the Motion as failing to provide a rationale with substantial evidentiary support in the factual record.

During oral argument, the Commissioner's counsel provided additional factual detail that should have been included in his written submissions. Although the court could have denied the Commissioner's Motion and required that he start again from scratch, the court invited the Commissioner to provide a supplemental submission.

The supplemental submission provided a factual basis for the Commissioner's determination that the Pre-Plan Payments would not jeopardize the rehabilitation process. The supplemental submission contained financial data points, including documented amounts of unrestricted assets, forecast unrestricted assets, and a calculation of the projected amount of total unrestricted cash and invested assets after the Pre-Plan Payments were made to Participating Cedents. Dkt. 669. The submission also included detailed factual affidavits from the top leaders of the Company. *Id.* Exs. 1, 2. At this point, the Commissioner has provided substantial evidence for his assertion that the Pre-Plan Payments would not jeopardize the rehabilitation process.

At the same time, the supplemental submission did not provide substantial evidentiary support for the Commissioner's assertion that the Company could support the Pre-Plan Payments out of operating cash flow. The Company incurred an operating loss in 2020 and has projected surplus for 2021 that is far less than would be required to fund the Pre-Plan Payments. If that had been the only justification that the Commissioner provided for the Pre-Plan Payments, then the Commissioner's rationale would have lacked substantial evidentiary support, and the court would have rejected the proposal as arbitrary and capricious.

The Commissioner's proposal to make the Pre-Plan Payments is based on a rationale that has substantial support in the record. The second step in the process is therefore satisfied.

E. An Appropriate Exercise Of Discretion

With the first and second stages of the process satisfied, the inquiry reaches the third stage. In this phase, the court will defer to the Commissioner's judgment as long as it is rational and made in good faith. For the court not to defer to the Commissioner's judgment, the decision must be the product of fraud or bad faith or "exceed[] the bounds of reason." *See Banner v. State Emp. Rels. Bd.*, 123 A.3d 472, 2015 WL 5073740, at *2 (Del. Aug. 26, 2015) (TABLE) (cleaned up).

The Objecting Cedents and Merced have not shown that the Commissioner abused his discretion. It was rational for the Commissioner to seek to provide some value to cedents who have not received substantial (or any) value through the Offset Plan. The Objecting Cedents and Merced did not object to the concept of the Pre-Plan Payments; they

simply wanted to receive some of the money. There is nothing in the record to suggest that the Commissioner has acted in bad faith. There is nothing in the record to suggest that the Commissioner's decision was irrational. The decision to make the Pre-Plan Payments falls within the broad scope of discretion that the Commissioner possesses.

III. CONCLUSION

The Motion is granted. The Commissioner is authorized to cause the Company to make the Pre-Plan Payments.