

2010

Mellor v. Wasatch Crest Mutual Insurance : Reply Brief

Utah Court of Appeals

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IN THE SUPREME COURT OF UTAH

CHRIS ANN MELLOR, individually and
as guardian of HAYDEN WILLIAMS,

Appellant,

vs.

WASATCH CREST MUTUAL INSURANCE
and WASATCH CREST INSURANCE,

Respondent.

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**REPLY BRIEF OF
APPELLANT CHRIS ANN
MELLOR**

Case No. 20100952 SC

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**FILED
UTAH APPELLATE COURTS**

AUG 22 2011

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	:	APPELLANT CHRIS ANN
	:	MELLOR
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	:	
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The plaintiff and appellant, Chris Ann Mellor, through her undersigned counsel, submit this reply brief in response to the brief of appellee Wasatch Crest Insurance Company in Liquidation (“Wasatch Crest” or “the Liquidator”).

**RESPONSE TO THE LIQUIDATOR’S STATEMENT OF THE COURSE OF
PROCEEDINGS AND STATEMENT OF FACTS**

The Liquidator bases much of its argument on the existence of the Second Amended Notice of Determination (“SANOD”) it attached as an exhibit to its Reply Brief in the lower court dated June 29, 2010. Record at 5641-5653. *See*, Liquidator’s Brief, pp. 9, 12 (¶ 2), 18, 19, 21-26; However, the Liquidator attached the SANOD as an Exhibit to his Reply brief before the trial court purely for litigation strategy purposes. The SANOD was not provided within reasonable time frames after Mellor requested the Liquidator to decide her claim and was never properly served on either Mellor or her counsel. As outlined in Mellor’s Memorandum of Points and Authorities in Opposition to Respondent and Appellee’s Motion to Dismiss Appeal dated March 25, 2011, pp. 2-4, the SANOD was provided only after the parties, through their counsel, had made efforts to both obtain a decision from the Liquidator concerning the priority of Mellor’s claim and had also discussed the possibility of settling that claim. *See* the Affidavit of Brian S. King dated March 25, 2011 filed previously in this appeal, ¶¶ 3-11.

It was approximately a year after the final communications between counsel for the parties in the summer of 2009 and approximately six months after the filing of Mellor’s Motion for Summary Judgment in January of 2010 in this matter that the Liquidator provided the SANOD. The Liquidator asserts that the SANOD triggered a 60-

day time frame within which Mellor was obligated to either object to and appeal the determination or be bound by the Liquidator's decision. However, even if the SANOD did trigger the 60-day time frame, it would end on August 29, 2010, approximately two months before the trial court issued a ruling on Mellor's Motion for Summary Judgment. In that Motion for Summary Judgment, Mellor requested a ruling from the trial court on the very issue the SANOD purported to decide: the classification of Mellor's claim.

In its Statement of Facts, the Liquidator also states that "neither ORS nor Medicaid ever filed a claim on its own behalf in the liquidation proceeding." Liquidator's Brief, p. 11. This statement of fact is true in the sense that ORS did not avail itself of its right under UCA § 26-19-5(1)(a) to bring a claim directly against Wasatch Crest or the Liquidator to recover the medical assistance it provided to Mellor for Hayden Williams' medical expenses. However, UCA § 26-19 *et. Seq.* Utah's Medical Benefit Recovery Act, makes clear that ORS is not obligated to proceed directly against Wasatch Crest or the Liquidator in matters involving claims for reimbursement of Medicaid expenses. ORS may include its claim for reimbursement of monies paid to a Medicaid recipient in a cause of action asserted by the Medicaid recipient against a third party tortfeasor, or against entities such as Wasatch Crest, when those individuals or entities are primarily responsible for paying medical expenses that Medicaid has initially paid. *See* UCA § 26-19-7(2) and (4). In addition, state and federal law, read in combination, create a lien by operation of law on any proceeds arising out of a claim a Medicaid recipient, such as Mellor, pursues against a third party that results in

reimbursement of Medicaid funds. Houghton v. Dept. of Health, 2002 UT 101, ¶8-9; 57 P.3d 1067, 1069.

ARGUMENT

I. Standard of Review and Preservation of Error

The Liquidator points out that Mellor’s Opening Brief was deficient for failing to identify “the standard of appellant review with supporting authority” with either “citations to the record showing that the issue was preserved in the trial court; or a statement of grounds for seeking review of an issue not preserved in the trial court.” Wasatch Crest Opening Brief p. 14. Mellor acknowledges the oversight in its Opening Brief and apologizes to the Court.

With regard to the issue presented for review identified in Mellor’s Opening Brief, the standard of appellate review is *de novo* based on the fact that the question before the Court regarding whether Mellor’s claim has Class Three or Class Six distribution priority is a question of law. Mellor v. Wasatch Crest Ins. Co., 2009 UT 5, ¶7, 201 P.3d 1004, 1007. With regard to issues raised by Wasatch Crest in its Brief relating to whether the trial court’s Memorandum Decision and Order is a final Order appealable as a final judgment, this issue is likewise a question of law that is reviewed under a *de novo* standard of review. Id. Finally, with regard to Wasatch Crest’s assertion that Mellor’s claim is barred because she failed to file a timely objection to the Second Amended Notice of Determination, this question is likewise a question of law that is reviewed under a *de novo* standard of review. Id. The first issue was briefed by both parties in their papers before the district court and was a focus of the trial court’s ruling. Record, vol. 12,

pp. 5141-5327, vol. 13, pp. 5564-5603; 5615-5634; 5641-5653; 5702-5709. The second and third issues are raised for the first time on appeal and were not in existence or ripe at the time the parties briefed the issues before the trial court.

II. The Trial Court's 11/1/10 Order is a Final Appealable Judgment

As stated by this Court in its March 31, 2011, Order on Wasatch Crest's Motion to Dismiss, the jurisdictional dispute was deferred by this Court until this plenary briefing. As Wasatch Crest incorporated into its Brief the arguments made in its January 21, 2011, Memorandum of Points and Authorities in Support of Dismissal, Mellor incorporates into this Reply Brief her Memorandum of Points of Authorities in Opposition to Respondent and Appellee's Motion to Dismiss Appeal dated March 25, 2011.

The Liquidator argues that the trial court's November 1, 2010, Memorandum Decision and Order ("the 11/1/10 Order") is not a final appealable order because it simply ratified the Liquidator's request that the action be stayed and did not constitute entry of a final decision on the merits. The face of the 11/1/10 Order indicates that Wasatch Crest moved the Court to deny Mellor's motion for summary judgment or stay the motion. 11/1/10 Order, p. 3. The trial court did both. It also analyzed the merits of whether Wasatch Crest was estopped from denying payment of Mellor's claims and discussed at some length whether Mellor had standing to pursue claims against Wasatch Crest. 11/1/10 Order, pp. 3-5. In addition, the trial court analyzed where Mellor's claim belonged in U.C.A. §31A-27-335's class framework. It basically adopted the Liquidator's analysis and ruled that Mellor's claim fell into Class Six rather than Class Three. 11/1/10 Order, pp. 6-7. The trial court disposed of all claims presented to it and

left nothing for the Liquidator to determine in additional administrative proceedings. Indeed, the Liquidator has not identified any issues it asserts remain unresolved or have yet to be decided based on the 11/1/10 Order. The only thing left to do in the case is calculate the specific amount to be paid on Mellor's claim.

The existence of Mellor's Motion for Summary Judgment filed in January, 2010, eventually prodded the Liquidator to provide the SANOD. It was months late in coming and was not effective to fairly and properly serve notice of the Liquidator's decision to either Mellor or her counsel. However, the SANOD does make clear that the reasoning behind the Liquidator's decision to classify Mellor's claim as Class Six rather than Class Three was the same as the trial court's eventual analysis. Taken together, the SANOD and the 11/1/10 Order make unnecessary a stay and remand of the case to the Liquidator. There is no question about what the Liquidator's decision would be if this Court rules that the 11/1/10 Order was not a final appealable ruling and instead remands the matter to the Liquidator for additional consideration. Remanding the case to the Liquidator would be futile and a waste of resources and time.

In addition, there is risk of unfairness to Mellor associated with a remand to the Liquidator. He has made clear his position that any claim by Mellor is barred based on her failure to object to the SANOD within the 60 day time frame supposedly triggered by the Liquidator's inclusion of the SANOD as an exhibit to the Liquidator's June 29, 2010, Reply brief. For the reasons outlined in her March 25, 2011, Memorandum of Points and Authority in Opposition to the Liquidator's Motion to Dismiss filed with this Court, Mellor asserts that no 60 day time frame began to run. However, remanding the matter to

the Liquidator for further proceedings would not simply be a futile gesture. Rather, it would prejudice Mellor's ability to require the Liquidator to consider the priority of her claim under U.C.A. §31A-27-335 on the merits.

The Liquidator also asserts that the 11/1/10 Order states Mellor retains "the option of challenging the latest notice of determination" within the Liquidation proceeding. However, since the trial court made that statement, the Liquidator has made his position clear to this Court that Mellor has lost the right to challenge the Liquidator's decision to classify Mellor's claim as Class Six rather than Class Three. This makes more clear the futility and risk of prejudice to Mellor of a remand to the Liquidator for additional consideration of the appropriate classification of Mellor's claim.

In its brief the Liquidator asserts it was Mellor's "impatience" that improperly caused her to appeal the trial court ruling. Liquidator's Brief, p. 19. This argument is problematic in light of the Liquidator's failure to provide a timely notice of determination of the priority of Mellor's claims after this Court's first decision in Mellor v. Wasatch Crest, 2009 UT 5. The Liquidator's assertion that "... he learned new information once the claim was remanded—that is, Medicaid had paid all of Hayden's medical expenses," Liquidator's Brief, p. 19, is implausible on its face. The Record shows that the Liquidator had known for years that Medicaid stepped in and paid Mellor's medical expenses for Hayden's treatment. Record, vol. 13, pp. 5583; 5602-5603; 5628-5634. Indeed, it was Wasatch Crest's knowledge of Medicaid's involvement in paying Hayden William's medical expenses that initially caused it to improperly terminate Hayden's coverage in 2001.

III. Mellor is Not Barred From Challenging the Liquidator's Classification of Her Claim Based on a Failure to Timely Object to the SANOD.

The Liquidator asserts that Mellor's failure to file an objection to the SANOD within 60 days after June 29, 2010 bars her ability to appeal the Liquidator's decision on that issue. The problem with imposing the 60-day deadline referenced in UCA § 31-A-27-332(1) is that the Liquidator's process for considering Mellor's claim and issuing a timely notice of determination was fundamentally flawed. In fact, shortly after this Court's decision in Mellor v. Wasatch Crest, 2009 UT 5, Mellor again requested payment of her claims from the Liquidator. But the Liquidator did not make any sort of timely decision regarding the priority of her claim. Rather, as outlined in the Affidavit of Brian S. King dated March 25, 2011, counsel for Mellor and the Liquidator traded correspondence, had a face to face meeting together with the attorney for ORS, and exchanged several telephone calls. Mellor's counsel offered to appear and provide additional information to the Liquidator or the Utah Life and Health Insurance Guaranty Association or respond to questions about Mellor's claim. However, nothing happened. The claim stagnated. There were no additional communications from the Liquidator after July, 2009, nor did the Liquidator provide any decision on the priority of Mellor's claim. Consequently, Mellor filed a Motion for Summary Judgment in January of 2010. Record at 5141-5187.

Even the filing of Mellor's Motion for Summary Judgment did not prod any timely decision on the priority of Mellor's claim. Rather, the Liquidator responded on April 27, 2010, by filing a Motion to Dismiss or in the alternative a Motion to Stay Claimant's

Motion for Summary Judgment or in the alternative a Memorandum in Opposition to Mellor's Motion for Summary Judgment. Record at 5564-5603. After Mellor filed her Consolidated Memorandum in Support of her Motion for Summary Judgment in Opposition to Defendant's Motion to Dismiss on June 1, 2010, the Liquidator filed his June 29, 2010, Reply Memorandum in Support of his various motions. Only then did the Liquidator provide the SANOD – as an exhibit to the Reply Memorandum. There was nothing other than a reference to the SANOD in the Reply Memorandum to give notice to Mellor or her counsel of the Liquidator's position that a 60-day time frame had begun on June 29, 2010. The Reply Memorandum was simply part of litigation before the trial court that, among other things, asked the trial judge to decide the same issue the SANOD purported to address: what was the appropriate classification of Mellor's claim. The Liquidator identifies no basis for his untimely issuance of the SANOD without waiting for a resolution by a District Court Judge on the issue before the trial court. Mellor had no reason to believe that the Liquidator's issuance of the SANOD overrode or cut short the trial court's authority to rule on the issues the parties had briefed and placed before the trial court.

The Liquidator is not just an adverse party in litigation. His powers and duties under the Utah insurance code are in the nature of acting as a fiduciary to all interested parties and stakeholders in connection with the liquidation of an insolvent insurer. U.C.A. §31A-27-314. Mellor and other claimants against Wasatch Crest Insurance Company in Liquidation are entitled to treatment by a Liquidator committed to thoroughly and

impartially evaluate all claims presented to him. The Liquidator's action in sandbagging Mellor with the SANOD is inconsistent with those fiduciary obligations.

IV. Mellor's Claim is a Class Three Claim Under the Liquidation Statute

The language of the liquidation statute categorizes Class Three as "all claims under the policies for losses incurred" including the following: (A) claims with the federal, state or local governments; (B) third party claims" U.C.A. § 31A-27-335(2)(c)(i)(A)-(B). The statute also excludes from Class Three claims, ". . . that portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant" U.C.A. §31A-27-335(2)(c)(iii).

Mellor's claim was a "loss incurred" by Mellor. Hayden Williams' medical expenses should have been paid by Wasatch Crest but were not. Alternatively, the Utah State Medicaid program, funded by federal and state tax dollars, incurred a loss when it stepped up to the plate in lieu of Wasatch Crest, and paid Hayden Williams' medical expenses. In addition, the lien ORS has under its collection agreement with Mellor or by operation of law under the Medical Benefits Recovery Act constitutes a "third party claim" which Mellor has the ability to assert.

The Liquidator argues that Medicaid's payment of Hayden Williams' medical providers constitutes "indemnification," as that word is used under U.C.A. §31A-27-335(2)(c)(iii) and this converts Mellor's claim to Class Six rather than Class Three. However, while the entry of Medicaid onto the scene shortly after Hayden's accident in 2001 relieved Mellor of financial obligation to Hayden's medical providers, more than this is required to constitute "indemnification" under this section of the insurance code.

The government assistance provided from state and federal funds from Medicaid to Mellor for Hayden William's medical expenses were not "indemnification" in the true sense of the word. Medicaid's payment of benefits constituted a stop-gap measure by the payor of last resort to prevent the financial problems that Hayden's large medical expenses would have created for Mellor. The express terms of the United States Code make clear that to the extent any third party such as Wasatch Crest is determined to be primarily responsible for medical expenses initially paid by Medicaid, that third party has an obligation to repay Medicaid. Thus, Medicaid's payment was not "indemnification" of Hayden's medical expenses because that government program contemplates being repaid by the party that should have been responsible for payment of those medical expenses in the first place.

Cases involving the Medical Benefit Recovery Act are more commonly seen in the context of personal injury claims. Recipients of Medicaid benefits have their medical bills paid following an accidental injury and are therefore not responsible for additional payment to their healthcare providers. However, it is very clear in those cases that the recipients are in no way indemnified from an obligation to reimburse Medicaid upon recovery from a third party. In S.S. v. State of Utah, 972 P.2d 439 (UT 1998), Medicaid's right to reimbursement had priority over the creation of a special needs or supplemental needs trust for S.S. Id. at 444. The Utah Supreme Court has previously held that:

[p]ayments made by a third party do not legally become the property of the recipient until after a valid settlement, which necessarily must include reimbursement to Medicaid.

Houghton, 57 P.3d at 1069, citing State v. McCoy, 2000 UT 39, P10, 999 P.2d 572 (UT 2000) and Wallace v. Estate of Jackson, 972 P.2d 446, 448 (UT 1998).

Even if Medicaid indemnified Mellor for Hayden's medical claims, nothing in the insurance code prevents the indemnitor, the Utah State Medicaid program through its agent, ORS and Mellor in this case, from stepping up to assert a Class Three rather than Class Six claim under the statute. In placing Mellor's claim in the proper category, the priority classification framework found in U.C.A. §31A-27-335 must be read in combination with the Medical Benefits Recovery Act and federal statutes designed to protect the integrity of the federal and state monies used to fund the Utah State Medicaid program. Synthesizing these state and federal statutes requires that the Liquidator provide funds to make the taxpayer whole to the greatest extent possible rather than favor the interests of insurance company shareholders.

The Liquidator argues that as of July 31, 2003 when Wasatch Crest was taken into liquidation, there was no policy in force on that date. Liquidator's Brief, p. 29. However this is sophistry. Under this Court's initial decision, the policy should have been into effect as of August 1, 2001 and thereafter for the entire time frame Hayden Williams was entitled to COBRA coverage under the Wasatch Crest policy. The only reason it was not in place was because Wasatch Crest improperly terminated that coverage. Mellor v. Wasatch Crest, 2009 UT 5, ¶21.

Next, Wasatch Crest asserts that Mellor's claim is not a governmental claim because it was only she, and not ORS, who filed a claim for loss under her Wasatch Crest

policy. Liquidator's Brief, p. 29. In this, the Liquidator is simply wrong. ORS did assert a claim, albeit through Mellor, as allowed under the Medical Benefits Recovery Act.

U.C.A. §26-19-7.

To the extent that medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third party otherwise payable to or on behalf of a recipient are *deemed to be assigned* to [Medicaid] if [Medicaid] provides, or becomes obligated to provide, medical assistance. . . .

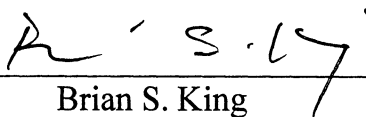
U.C.A. §26-19-4.5(1) (emphasis added). The Liquidator provides no authority to support the idea that he may ignore that claim or treat ORS's lien as inferior in any way to a claim by any insured under the policy.

The Liquidator argues that Mellor's claims are not claims of the federal, state or local government because ORS has never filed a claim as required under the Liquidation Act with respect to benefits paid for Hayden William's medical expenses. Liquidator Brief, p. 32. However, the Medical Benefits Recovery Act states that once notice is given to a third party, such as Wasatch Crest, of the interest that ORS has in a claim, the insurer must "accept the state's right of recovery and the assignment to the state of any right of a person to payment from a party for an item or service for which payment has been made under the state plan." U.C.A. §26-19-4.7(2). The Medical Benefits Recovery Act also makes clear that ORS has no obligation to directly file a claim against third parties such as Wasatch Crest for payment of unreimbursed medical expenses. Rather, ORS has the ability to rely on the efforts of Mellor and her counsel in pursuing third parties for recovery of medical expenses that constitute unreimbursed funds owed to ORS.

In short, the Medical Benefits Recovery Act acknowledges the standing Mellor has as an insured and also requires the Liquidator to acknowledge that ORS, standing in the shoes of Mellor, may assert a claim with the same authority and priority Mellor herself has. So long as notice of both Mellor's and ORS's interests were timely provided to Wasatch Crest and the Liquidator, they have no ability to treat Mellor's claim as Class Six rather than Class Three. Paragraphs 27 through 29 of Mellor's Statement of Facts in her Opening Brief make clear the requisite notice of both Mellor's and ORS's claims was provided to both Wasatch Crest and the Liquidator.

The Liquidator repeatedly attempts to characterize Mellor's arguments as "equitable" to tie into the language of UCA § 31A-27-335(1)(d) that states that "claims by shareholders, policy holders or other creditors may not be permitted to circumvent priority classes outlined in the statute through the use of equitable remedies." However, this is simply an inaccurate characterization of Mellor's claims. They were and are based on contract, tort and statutory language. There is nothing "equitable," as that term is used in UCA § 31A-27-335(1)(d), about Mellor's claims.

DATED this 22 day of August, 2011.



Brian S. King
Attorney for Appellant

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been delivered via first class U.S. mail, postage prepaid, in both hard copy and on CD to the following:

John P. Harrington
HOLLAND & HART
222 South Main Street, Suite 2200
Salt Lake City, UT 84101-2001

DATED this 22nd day of August, 2011.



ADDENDUM

U.C.A. §26-19-4.5(1)

U.C.A. §26-19-4.7(2)

U.C.A. §26-19-5(1)(a)

U.C.A. §26-19-7

U.C.A. §26-19-7(2) and (4)

U.C.A. §31A-27-314

U.C.A. §31A-27-332(1)

U.C.A. §31A-27-335

U.C.A. §31A-27-335(1)(d)

U.C.A. §31A-27-335(2)(c)(i) (A) and (B)

U.C.A. §31A-27-335(2)(c)(iii)

(9) "Provider" means a person or entity who provides services to a recipient.

(10) "Recipient" means:

(a) a person who has applied for or received medical assistance from the state;

(b) the guardian, conservator, or other personal representative of a person under Subsection (10)(a) if the person is a minor or an incapacitated person; or

(c) the estate and survivors of a person under Subsection (10)(a) if the person is deceased.

(11) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

(12) "Third party" includes:

(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by department rule; and

(b) a spouse or a parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or

(ii) has been ordered to maintain health, dental, or accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order.

(13) "Trust" shall have the same meaning as provided in Section 75-1-201. 2007

9-3. Program established by department — Promulgation of rules.

The department shall establish and maintain a program for the recoupment of medical assistance.

The department may promulgate rules to implement purposes of this chapter. 1984

9-4. Repealed.

1984

9-4.5. Assignment of rights to benefits.

(a) To the extent that medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third party otherwise payable to or on behalf of a recipient are assigned by operation of law to the department if the department provides, or becomes obligated to provide, medical assistance, regardless of who made application for the benefits on behalf of the recipient.

(b) The assignment:

(i) authorizes the department to submit its claim to the third party and authorizes payment of benefits directly to the department; and

(ii) is effective for all medical assistance.

The department may recover the assigned benefits or amounts in accordance with Section 26-19-5 and as otherwise provided by law.

The assignment of benefits includes medical support third party payments ordered, decreed, or adjudged by court of this state or any other state or territory of the United States. That assignment is not in lieu of, and does not supersede or alter any other court order, decree, or judgment.

When an assignment takes effect, the recipient is entitled to receive medical assistance, and the benefits paid to the department are a reimbursement to the department. 1998

26-19-4.7. Health insurance entity — Duties related to state claims for Medicaid payment or recovery.

As a condition of doing business in the state, a health insurance entity shall:

(1) with respect to a person who is eligible for, or is provided, medical assistance under the state plan, upon the request of the Department of Health, provide information to determine:

(a) during what period the person, or the spouse or dependent of the person, may be or may have been, covered by the health insurance entity; and

(b) the nature of the coverage that is or was provided by the health insurance entity described in Subsection (1)(a), including the name, address, and identifying number of the plan;

(2) accept the state's right of recovery and the assignment to the state of any right of a person to payment from a party for an item or service for which payment has been made under the state plan;

(3) respond to any inquiry by the Department of Health regarding a claim for payment for any health care item or service that is submitted no later than three years after the day on which the health care item or service is provided; and

(4) not deny a claim submitted by the Department of Health solely on the basis of the date of submission of the claim, the type or format of the claim form, or failure to present proper documentation at the point-of-sale that is the basis for the claim, if:

(a) the claim is submitted no later than three years after the day on which the item or service is furnished; and

(b) any action by the Department of Health to enforce the rights of the state with respect to the claim is commenced no later than six years after the day on which the claim is submitted. 2007

26-19-5. Recovery of medical assistance from third party — Lien — Notice — Action — Compromise or waiver — Recipient's right to action protected.

(1) (a) When the department provides or becomes obligated to provide medical assistance to a recipient that a third party is obligated to pay for, the department may recover the medical assistance directly from that third party.

(b) Any claim arising under Subsection (1)(a) or Section 26-19-4.5 to recover medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by that third party. This lien has priority over all other claims to the proceeds, except claims for attorney's fees and costs authorized under Subsection 26-19-7(2)(c)(ii).

(2) (a) The department shall mail or deliver written notice of its claim or lien to the third party at its principal place of business or last-known address.

(b) The notice shall include:

(i) the recipient's name;

(ii) the approximate date of illness or injury,

(iii) a general description of the type of illness or injury; and

(iv) if applicable, the general location where the injury is alleged to have occurred.

(3) The department may commence an action on its claim or lien in its own name, but that claim or lien is not enforceable as to a third party unless:

(a) the third party receives written notice of the department's claim or lien before it settles with the recipient; or

(b) the department has evidence that the third party had knowledge that the department provided or was obligated to provide medical assistance.

- (4) The department may:
 - (a) waive a claim or lien against a third party in whole or in part; or
 - (b) compromise, settle, or release a claim or lien.
- (5) An action commenced under this section does not bar an action by a recipient or a dependent of a recipient for loss or damage not included in the department's action.
- (6) The department's claim or lien on proceeds under this section is not affected by the transfer of the proceeds to a trust, annuity, financial account, or other financial instrument.

2005

26-19-6. Action by department — Notice to recipient.

- (1) (a) Within 30 days after commencing an action under Subsection 26-19-5(3), the department shall give the recipient, his guardian, personal representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action by:
 - (i) personal service or certified mail to the last known address of the person receiving the notice; or
 - (ii) if no last-known address is available, by publishing a notice:
 - (A) once a week for three successive weeks in a newspaper of general circulation in the county where the recipient resides; and
 - (B) in accordance with Section 45-1-101 for three weeks.
- (b) Proof of service shall be filed in the action.
- (c) The recipient may intervene in the department's action at any time before trial.
- (2) The notice required by Subsection (1) shall name the court in which the action is commenced and advise the recipient of:
 - (a) the right to intervene in the proceeding;
 - (b) the right to obtain a private attorney; and
 - (c) the department's right to recover medical assistance directly from the third party.

2009

26-19-7. Notice of claim by recipient — Department response — Conditions for proceeding — Collection agreements — Department's right to intervene — Department's interests protected — Remitting funds — Disbursements — Liability and penalty for noncompliance.

- (1) (a) A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the department has provided or has become obligated to provide medical assistance, without the department's written consent as provided in Subsection (2)(b) or (4).
- (b) For purposes of Subsection (1)(a), consent may be obtained if:
 - (i) a recipient who files a claim, or commences an action against a third party notifies the department in accordance with Subsection (1)(d) within ten days of making his claim or commencing an action; or
 - (ii) an attorney, who has been retained by the recipient to file a claim, or commence an action against a third party, notifies the department in accordance with Subsection (1)(d) of the recipient's claim:
 - (A) within 30 days after being retained by the recipient for that purpose; or
 - (B) within 30 days from the date the attorney either knew or should have known that the recipient received medical assistance from the department.
- (c) Service of the notice of claim to the department shall be made by certified mail, personal service, or by

e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure, to the director of the Office of Recovery Services.

(d) The notice of claim shall include the following information:

- (i) the name of the recipient;
 - (ii) the recipient's Social Security number;
 - (iii) the recipient's date of birth;
 - (iv) the name of the recipient's attorney if applicable;
 - (v) the name or names of individuals or entities against whom the recipient is making the claim, if known;
 - (vi) the name of the third party's insurance carrier, if known;
 - (vii) the date of the incident giving rise to the claim; and
 - (viii) a short statement identifying the nature of the recipient's claim.
- (2) (a) Within 30 days of receipt of the notice of the claim required in Subsection (1), the department shall acknowledge receipt of the notice of the claim to the recipient or the recipient's attorney and shall notify the recipient or the recipient's attorney in writing of the following:
 - (i) if the department has a claim or lien pursuant to Section 26-19-5 or has become obligated to provide medical assistance; and
 - (ii) whether the department is denying or granting written consent in accordance with Subsection (1)(a).
 - (b) The department shall provide the recipient's attorney the opportunity to enter into a collection agreement with the department, with the recipient's consent, unless:
 - (i) the department, prior to the receipt of the notice of the recipient's claim pursuant to Subsection (1), filed a written claim with the third party, the third party agreed to make payment to the department before the date the department received notice of the recipient's claim, and the agreement is documented in the department's record; or
 - (ii) there has been a failure by the recipient's attorney to comply with any provision of this section by:
 - (A) failing to comply with the notice provisions of this section;
 - (B) failing or refusing to enter into a collection agreement;
 - (C) failing to comply with the terms of a collection agreement with the department; or
 - (D) failing to disburse funds owed to the state in accordance with this section.
 - (c) (i) The collection agreement shall be:
 - (A) consistent with this section and the attorney's obligation to represent the recipient and represent the state's claim; and
 - (B) state the terms under which the interests of the department may be represented in an action commenced by the recipient.
 - (ii) If the recipient's attorney enters into a written collection agreement with the department, or includes the department's claim in the recipient's claim or action pursuant to Subsection (4), the department shall pay attorney's fees at the rate of 33.3% of the department's total recovery and shall pay a proportionate share of the litigation expenses directly related to the action.
 - (d) The department is not required to enter into a collection agreement with the recipient's attorney for collection of personal injury protection under Subsection 31A-22-302(2).

If the department receives notice pursuant to Subsection (1), and notifies the recipient and the recipient's attorney that the department will not enter into a collection agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or action against a third party if the recipient excludes from the claim:

- (i) any medical expenses paid by the department; or
- (ii) any medical costs for which the department is obligated to provide medical assistance.

b) When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall provide written notice to the third party of the exclusion of the department's claim for expenses under Subsection (3)(a)(i) or (ii).

If the department receives notice pursuant to Subsection (3)(a), and does not respond within 30 days to the recipient or the recipient's attorney, the recipient or the recipient's attorney:

- (a) may proceed with the recipient's claim or action against the third party;
- (b) may include the state's claim in the recipient's claim or action; and

(c) may not negotiate, compromise, settle, or waive the department's claim without the department's consent.

The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical costs for which the department has provided or has become obligated to provide medical assistance.

(a) If the recipient proceeds without complying with the provisions of this section, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action.

(b) The department may recover in full from the recipient or any party to which the proceeds were made payable all medical assistance which it has provided and retains its right to commence an independent action against the third party, subject to Subsection 26-19-5(3).
) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days after receipt.

) (a) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient's attorney must be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account.

(b) The date by which the funds must be remitted to the department may be modified based on agreement between the department and the recipient's attorney.

(c) The department's consent to another date for remittance may not be unreasonably withheld.

(d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.

(9) A recipient or recipient's attorney who knowingly and intentionally fails to comply with this section is liable to the department for:

- (a) the amount of the department's claim or lien pursuant to Subsection (5);
- (b) a penalty equal to 10% of the amount of the department's claim; and
- (c) attorney's fees and litigation expenses related to recovering the department's claim.

2005

26-19-8. Statute of limitations — Survival of right of action — Insurance policy not to limit time allowed for recovery.

(1) (a) Subject to Subsection (6), action commenced by the department under this chapter against a health insurance entity must be commenced within:

- (i) subject to Subsection (7), six years after the day on which the department submits the claim for recovery or payment for the health care item or service upon which the action is based; or
- (ii) six months after the date of the last payment for medical assistance, whichever is later.

(b) An action against any other third party, the recipient, or anyone to whom the proceeds are payable must be commenced within:

- (i) four years after the date of the injury or onset of the illness; or
- (ii) six months after the date of the last payment for medical assistance, whichever is later.

(2) The death of the recipient does not abate any right of action established by this chapter.

(3) (a) No insurance policy issued or renewed after June 1, 1981, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than 24 months from the date the provider furnishes services or goods to the recipient.

(b) No insurance policy issued or renewed after April 30, 2007, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than that described in Subsection (1)(a).

(4) The provisions of this section do not apply to Section 26-19-13.5.

(5) The provisions of this section supercede any other sections regarding the time limit in which an action must be commenced, including Section 75-7-509.

(6) (a) Subsection (1)(a) extends the statute of limitations on a cause of action described in Subsection (1)(a) that was not time-barred on or before April 30, 2007.

(b) Subsection (1)(a) does not revive a cause of action that was time-barred on or before April 30, 2007.

(7) An action described in Subsection (1)(a) may not be commenced if the claim for recovery or payment described in Subsection (1)(a)(i) is submitted later than three years after the day on which the health care item or service upon which the claim is based was provided.

2007

26-19-9. Employee benefit plans.

As allowed pursuant to 29 U.S.C. Section 1144, an employee benefit plan may not include any provision that has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan based on the fact that the individual is eligible for or is provided services under the state plan.

1993

26-19-9.5. Availability of insurance policy.

If the third party does not pay the department's claim or lien within 30 days from the date the claim or lien is received, the third party shall:

- (1) provide a written explanation if the claim is denied;
- (2) specifically describe and request any additional information from the department that is necessary to process the claim; and
- (3) provide the department or its agent a copy of any relevant or applicable insurance or benefit policy.

2004

health care obligations of the insolvent managed care organization to other managed care organizations or other insurers, if those other managed care organizations and other insurers are licensed or have a certificate of authority to provide the same health care services in this state that is held by the insolvent managed care organization.

(ii) The rehabilitator or liquidator may combine group and individual health care obligations of the insolvent managed care organization in any manner the rehabilitator or liquidator considers best to provide for continuous health care coverage for the maximum number of enrollees of the insolvent managed care organization.

(iii) If the terms of a proposed transfer of the same combination of group and individual policy obligations to more than one other managed care organization or insurer are otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group and individual policy obligations of an insolvent managed care organization as follows:

(A) from one category of managed care organization to another managed care organization of the same category, as follows:

(I) from a limited health plan to a limited health plan;

(II) from a health maintenance organization to a health maintenance organization;

(III) from a preferred provider organization to a preferred provider organization;

(IV) from a fraternal benefit society to a fraternal benefit society; and

(V) from any entity similar to any of the above to a category that is similar;

(B) from one category of managed care organization to another managed care organization, regardless of the category of the transferee managed care organization; and

(C) from a managed care organization to a nonmanaged care provider of health care coverage, including insurers.

(f) If an insolvent managed care organization has required surplus, a rehabilitator or liquidator may use the insolvent managed care organization's required surplus to continue to provide coverage for the insolvent managed care organization's enrollees, including paying uncovered expenditures.

31A-27-312. Dissolution of insurer.

The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time the commissioner applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. *If the dissolution has not previously been ordered, it shall be* effected by operation of law upon the discharge of the liquidator if the insurer is insolvent. However, dissolution may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason. Notwithstanding the above, upon application by the commissioner and following notice as prescribed by the court and a hearing, the court may sell the corporation as an entity, together with any of its licenses to do business, despite the entry of an order of liquidation. The sale may be made on terms and conditions the court considers appropriate. However, the order approving the sale shall provide that the proceeds of the sale shall become part of the assets of the liquidation estate, to be distributed in the manner set forth in Section 31A-27-335, and that the corporate entity and its

licenses shall thereafter be free and clear from the claims or interests of all claimants, creditors, policyholders, and stockholders of the corporation under liquidation.

31A-27-313. Legislative intent concerning retention of jurisdiction.

Jurisdiction for rehabilitation and liquidation actions is in the state courts of the insurer's state of domicile, when possible and practical.

31A-27-314. Powers and duties of the liquidator.

(1) The liquidator shall report to the court, at intervals specified by the court, on the progress of the liquidation in whatever detail the court orders. Unless the court orders otherwise, the liquidator has the powers and responsibilities described in this Subsection (1).

(a) (i) The liquidator may:

(A) appoint a special deputy to act for the liquidator under this chapter; and

(B) determine the special deputy's compensation, subject to the approval of the court.

(ii) The special deputy has all the powers of the liquidator granted by this section.

(iii) The special deputy serves at the pleasure of the liquidator.

(b) (i) The liquidator may appoint or engage:

(A) employees and agents;

(B) legal counsel pursuant to Section 31A-2-108;

(C) actuaries;

(D) accountants;

(E) appraisers;

(F) consultants; and

(G) other personnel necessary to assist in the liquidation.

(ii) The career service laws do not apply to the persons described in Subsection (1)(b)(i).

(c) The liquidator may fix the compensation of persons under Subsection (1)(b), subject to the approval of the court.

(d) (i) The liquidator may defray all reasonable expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer.

(ii) If the property of the insurer does not contain sufficient cash or liquid assets to defray the reasonable costs incurred, the commissioner may advance the costs so incurred out of the department's appropriation.

(iii) Any amounts paid under Subsection (1)(d)(ii) are expenses of administration and shall be repaid for the credit of the department out of the first available cash of the insurer.

(e) The liquidator may:

(i) hold hearings;

(ii) subpoena witnesses and compel their attendance;

(iii) administer oaths;

(iv) examine any person under oath;

(v) compel any person to subscribe to that person's testimony after it has been correctly reduced to writing; and

(vi) in connection with a proceeding under this Subsection (1)(e), require the production of any books, papers, records, or other documents that the liquidator considers relevant to the inquiry.

(f) The liquidator may collect all debts and claims due and money belonging to the insurer, wherever located and for this purpose:

(4) The liquidator shall make recommendations to the court under Section 31A-27-336 for the allowance of an insured's claim under Subsection (3) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance of the claim by the court, the liquidator shall withhold any distributions payable on the claim, pending the outcome of the litigation and negotiation with the insured. Whenever it seems appropriate, the liquidator may reconsider the claim on the basis of additional information and amend the recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it determines is appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage distribution as was paid on other claims of like priority, based on the lesser of:

- (a) the amount actually recovered from the insured by the action or paid by the agreement, plus the reasonable costs and expenses of defense; and
- (b) the amount allowed on the claims by the court.

After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection is not a reason for unreasonable delay of final distribution and discharge of the liquidator.

(5) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this action, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured are evaluated as in Subsection (4). If any insured's claim is subsequently reduced under Subsection (4), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

1985

31A-27-332. Disputed claims.

- (1) (a) When a claim is disallowed in whole or in part by the liquidator, written notice of the determination and of the right to object shall be given promptly to the claimant or the claimant's attorney of record, if any, by first-class mail at the addresses shown in the proof of claim.
- (b) (i) Within 60 days from the mailing of the notice required by Subsection (1)(a), the claimant may file objections with the court.
- (ii) If objections are not filed within the period provided in Subsection (1)(b)(i), the claimant may not further object to the determination.
- (2) (a) Whenever objections are filed with the court and the liquidator does not alter the liquidator's ruling, the liquidator shall ask the court for a hearing as soon as practicable.
- (b) If the liquidator asks for a hearing under Subsection (2)(a), the court shall issue an order setting a date as early as possible.
- (c) At the request of the liquidator, the court may establish procedures for the objections hearing.
- (d) The liquidator shall give notice of a hearing under this Subsection (2) by first-class mail to:
 - (i) the claimant or the claimant's attorney; and
 - (ii) any other persons directly affected.
- (e) A hearing under this Subsection (2):
 - (i) shall be heard without a jury; and
 - (ii) may be heard by:
 - (A) the court; or
 - (B) a court-appointed referee.

(f) A hearing under this Subsection (2) shall be limited to the evidence upon which the liquidator made the determination of the claims.

(g) If a referee is appointed under this Subsection (2), the referee shall submit to the court:

- (i) findings of fact; and
- (ii) recommendations.

(h) Consistent with Subsection 31A-27-336(2), the court may approve, disapprove, or modify:

- (i) the liquidator's determination of a claim; or
- (ii) a referee's recommendations on a claim.

(3) A court order issued after a hearing and pursuant to this section may be appealed as a final order for purposes of Rule 54, Utah Rules of Civil Procedure.

2002

31A-27-333. Surety's claims against insurer.

Whenever a creditor whose claim against an insurer is secured in whole or in part by the undertaking of another person fails to prove and file that claim, the other person may do so in the creditor's name. The other person is subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that the other person discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person is not entitled to any distribution until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held in trust for the other person. As used in this section, "another person" or "other person" does not apply to a guaranty fund or association.

1986

31A-27-334. Secured claims.

(1) An allowed claim of a creditor that is secured by a lien on property in which the insurer who is subject to a liquidation has an interest, or that is subject to setoff under Section 31A-27-323, is a secured claim to the extent of the value of the creditor's interest in the insurer's interest in the property or to the extent of the amount subject to setoff.

(2) The value of any security for a claim is determined under the supervision and control of the court:

- (a) by converting it into money according to the terms of the agreement under which the security was granted to or retained by the creditor; or
- (b) by agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(3) The net amount received under Subsection (2)(a) or the amount determined under Subsection (2)(b) shall be credited upon the secured claim, and any deficiency shall be allowed as an unsecured claim. If the claimant surrenders the security to the liquidator, the entire claim shall be allowed as if unsecured.

1986

31A-27-335. Priority of distribution.

(1) (a) Every claim in each class of claims from the insurer's estate shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment

(b) Once the funds are retained by the liquidator and approved by the court, the insurer's estate shall have no further liability to members of that class except to the extent of the retained funds and any other undistributed funds.

(c) Subclasses may not be established within any class.

(d) A claim by a shareholder, policyholder, or other creditor may not be permitted to circumvent the priority classes through the use of equitable remedies.

(2) The classes and order of distribution are as described in Subsections (2)(a) through (i).

(a) Class one is the costs and expenses of administration expressly approved by the liquidator, including:

- (i) the actual and necessary costs of preserving or recovering the assets of the insurer;
- (ii) compensation for all authorized services rendered in the supervision, rehabilitation, or liquidation;
- (iii) any necessary filing fees;
- (iv) the fees and mileage payable to witnesses; and
- (v) reasonable attorney's fees and other professional services rendered in the supervision, rehabilitation, or liquidation.

(b) (i) Class two is the administrative expenses of guaranty associations.

(ii) For purposes of this section, "administrative expenses of a guaranty association" means the reasonable expenses incurred by a guaranty association:

(A) when the expenses are not payments or expenses that are required to be incurred as direct policy benefits in fulfillment of the terms of the insurance contract or policy; and

(B) that are of the type and nature that, but for the activities of the guaranty association, otherwise would have been incurred by the liquidator, including:

- (I) evaluations of policy coverage;
- (II) activities involved in the adjustment and settlement of claims under policies, including those of in-house or outside adjusters; and
- (III) the reasonable expenses incurred in connection with the arrangements for ongoing coverage through transfer to other insurers, policy exchanges, or maintaining policies in force.

(iii) The liquidator may in the liquidator's sole discretion approve as an administrative expense of a guaranty association any other reasonable expenses of the guaranty association if the liquidator finds:

(A) the expenses are not expenses required to be paid or incurred as direct policy benefits by the terms of the policy; and

(B) the expenses were incurred in furtherance of activities that provided material economic benefit to the estate as a whole irrespective of whether the activities resulted in additional benefits to covered claimants.

(iv) The court shall approve the expenses approved by the liquidator under Subsection (2)(b)(iii) unless the court finds the liquidator abused the liquidator's discretion in approving the expenses

(c) (i) Class three is all claims under policies for losses incurred including:

(A) claims of the federal, state, or local government;

(B) third party claims;

(C) claims for unearned premiums; and

(D) claims of a guaranty association, other than those included in class two, including claims for payment of covered claims or covered obligations of the insurer

(ii) All claims under life and health insurance and annuity policies shall be treated as loss claims.

(iii) That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant are not included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support, by way of succession at death,

as proceeds of life insurance, or as gratuities, if payment made by an employer to the employer's employee may not be treated as a gratuity.

(iv) Notwithstanding Subsections (2)(c)(i), (ii), and (iii), the following claims shall be excluded from class three priority:

(A) obligations of the insolvent insurer arising out of reinsurance contracts;

(B) obligations incurred after:

(I) the expiration date of the insurance policy;

(II) the policy has been replaced by the insured;

(III) the policy has been canceled at the insured's request; or

(IV) the policy has been canceled as provided in the chapter;

(C) obligations to insurers, insurance pools, or underwriting associations and their claims for contribution, indemnity, or subrogation, equitable or otherwise;

(D) any claim that is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer;

(E) any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy; and

(F) tort claims of any kind against the insurer and claims against the insurer for bad faith or wrongful settlement practices.

(v) Notwithstanding Subsection (2)(c)(iv)(B), unearned premium claims on policies, other than reinsurance agreements, may not be excluded.

(d) Class four is claims of the federal government other than those claims included under class three.

(e) (i) Class five is debts due employees for services benefits, contractual or otherwise due, arising out of reasonable compensation to employees for service performed:

(A) to the extent that they:

(I) do not exceed two months of monetary compensation; and

(II) represent payment for services performed within six months before the filing of the petition for liquidation; or

(B) if rehabilitation preceded liquidation within one year before the filing of the petition for rehabilitation.

(ii) Principal officers and directors are not entitled to the benefit of class five priority except as otherwise approved by the liquidator and the court.

(iii) Class five priority shall be in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

(f) (i) Class six is claims of:

(A) any person, including claims of state or local governments, except those specifically classified elsewhere in this section, or

(B) attorneys for fees and expenses owed them by a person for services rendered in opposing a formal delinquency proceeding.

(ii) To prove the claim for attorneys' fees and expenses, the claimant shall show that:

(A) the insurer that is the subject of the delinquency proceeding incurred the fees and expenses based on its best knowledge, information and belief, formed after reasonable inquiry indicating opposition was:

(I) in the best interests of the person;

- (II) well grounded in fact, and
- (III) warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and
- (B) opposition was not pursued for any improper purpose, such as to:

- (I) harass;
- (II) cause unnecessary delay; or
- (III) cause needless increase in the cost of litigation.

(g) (i) Class seven is claims of any state or local government for a penalty or forfeiture, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, including the reasonable and actual costs incurred from the act, transaction, or proceeding.

(ii) The remainder of the claims shall be postponed to class eight claims.

(h) Class eight is:

- (i) surplus or contribution notes or similar obligations;
- (ii) premium refunds on assessable policies;
- (iii) interest on claims of classes one through seven; and
- (iv) any other claims specifically subordinated to this class.

(i) Class nine is claims of shareholders or other owners, including policyholders of a mutual insurance corporation within the limits of Subsection 31A-27-337(4)(b) except as they may be qualified in class three or four.

(3) (a) If the liquidator determines that the assets of the estate will be sufficient to pay all class one claims in full, class two claims shall be paid currently, only after the liquidator secures from each of the guaranty associations receiving disbursements under this section an agreement to return to the liquidator the disbursements, together with investment income actually earned on the disbursements, as may be required to pay class one claims.

(b) A guaranty association entering into an agreement under Subsection (3)(a) may not be required to post a bond.

(4) As to a nonprofit corporation organized and operating under Chapter 7 with assets not fully liquidated under Subsections (1) and (2), the remaining assets shall be distributed under Subsections 16-6a-1405(1)(b) and (c) and Subsection 16-6a-1405(2).

(5) (a) If any claimant of this state, another state, or foreign country is entitled to or receives a distribution upon the claimant's claim out of a statutory deposit or the proceeds of any bond or other asset located in another state or foreign country, unless the deposit or proceeds shall have been delivered to the domiciliary liquidator, the claimant is not entitled to any further distribution from the liquidator until and unless all other claimants of the same class, irrespective of residence or place of the acts or contracts upon which their claims are based, shall have received an equal distribution upon their claims.

(b) After the equalization under Subsection (5)(a), the claimants of the same class are entitled to share in the further distributions by the liquidator, along with and like all other creditors of the same class, wherever the claimants reside.

(6) Upon the declaration of a distribution, the liquidator shall apply the amount of the distribution against any indebtedness owed to the insurer by the person entitled to the distribution. There shall be no claim allowed for and deductible charged by a guaranty association or entity performing a similar function.

(7) This section applies retrospectively to any proceeding under this chapter initiated after January 1, 1992 1990

31A-27-335.5. Health maintenance organization claims.

In the liquidation of a health maintenance organization, claims for uncovered expenditures have priority over the third class of claims as provided for in Section 31A-27-335. All other claims shall follow the priority of distribution outlined in Section 31A-27-335 1995

31A-27-336. Liquidator's recommendations to the court.

(1) The liquidator shall review all claims duly filed in the liquidation and shall make any further investigation as he considers necessary. He may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court, except where the liquidator is required by law to accept claims as settled by another person, including a guaranty fund or association. Unresolved disputes shall be determined under Section 31A-27-332. As soon as practicable, the liquidator shall present to the court the reports of claims against the insurer with the liquidator's recommendations. The liquidator shall notify claimants of these recommendations. The report shall include the name and address of each claimant, the particulars of the claim, and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment values and the amounts owed. If the insurer has issued policies on the advance premium plan, the liquidator shall report the persons to whom, according to the records of the insurer, unearned premiums are owed and the amounts that are owed.

(2) The court may approve, disapprove, or modify the report on claims by the liquidator, except that the liquidator's agreements with other parties are final and binding on the court on claims of any size which are settled by a payment of \$1,500 or less. No claim under a policy of insurance may be allowed for an amount in excess of the applicable policy limits. 1985

31A-27-337. Distribution of assets.

(1) (a) Subject to any instructions the court may give, the liquidator shall make distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims.

(b) Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court in advance of the distribution.

(2) (a) The liquidator shall make distributions to guaranty funds and associations under Subsection (1) to satisfy their claims under Chapter 28, Guaranty Associations, or similar laws of other states, if the claims have been filed pursuant to rules established under Subsections 31A-27-328(1) and (4).

(b) The total distributions to guaranty funds and associations paid under this Subsection (2) may not exceed the total of the claims properly made by the funds and associations under Subsections 31A-27-328(1) and (4).

(c) The liquidator shall pay distributions as frequently as is practicable and in sums as large as possible without sacrificing asset values by untimely disposition or inequitable allocation of available assets.

(d) The liquidator may protect against inequitable allocations by making payments to funds and associations subject to binding agreements by the funds or associa-