NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 12/12/22

Virtual Meeting

RECEIVERS' HANDBOOK (E) SUBGROUP
Wednesday, December 21, 2022
12:00 – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 a.m. – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

ROLL CALL

Kevin Baldwin, Chair	Illinois	Leatrice Geckler	New Mexico
Miriam Victorian, Vice Chair	Florida	Donna Wilson/Jamin Dawes	Oklahoma
Joe Holloway	California	Laura Lyon Slaymaker/ Crystal McDonald	Pennsylvania
Jared Kosky	Connecticut	Brian Riewe	Texas
James Gerber	Michigan		

NAIC Support Staff: Sherry Flippo

AGENDA

1. Adopt the minutes from July 19, 2022—*Kevin Baldwin (IL)* — Attachment A
2. Consider adopting Chapters 3, 4, & 5 of the *Receivers' Handbook for Insurance Company Insolvencies—Kevin Baldwin (IL)* — Attachments B
3. Consider exposing Chapters 6 & 7 of the *Receivers' Handbook for Insurance Company Insolvencies—Kevin Baldwin (IL)* — Attachment C
4. Discuss Any Other Matters Brought Before the Subgroup —*Kevin Baldwin (IL)*
5. Adjournment

Draft: 7/20/2022

Receiver's Handbook (E) Subgroup
Virtual Meeting
July 19, 2022

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met July 19, 2022. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Miriam Victorian, Vice Chair (FL); Joe Holloway (CA); James Gerber (MI); Leatrice Geckler (NM); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brian Riewe (TX).

1. Adopted its Nov. 19, 2021, Minutes.

The Subgroup met Nov. 19, 2021, and took the following action: 1) adopted its June 14, 2021, minutes; 2) and exposed Chapter 1 and Chapter 2 of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook).

Ms. Slaymaker made a motion, seconded by Mr. Holloway, to adopt the Subgroup's Nov. 19, 2021, minutes (Attachment 1). The motion passed unanimously.

2. Adopted Revised Chapter 1 and Chapter 2 of the Receiver's Handbook

Mr. Baldwin thanked the volunteers who had participated in the drafting groups for the chapters of the Receiver's Handbook. Sherry Flippo (NAIC) summarized the changes to Chapters 1 and Chapter 2 based on the exposure period.

Ms. Victorian made a motion, seconded by Ms. Slaymaker, to adopt Chapter 1 and Chapter 2 of the Receiver's Handbook with the revisions from the exposure period (Attachment 2, Attachment 3, and Attachment 4). The motion passed unanimously.

3. Exposed Revised Chapter 3, Chapter 4, and Chapter 5 of the Receiver's Handbook

Chapter 3, Chapter 4, and Chapter 5 had extensive revisions and were presented in the meeting materials as a clean copy. To view the original Receiver's Handbook, the current Receiver's Handbook version is posted on the Subgroup's website under the documents tab.

Ms. Victorian made a motion, seconded by Ms. Geckler, to expose Chapter 3, Chapter 4, and Chapter 5 of the Receiver's Handbook (Attachment 5) for a 30-day public comment period ending Aug. 19. The motion passed unanimously.

Having no further business, the Receiver's Handbook (E) Subgroup adjourned.

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CHAPTER 3—ACCOUNTING AND FINANCIAL ANALYSIS

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I. INTRODUCTION: OBJECTIVES OF THE ACCOUNTING FUNCTION

The purpose of this chapter is to identify and explain the various objectives of the accounting function for an insurer in receivership and provide guidelines for the preparation of reports summarizing the financial position of the receivership.

It is important to highlight the context or perspective from which this chapter was prepared. Any accountant serving a receiver is, by necessity, an integral part of a team of regulatory, legal, actuarial, and other professionals working together to achieve common goals. The nature of these goals is described at length in Chapter 1—Takeover & Administration. In most receivership situations, the duties of the receiver's accountants, investigators, and attorneys will overlap when information about a common topic such as a reinsurance treaty is needed by staff members. While these other individuals have a legitimate interest in accounting and financial information, this chapter has been prepared from the perspective of the accountant serving the receiver.

This chapter will deal with the following issues:

- The objectives of the receiver and how they may vary from the traditional accounting objectives of a going concern.
- The need to gain an understanding and control of the impaired or insolvent company's bank accounts and assets.
- The importance of evaluating the impaired or insolvent company's accounting staffing and consulting needs early on in the receivership, as well as the need for assistance from certified public accountant (CPA) or actuarial firms to do projections, forensic accounting, and tax reporting.
- The need to inventory and safeguard documents, ledgers, contracts, and other financial items that will shed light on the financial position of the insolvent insurer and provide support to the receiver in collecting assets, settlement of balances, litigation, and other matters.
- The need to focus on the corporate structure of the enterprise, the importance of analyzing related-party transactions and intercompany accounts, and consideration of restructuring certain transactions.
- The need to identify and scrutinize tax issues, including necessary informational filings with the IRS (such as 1099s), various areas of tax exposure, premium and payroll tax consequences, and other taxes.
- Considerations related to the nature of the insolvent insurer's investments and safeguarding and valuing the investment portfolio.
- Considerations relating to direct and assumed reinsurance premium receivables, including the need to identify and control treaties, to determine if in-force treaties should be maintained or cancelled, and to quantify setoffs and other issues. Consideration should also be given to ceded reinsurance receivables and the identity of the various lines of business and policies ceded to other insurers. Insurers often have excess of loss or stop-loss reinsurance where recoveries of amounts due the health maintenance organization (HMO) should be investigated.
- The need to prepare financial statements and related information in a format that will support the receiver directly in managing the affairs of the estate and in responding to the needs of various third parties, such as state insurance departments, the courts, guaranty funds, policyholders and other creditors, attorneys, and other parties.
- The need to review and understand the various cost centers and associated expenses and contracted services.

The overall objective of the accounting function in receivership can be expressed as follows:

> **To assist the receiver in securing control of the insurer's assets and to provide timely, relevant, and accurate financial information as to the assets, liabilities, surplus (deficit), and cash flow of the insolvent insurer to support the duties of the receiver, and to assist in making economic decisions.**

The sections that follow will discuss the points above in more detail as they relate to the overall objective of the accounting function in a receivership.

II. OBJECTIVES DIFFERENT THAN GOING CONCERN

In many respects, the overall accounting function objective discussed above is equally fitting for the accounting function of a going concern. However, the important phrase that distinguishes this objective for receivership is "to support the duties of the receiver."

For solvent insurers, the accounting function is generally designed to support management and to fulfill the insurer's responsibility to report information to shareholders, creditors, taxing authorities such as the IRS, regulatory authorities such as state insurance departments, and others. The purpose of this information is to allow these parties to monitor the insurer's financial operations and protect their interests (e.g., investment, loan, or tax obligations). The accounting system may be designed to support reporting on the basis of both U.S. generally accepted accounting principles (GAAP) and statutory accounting principles (SAP) prescribed or permitted by the insurer's state of domicile.

For an insurer in receivership, the situation is different. The state insurance regulator has already determined that the insurer is in an impaired or insolvent financial position. A receiver has been appointed. For an insurer in rehabilitation, the objective may be to identify the causes of the impairment, eliminate them, and work to return the insurer to a solvent position. Alternatively, it may be determined that a successful rehabilitation is not achievable, in which case an order of liquidation will be sought. For the insurer in liquidation, the objectives are to identify and marshal the assets of the insurer; identify and evaluate liabilities and determine the appropriate class of each creditor in accordance with the domiciliary state's priority of distribution statute; and liquidate the insurer in a manner that minimizes the cost to policyholders, state guaranty funds, and other creditors.

Thus, the new and important user of the financial information is the receiver. In rehabilitation, pro forma reporting is often used to help the receiver assess the feasibility of potential transactions that have been proposed to mitigate the surplus deficit. Additionally, liquidation-basis accounting becomes an important form of reporting to help the receiver assess the realizable value of the assets of the insurer and the extent such assets will be available and sufficient to cover approved claims of policyholders and other creditors.

It is important to understand the difference between the responsibilities of the receiver and those of former management. In a going concern, management has the responsibility to develop internal controls and procedures covering a variety of items such as payroll, transfers to affiliates, reinsurance balances, etc. However, the receiver will review and perhaps revise these internal control procedures. The receiver will approve disbursements; revise wage and salary schedules (especially for excessive amounts payable to officers); streamline the organizational structure if needed; and place a moratorium on payments to reinsurers, related parties such as the insurer's affiliates and others, pending a complete analysis of the insurer's financial position.

In some instances, the duties of the receiver and that of management will differ in subtle ways. For example, consider an insurer that has been placed in rehabilitation: The insurer is a wholly owned subsidiary of a publicly held insurance holding corporation. The receiver, by statute and court order, has responsibility and authority only for the affairs of the insolvent insurer/company subsidiary. Thus, the accountant working with the receiver may assist in or direct the preparation of financial information relating to the insurer/subsidiary that may ultimately be provided to and used by management of the holding company/parent to prepare its filings with the U.S. Securities and Exchange Commission (SEC) or consolidated tax returns for the IRS. However, it is generally not the

responsibility of the receiver or his or her accountant to prepare or file such documents that relate to the holding company.

It is not uncommon for the receiver to maintain certain of the insurer's key management personnel on staff because of their knowledge of the insurer and their familiarity with its business, reinsurance treaties, data processing systems, and various other matters. The receiver should ensure that such staff be sensitive to the new responsibilities created by the order of rehabilitation or liquidation. It is unlikely that these individuals have ever been through a receivership before and may unknowingly perform their duties as if it were business as usual, not realizing that the receiver now must be informed of, and approve, procedures and disbursements. Additionally, the receiver should identify those individuals who may conceivably have an interest in concealing or altering information because of their concern about their role in the events that may have precipitated or contributed to the insolvency.

The principal responsibility of the accountant is to the receiver. However, the accountant should be aware that the receiver must provide certain financial information to other parties, including (in no particular order of importance):

- Domiciliary state insurance department.
- Other insurance departments in states where the insurer is licensed.
- The receivership court, other state courts, or federal courts.
- Creditors, including banks, premium finance companies, providers of health care (if an HMO), and reinsurers.
- Shareholders.
- Federal, state, and local taxing authorities.
- State guaranty funds, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), or the National Conference of Insurance Guaranty Funds (NCIGF)
- Policyholders.
- Prospective investors.
- Other regulatory agencies, such as the SEC.
- Legislatures (state and federal).
- State and federal agencies responsible for Medicaid/Medicare (if an HMO).
- Reinsurers.
- Agents.

Financial information for a receivership is similar to that of an ongoing enterprise with some important differences. These include the following:

- The need to identify and provide for various classes of creditors pursuant to the domiciliary state's receivership priority statute. The receiver's accounting system should be capable of capturing information provided by creditors on proofs of claim in order to review and adjust those claims and to aggregate them by creditor class.
- Reinsurance recoverables must be viewed from a different perspective, particularly ceded unearned premium for property and liability companies. In a going concern, a ceding insurer would not expect to

receive ceded unearned premium. However, when reinsurance is not renewed, the ceded unearned premium recoverable can be quite substantial if the termination clause of the contract is written on a cut-off basis. In a runoff situation, the insurer would have reinsurance until the ceded premium ran off.

- Setoffs are another reinsurance issue that should be identified and reviewed to determine if they are acceptable under the applicable state receivership statutes. Setoffs (often referred to as "net accounting" in going-concern accounting) frequently occur in reinsurance transactions and may involve setoff of amounts within a contract. These may include premiums due to the reinsurer from the ceding insurer set off against recoverables for paid losses owed by the reinsurer to the insurer, setoff of balances under two or more contracts with the same two entities, or setoff of amounts owed to or from different ceding insurers and/or reinsurers that have been set off by a reinsurance intermediary or broker, usually on a monthly or quarterly net reporting basis to the insurer. If necessary, setoff transactions will need to be recast or set aside. (Note: Identification of setoffs is an accounting function. The receiver's counsel should address the legality of identified transactions. See Chapter 9—Legal Considerations for discussion of setoffs.)

- The need to separate any commingled assets and liabilities of the insurer from entities affiliated with the insurer, such as the parent corporation, other subsidiaries or affiliates, and employee benefit plans.

- The need to identify transactions that are significant to the receiver because of the potential for recovery from third parties, as well as the possible institution of criminal proceedings. Generally, these may include transactions with affiliates or officers and directors, for example, and preferential payments made within statutorily prescribed periods. (See Chapter 9—Legal Considerations.)

- The need for a clear cutoff date in the accounting records to establish a beginning balance sheet that represents the point at which the receiver has become accountable for the financial affairs of the insurer.

- Payments for pre-receivership transactions may be suspended pending review by the receiver. It is also important to immediately change company procedures and implement controls to assure that the insurer's assets are not disbursed unless approved by the receiver or his representative. The receiver may wish to consider placing a stop order on outstanding checks, both claims-related and administrative.

- The need to recognize differences between liquidation accounting and statutory accounting practices followed by the insurer as a going concern. For example, certain assets of the insurer—such as furniture, equipment, and overdue agent balances—may not be admitted for statutory accounting. An HMO's membership may also have potential value that is not admitted for statutory accounting purposes. Nonetheless, in a receivership, they should be considered for possible collection or sale, even if they are not considered in evaluating the solvency of the insurer.

- The need for preliminary assessment of the causes of the impairment or insolvency, with an analysis of whether any parties have potential civil or criminal liability for their role in causing the insolvency. (See Chapter 4—Investigation and Asset Recovery.)

- The need to challenge, with an appropriate degree of professional skepticism, the adequacy of the insurer's personnel who may be retained by the receiver, and assess skills, loyalties, and potential conflicts of interest that they may have because of their roles in, or knowledge of, events that precipitated or contributed to the receivership.

III CASH AND LIQUID INVESTMENTS

A. Cash

The receiver must determine the existence, location, and amount of all cash, cash equivalents, and short-term investments through direct confirmation with financial institutions, investment managers, and other parties thought to be holding cash, cash equivalent, or short-term investments. The insolvent company's financial management should be able to provide a listing of financial institutions and contacts.

The receiver should immediately determine who has access to the cash and investments and should consider changing or restricting this access. In this era of electronic banking, Internet banking access should be closely scrutinized. Administrative controls of Internet banking should be evaluated by the receiver as soon as possible and modified as necessary. If the company holds cryptocurrencies, access to the cryptocurrency wallet and any associated hardware should be restricted. Large amounts of cash can be removed from an estate via wire transfer. Procedures should be established with the financial institutions to curtail or limit access regarding wire transfers. Wire transfer capabilities must be limited to receivership staff immediately upon receipt of a receivership order. Operations of the insurer may be affected temporarily, but that situation pales in comparison to allowing large amounts of money to be wired out of an estate.

All financial institutions should be notified immediately of the receivership order. A receivership order should be faxed or emailed to the contact person at each financial institution, and a proof of service should be signed by an appropriate financial institution representative as corroboration that the financial institution received the order. Some receivers, especially in liquidation, advocate immediately closing all existing bank accounts to ensure complete control of cash. The receiver should also consider whether to continue relationships with the banks used by the insurer or to establish new accounts with only the receiver or their designated representatives having signatory authority to disburse funds. The receiver must decide whether to allow certain checks to clear, as a disruption in payments to claimants may cause hardship, lead to complaints, and would be viewed negatively by regulators. Another consideration associated with account closure is the magnitude of penalties and interest that would accompany any substantial delay in payments.

A letter should be sent that gives the bank or other financial institution instructions with regard to allowing or not allowing checks to clear the account. As soon as possible, signatories on bank accounts should be changed to the receiver's designated personnel.

All check stock should be inventoried and bank accounts reviewed to determine which accounts are related to the insurer's business and which accounts, if any, are still needed. If bank accounts are closed, the related check stock should be voided and destroyed. If the accounts are required, an appropriate protocol needs to be established between the banking institution and the receiver. The normal practice would be to freeze all accounts or, at a minimum, the signatories should be changed to individuals on the receiver's staff.

The receiver may consider moving out-of-state assets into the domiciliary state to improve control and lessen the chance they may be subject to attachment by creditors. This step should be completed as soon as possible after the liquidation order is filed with the court. If an ancillary receivership is established, the receiver should work in conjunction with the ancillary receiver when moving assets out of the ancillary state.

Special care should be applied to the identification of accounts not held in the insurer's name but to its benefit. Bank statements, investment statements, cash ledgers, and cash-flow statements should be reviewed. This process should also include any funds held as collateral, letters of credit (LOCs), or other restricted cash.

Credit or debit cards in the company name should be gathered and secured in the same manner as cash. Determine if there are recurring charges on the card and if those recurring charges need to be continued or can be canceled. If the cards are no longer needed, consider canceling the cards. Credit or debit cards are often kept in the accounting or human resources department but could exist in other areas of the company.

A company may also have recurring charges set up as Automated Clearing House (ACH) transactions. Review all accounts for recurring charges so they can be canceled as appropriate.

Some companies will have gift cards or prepaid debit cards (for example Visa- or American Express-branded prepaid cards) that have been purchased for agent/broker incentives, employee incentives, or wellness incentives. These cards may not be accounted for in the company's general ledger and could potentially be kept by many different departments of the company. They should be gathered and treated in the same manner as cash.

B. Liquid Investments

Determine the existence, location, amount, and type of liquid securities (bonds, stocks, mortgage loans, etc.) through direct confirmation with financial institutions, investment managers, and other parties thought to be holding securities. Investment statements from financial institutions, portfolio statements from investment managers, and other similar reports should be secured and used to establish a balance as of the receivership date.

As with cash, company personnel should provide a list of brokerage houses, financial institutions that have custody of investments, and related contact names. All institutions having custody of the insurer's investments should be sent a copy of the receivership order. The brokerage house or financial institution should be given instructions by cover letter that only receivership staff is authorized to buy or sell investments. The receiver should be aware of who has access to the investments and who had the authority to direct the investment managers/brokers. Once again, the investment managers/brokers should only take direction from the receiver.

The receiver should determine whether any of the liquid investments are hedged and who the counterparties are, as well get a description of the entity's hedging program.

Sometimes it is easier for the receiver to transfer securities to a financial institution with which they are familiar. Doing so facilitates transactions, as sales can be efficiently executed to maximize the value to the estate, after obtaining the appropriate advice about the most advantageous time to liquidate a security.

IV. INITIAL REVIEW OF FINANCIAL STATEMENTS AND PROJECTIONS

It is imperative that the receiver's accountants perform an initial review of the financial statements that had been produced by the company as soon as possible. Obviously, these financial statements should be viewed with a heavy dose of professional skepticism. However, the receiver's accountants can usually garner a lot of information from company accounting personnel. The receiver's accountants must use professional judgment in determining the accuracy of the information provided by the company or whether further investigation/confirmation is required. In either case, it is critical that the receiver's accounting staff perform an evaluation of the company's surplus and cash position in the first few months (or sometimes weeks) of a receivership. The receiver's accountants must provide this information to the receiver so that objective decisions regarding the company's rehabilitation or liquidation may be made.

The receiver's accountants should obtain the last published statutory quarterly or annual statement that the company filed. If the company is an unauthorized entity or it did not file financial statements, internal financial statements will have to suffice (preferably financial statements that were audited or reviewed by an outside CPA firm). The receiver's accounting staff can use these statements as a starting point for surplus and cash projections. Another source for financial statements is those prepared by insurance department examiners. If the entity is publicly traded, get copies of the latest 10-K and 10-Q at *https://www.sec.gov/edgar.shtml*.

Admittedly, the analysis of a company's cash or surplus position in the early stages of a receivership is not an exact science. In addition to calculating anticipated receiver administrative expenses, the following measures should be incorporated to make projections and analysis more meaningful:

- Confirm that bank reconciliations are brought up to date.
- Review anticipated premium income. Look at recent premium written reports, and review the timing of any anticipated policy cancellations or non-renewals.
- Review any capitation arrangements, contracts with hospitals and doctors, and the federal Centers & Medicare and Medicaid Services (CMS) for all approved plans.
- Review recent claims and loss adjustment expense (LAE) payment history to use as an estimate for the future claims liability of insurers in receivership.
- Claims payments should begin to decrease after policies are cancelled (if applicable).
- Review all active reinsurance treaties, especially for the current treaty year. Ceded reinsurance is especially important for property and liability companies.
- Review recent large expense payments such as rent, commissions, legal expenses, etc.
- Review potential voidable preferences.
- Review monthly investment income and sources generating the income.

V. INVENTORY AND DESCRIPTION OF ACCOUNTING RECORDS

A. Inventory of Accounting Records

As soon after the takeover of an insurer as is practicable, the receiver should identify and secure the books, records, systems, and documents that are necessary to maintain and review the accounting functions of the insurer. Familiarity with the preexisting accounting processes and related accounting records and their location will help the receiver prepare for the many other tasks that will follow. The receiver may find that accounting processes should be consolidated, streamlined, or simplified, particularly for insurers in liquidation. A thorough knowledge of the preexisting accounting systems is an integral step in identifying those systems that can be eliminated or simplified. Furthermore, such knowledge will greatly assist in the investigation and asset recovery processes, which are discussed in the next chapter.

This section summarizes and describes the preexisting accounting records that are typically maintained at various locations of the insurer and/or at affiliated and nonaffiliated entities. This chapter should be read in conjunction with Chapter 1—Takeover and Administration, Chapter 2—Information Systems, and Chapter 4—Investigation and Asset Recovery, which may identify additional records and functions that may be useful to the receiver.

Types of documentation vary, but one thing is certain: The records of an insurer that has been placed into receivership will be, or at least may seem to be, incomplete, confusing, and, in many cases, inaccurate. To the extent systems and account balances are undocumented, some documentation may have to be recreated. Work papers of state insurance examiners, outside auditors, and actuaries may be useful in reconstructing records. In addition, existing personnel may be retained by the receiver to assist in this process because of their knowledge of the insurer's operations and systems.

B. Records at the Administrative Office of the Insurer

The administrative or "home" office of the company will, most likely, be the location from which the domiciliary receiver will direct the receivership. The bulk of the insurer's financial and accounting records usually are located and maintained at the home office. However, the domiciliary receiver should be aware

that the company records may also be located at third-party administrator (TPA), managing general agent (MGA) and branch offices.

The following is an overview and brief description of accounting records that the receiver should attempt to locate and secure. If documentation of this nature does not exist or cannot be located, special effort may be required to understand how the financial data was compiled.

1. Organizational Chart of the Accounting Department, Flowchart of Accounting Process, Procedure Manuals, and Chart of Accounts

An organizational chart may give the receiver an overview of the organization, including the accounting department. It may identify the various functions (e.g., cash accounting, underwriting accounting, reinsurance accounting, etc.) of the accounting department and the individuals responsible for those functions. It can also indicate the reporting hierarchy and help assess the adequacy of segregation of duties consistent with sound internal control practices.

A flowchart of the accounting process might describe what action is taken for the significant functions or accounting processes. The flowchart may summarize the route of the original accounting documentation. Most importantly, the flowchart may well identify the key records relied upon to record financial information; when, how, and by whom it is entered into the accounting records; and how and by whom the resulting balance is verified by reconciliation or other procedures. The flowchart may also identify the responsibilities of each significant function in the accounting department. The flowchart may identify controls. The public CPA firm will normally have a process flowchart for the accounting function of the insurer and the controls within that process if not available directly from the insurer. If a flowchart is not available, the receiver may wish to request that one be created to assist in assessing the adequacy of internal controls over the significant accounting processes.

Procedure manuals may exist that describe the duties and functions to be performed by the accounting department. If the accounting system is computerized, the procedure manual of the computer system may describe the process and controls for specific job functions. Procedure manuals may be detailed by job function or by department function. If available, these manuals will assist the receiver in understanding the accounting process. Care should be taken by the receiver, however, because procedure manuals possibly will be incomplete or out-of-date, and they may be unintentionally misleading as to the actual processes currently in place. A walk-through documentation from CPAs/ exams/internal audit of the key systems and/or inquiry of the insurer's personnel will help to confirm the accuracy of such documentation. The degree of the walk-through depends on judgment and internal controls of the insurer.

The chart of accounts should detail the description and purpose of all general ledger accounts. The chart (a manual) of accounts may be a useful tool, especially to an external auditor. Again, care should be taken because account titles and descriptions may not reflect their true nature or use in practice by management. Typically, accounts are numbered in sequential order using the following convention:

- Assets.
- Liabilities.
- Surplus accounts.
- Income accounts.
- Expense accounts.

2. Accounting Records, Including the General Ledgers and Supporting Schedules

The receiver should find a complete set of records at the home office. The general ledger provides a listing of the dollar amounts in each of the accounts in the chart of accounts. The amounts in the general ledger may be posted on a monthly or quarterly basis. Automated and interfaced systems may post to the general ledger on a daily basis.

Depending on the size of the company and the type of reporting system, the general ledger listing may include:

- A transactional listing that reflects, by account, the items posted to that account by period entered. The period entered and supporting schedule may allow the receiver to locate the "support" or underlying documentation for the entry. This information will be valuable in the audit procedures.

- A journal entry listing that specifies, by period, the accounts and amounts affected by the entry. When a transaction from one particular account has been identified for investigation, this listing will allow the receiver to determine the other accounts affected and the amount.

The accounting records will provide details of balances that are summarized and posted in the general ledger. Some of specific detailed schedules that may be found at the insurer are:

- Investments.

- Agents and/or insured balances.

- Funds held.

- Premiums written.

- Reinsurance recoverables.

- Fixed assets (e.g., furniture and equipment).

- Claims paid.

- Claims outstanding (case reserves).

- Contingent commissions.

- Amounts retained for accounts of others.

Accounting records detail the daily accounting activity of the company. The daily cash activity of the insurer is maintained in the accounting records.

3. Accounting Files

Generally, accounting files are maintained by an insurer based on the various accounting functions. Accounting files usually contain original accounting source documentation (check remittance advices, invoices, and purchase orders) or images files of the documentation. The records are all important. The more crucial accounting records are:

- Certificate of deposit files and investment.

- Cash.

- Agents' and producers'.
- Contingent commission.
- Claim.
- Reinsurance.
- Federal, state, and local tax.
- Accounts payable.

The insurer may have several years of accounting files on the premises and keep the older accounting files/backups at a warehouse location. A records retention policy for the insurer may be available from the chief accounting officer. It is important to suspend any document destruction.

The investment accounting should support the investment transactions of the insurer. Included in the files should be broker slips, bank advices, and custodian statements. If the investment accounting is held by a custodian or asset management firm, the receiver should notify them of the receiver and request records. Monthly reconciliations of the custodian statements/files to the related general ledger account balances may also be found here. For more information on investment files, see Section IX on investments in this chapter.

Cash contains records often from bank lock boxes of cash receipt and disbursement that support the cash entries made on a daily basis. Deposit records, checks or checks images, wire transfer information, and records of disbursements may also be found in these files. In addition, banking records—such as authorized signatory lists, wire transfer instructions, sweep account information (bank orders to transfer daily receipts from depository accounts to investment accountings), and agreements with banks regarding custodial and other matters—may also be found here.

Agents' and producers' records should contain copies/images of the statements and billings to those entities for premiums written. Statements may be gross or net of commissions. Advance commissions statements and copies of agreements with the agents or producers that detail the rate of commission and the authority of the agent may also be found in these files.

Contingent commission records should contain the computations for any contingent commission or profit-sharing commission paid to agents and producers and the associated agent/producer agreements.

The accounting records for reinsurance ceded by the insolvent insurer prior to receivership should contain the details for any of the insurer's reinsurance transactions. The supporting schedules should contain summaries of reinsurance premiums and loss calculations for each treaty or reinsurer. The records should include: account statements; the reinsurance treaty; and endorsements thereto, including the interest and liability (the percentage participation) endorsement that each reinsurer has signed or a digest or summary thereof.

The documentation that an insurer maintains with respect to reinsurance assumed by the insolvent insurer prior to receivership depends on whether it was acquired directly from the cedent or through a reinsurance intermediary.

The direct method of acquiring assumed reinsurance may generate more documentation on the insolvent's end because the direct method generally requires an internal function to solicit or accept business from cedents. On the other hand, the broker market method may not require maintenance of an in-house reinsurance underwriting function because this role is assumed by the intermediaries. Therefore, only bordereaux or other summary information may be found at the reinsurer's offices.

Nonetheless, the receiver may want to determine that the documentary information maintained by the ceding company or intermediary supports the bordereau.

Tax records (federal, state, local, and payroll) should contain the tax returns that have been filed with each jurisdiction. The records may contain reference to the original source information. The tax issues section of this chapter (Section VIII) has more information on taxes. Copies of filed returns may also be found in the general corporate records, with independent accountants or legal counsel, or can be obtained from the IRS.

Accounts payable records should contain vendor invoices, identification, invoice date, date approved, and date paid.

4. Contracts and Agreements

The accounting, underwriting, or corporate legal department may be the custodian of agreements or copies of contracts into which the insurer has entered for insurance and general business operations. The agreements frequently may be referred to by the accounting department to assure that related transactions are authorized, recorded correctly, reported between the parties, and reconciled.

The contracts and agreements may include: real estate leases, furniture and equipment leases and maintenance agreements, information technology (IT) equipment leases, software licensing agreements, bank custodial agreements, hedging agreements, real estate management agreements, mortgage loan servicing agreements, trust funds, investment service, payroll service, management service, and allocation of federal income tax and expenses with affiliates. Other contracts related more to the insurance business may include agency contracts (general or managing), claims administration services, producer contracts, reinsurance contracts, interest and liability endorsements, and LOC agreements. For HMOs, it is important that the receiver have a complete inventory of all provider agreements, as well as a listing of all commercial groups with renewal dates and coverages.

Chapter 1—Takeover and Administration has more information on contracts, and Chapter 7—Reinsurance has more information on reinsurance treaties and LOCs.

5. Financial Reports, Filings, and Other Records

The accounting department is the originating department and custodian of financial reports, both for internal use and external compliance. The department may also be the originating department for many analytical reports that are used by management, although such reports may also originate from other departments, such as claims or underwriting. Filings for compliance with governing jurisdictions may also be the responsibility of the accounting department.

A list of reports that are produced periodically and a schedule of required filings may be available from the controller. Otherwise, the receiver should discuss what reports and filings are produced and available with the chief financial officer (CFO).

The financial reports that the insurer should have readily available include: NAIC annual statements, NAIC quarterly statements (if required), and all supplemental exhibits that are part of these documents. The last page of the annual statement under "Supplemental Exhibits and Schedules Interrogatories," if properly completed, reports the exhibits that should be filed. In addition to the reports, the accounting department maintains records and the supporting schedules that identify sources of data and reconcile the reports to the source.

Other external financial reports that may be found in the accounting department include: insurance department financial examination reports, actuarial reports and opinions, and CPAs' audit reports. Along with these reports, the receiver should request related correspondence files (CPA management letters and management responses to the reports). If the insurer's stock is publicly traded on a stock

exchange, the insurer is required to file an annual report and various interim documents with the SEC; i.e., 10K and 10Q for U.S. markets, which are available at: *https://www.sec.gov/edgar.shtml*. These are complex filings that may require involvement of outside counsel and/or external auditors.

The accounting department may also be involved in periodic rate filings made with insurance departments. Folders may be available that support the rate change requested. Responsibility for rate filings and approvals may rest with the legal or underwriting department.

Some insolvent or financially troubled insurers have internal audit departments. The receiver should request a listing of all internal audit reports issued and any internal control procedure documents.

C. Accounting Records at Other Locations

1. Branch Offices

Branch offices of an insurer may operate independently of the home or main administrative office. However, the branch offices usually use the same computer system, or they upload data daily to the main office. Branch authority, method of operation, and procedure manuals should be in place both at the home office and with the branch manager.

The branch may have limited authority to carry out only certain insurance functions; i.e., either underwriting, claims adjusting, or both. In such instances, the accounting records at the branch will be limited. The branch office may have claims folders and underwriting folders with original documents.

2. Claims Offices

The claims offices facilitate the adjustment and settlement of claims. As such, each claims office should maintain open claim files for losses in its respective region. The receiver should collect any checkbooks that the claims office has on-site. Closed claim files may have been returned to the administrative office.

3. Off-Site Storage

Many insurance departments and/or insurers themselves require that copies or duplicates of essential records be maintained at an off-site location for the purpose of reconstruction in the event the records are lost or destroyed at the primary location. If this procedure is followed by the insurer, duplicates of records that cannot be located at the primary location might be found at the off-site storage. The off-site storage may also be the location of periodically stored computer backups for the same purpose. Old files (e.g., accounting, claims, underwriting, etc.) and other records may also be in storage. The off-site storage may be a branch office of the insurer or a contracted warehouse. An inventory list of records at the off-site storage location may be available from the controller or CFO. Review the inventory and compare with any retention policies.

D. Records at Offices of Other Parties

1. Managing General Agent

The types of records to be found at the offices of the MGA will depend on the authority of the MGA. If the MGA has the full powers of the insurer—including accounting, underwriting, rate filings and reinsurance—then all related accounting records, as previously described, may be at the MGA's office. If the MGA has limited authority, then only records that pertain to the specific function will be in the MGA's office. The insurer may have duplicate copies of some of the records at its main administrative office, although these frequently include only summarized reports or bordereaux.

2. Third-Party Administrators

TPAs should maintain sufficient records to perform their assigned function. Authority from the insurer may be necessary before any action is taken by the TPA. Alternatively, certain limited discretionary authority may be granted in the agreement with the TPA. Copies of written authority granted should be available from the insurer and/or the TPA.

3. Reinsurance Intermediaries

The intermediary should have in its office copies of reinsurance treaties, interest and liability agreements, endorsements, lists of reinsurer participations, files on LOCs, and historical records on premiums paid to and losses collected from the reinsurers. Reinsurance intermediaries should also have details to support the balances due, including details of amounts set off.

4. Agents and Brokers

Both agents and brokers will have files for policies that have been issued to insureds. Agents and brokers periodically (monthly) submit to the insurer a list of policies that have been issued. The agents and brokers may be responsible for the collection of premiums. In such instances, the insurer will bill them for the premiums due. Otherwise, the insurer bills the insured directly.

Producers are compensated by a commission on the premiums written. If the insurer uses the direct billing method, the agent or broker may have been paid an advance commission until the premium is collected from the insured. Otherwise, the insurer may bill the agent or broker on a basis net of the commission due. The insurer may also require the producers to pay the full amount of the premium. In turn, the insurer will pay the commission. Producers will have records of all business placed with the insurer.

5. Department of Insurance

Insurers are required to file numerous documents with the insurance department of the state of domicile and/or other states where the insurer is authorized to transact business. The receiver may consult legal counsel, state statutes, or the department's staff for specific state requirements. In addition to the annual, and possibly quarterly, statements and financial and market conduct examination reports, the following documents may be on file with the insurance department: contracts (reinsurance, agents, management, investments, etc.), dividends payment approvals, holding company and related party transaction approvals, rate filings, minutes of meetings, and biographical affidavits of officers and directors.

The insurance department examiners, as part of the documentation for support of their findings, may have photocopied certain documents, flowcharts, procedure manuals, or other materials that may be of interest to the receiver. The copies would be found in the examination workpapers that are kept by the insurance department.

6. Certified Public Accounting and Actuarial Firms

The CPA firm that performed the last financial audit may be a valuable source for copies of many of the insurer's documents. As part of their workpapers, the auditors may have copied pertinent documentation from the various accounting files. The auditors may also have documented and flow-charted the various significant functions of the accounting department and their related controls. Similarly, independent actuarial firms may have copies of insurer documents and/or working papers that document the calculation or evaluation of the carried reserves or pricing of business.

7. Banks

Banks may be able to furnish images of canceled checks, check number sequence issued, bank statements, loan files, collateral files, safe deposit box records, and correspondence (signatories and requirements).

8. Internal Revenue Service

The IRS may be a source for the insurer's income tax returns and filed payroll tax forms.

9. Securities and Exchange Commission

If the insurer is regulated by the SEC (publicly traded company or public debt offering), then copies of any documents (10K, 10Q, etc.) filed with that agency may be obtained at SEC.gov | Filings & Forms.

E. Internal Controls

In an increasingly complex business, receivers manage insolvent insurers' investments, accounting systems, and other operations, all of which require close scrutiny and professional care in the safekeeping of the company's resources. If the company under receivership had an internal audit/control department, the receiver should request and review any internal control procedure documents and reports available.

There is currently no requirement that receivers of insolvent insurers prepare a report acknowledging responsibility for establishing and maintaining an adequate internal control structure. Even so, efforts should be made to ensure and promote effective controls. Further, the receiver should determine if, and to what extent, internal controls and other requirements of federal Sarbanes-Oxley Act-type documentation were created and maintained. All such documentation should be reviewed and matched to the processes and procedures observed and analyzed for identification of obvious control weaknesses.[1]

The receiver should consider establishing internal control policies and procedures and then periodically audit to determine compliance with established directives. Documentation of the receiver's accounting staff's evaluation or internal audit will be useful in identifying controls that should be maintained or strengthened, in providing a baseline for ongoing evaluations, and in demonstrating to other interested parties the rationale used in making the assessment.

This section addresses internal controls by identifying the broad functions typically found in a failed insurer.

The evaluation of controls over particular applications depends on the sources of information that flow into the applications and the nature of the processes to which the data are subject. These processes can be viewed as:

Accounting estimation processes: Processes that reflect the numerous judgments, decisions, and choices made in preparing financial statements. Examples of this include the actuarial reserve estimates or tax projections.

Routine data processes: Accounting applications/systems that process routine financial data (the detailed information about transactions) recorded in the records (e.g., the processing of receipts and disbursement transactions, other transaction processing, and payroll).

[1] The federal Sarbanes-Oxley Act of 2002 was in many respects a response to high-profile corporate scandals, but the Act contains corporate governance and accounting regulation concepts that had been proposed even before these scandals became public. Although, in most respects, the Act is directly applicable only to publicly held companies, many Sarbanes-Oxley concepts may eventually be brought to bear on mutual or privately held insurance companies through state regulation, changes in delivery of accounting and auditing services, adaptation of bank lending covenants, insurance and/or reinsurance requirements, and court decisions in state law fiduciary duty litigation.

Non-routine data processes: Other less-frequently applied processes used in conjunction with the preparation of financial statements (e.g., financial statement consolidation procedures, gathering of financial information for special reports, actuarial estimates of reserves, etc.).

In evaluating controls over an application/system, it is important to note that routine data processes generally are subject to a more formalized system of controls because of the objectivity of data and volume of information processed. Conversely, because accounting estimation processes and non-routine data processes typically are more subjective (involving estimates), or because they are performed less often, these processes typically do not have controls at the same level of formality. Consequently, the risk of errors occurring may be greater, and therefore additional scrutiny of the controls may be required.

It is suggested that the approach for evaluating internal controls consider five broad control objectives that affect the reliability of information in the accounts, records and financial statements of the insolvent insurer:

Segregation of duties: Are procedures in place to ensure that employees with the responsibility for recording or reporting transactions do not have custody of the assets on which they are reporting?

Authorization: Are controls in place to ensure that transactions are executed in accordance with the receiver's general or specific authorization?

Access to assets: Are controls in place to ensure that access to assets (including data) is permitted only in accordance with the receiver's authorization?

Asset accountability: Are controls in place to ensure that amounts recorded for assets are compared with the existing assets at reasonable intervals, and that appropriate action is taken regarding any differences?

Recording: Are controls in place to ensure that all transactions are recorded and that all recorded transactions are real, properly valued, recorded on a timely basis, properly classified, and correctly summarized and posted?

VI. AUDIT/INVESTIGATION OF FINANCIAL STATEMENTS

The first step in performing an audit/investigation of an insurer's financial statements is to secure the insurer's cash and investment assets (as discussed above), and then obtain the most recently published financial statement. This may be the most recent annual, quarterly, or monthly financial statement submitted to the domiciliary state insurance department. As discussed later in this chapter, control should be obtained over all automated and manual records of the company, including financial, underwriting and claims records.

Computer systems should be secured at the date of takeover, which includes creating a backup to preserve data at the time of takeover, limiting physical access, changing locks and passwords, and obtaining and taking inventory of all computer disks and related backups. (See Chapter 2—Information Systems.)

All manual records of the insurer, including those at off-site locations, should be inventoried. A central location for all records should be established, and all records should be transported to this location. An electronic inventory system should be created to track the location of records/files.

A review of internal controls should identify the nature and extent of significant problems within the insurer and the segregation of duties. This review should ideally be performed by independent auditors at the beginning of the receivership and on a periodic basis thereafter.

An examination of all accounts as of takeover date and a balance sheet as of the date of receivership may be required for reporting purposes or to support litigation. The balance sheet can be prepared using GAAP-basis, statutory-basis, or cash-basis accounting. The accounting department, insurance department personnel, or independent

accountants may perform this function. The balance sheet should be prepared using the accounts and the general ledger, as well as current bank statements, investment statements, cash reports, and other supporting documents.

The receiver's accountants should obtain workpapers from the last completed audit and/or from the preliminary audit done by an independent accounting firm. These workpapers and any documents or correspondence related to the audit should be reviewed, focusing on restricted assets, related-party transactions, commitments and contingencies, disclosure items, and any other support documentation or unusual items noted. The accountant may be asked to comment on the adequacy of the financial statements opined upon by the insurer's former accountants.

The accountants should also obtain the most recent audited annual statements, SEC reports, 10Ks, 10Qs, filed statutory blanks, and internal audit files and reports, again focusing on restricted asset documentation, related-party transactions, unusual items noted, and internal control studies.

The principal types of assets and liabilities that an insurer could have and the recommended procedures for establishing the balance sheet at the date of receivership and for securing assets on a prospective basis are discussed below.

A. Cash

As addressed in Section III, the existence, location, and amount of all cash, cash equivalent, short-term investments, and cryptocurrencies should be verified through direct confirmation with financial institutions, investment managers and other parties thought to be holding cash or investments. Special care should be applied to the identification of accounts not held in the insurer's name but to its benefit. Bank statements, investment statements, cash ledgers and cash-flow statements should be reviewed. This process should also include any funds held as collateral, LOCs, or other restricted cash. The initial procedures established with the financial institutions regarding wire transfers, as well as the identity of all who have access to the cash and investments, should be reevaluated and further consideration given to changing, restricting, or curtailing this access.

B. Investments

As with cash, the existence, location, amount, and type of liquid securities (bonds, stocks, mortgage loans, etc.) should be confirmed directly with financial institutions, any joint venture managing partners, investment and real estate managers, and other third parties thought to be holding securities. Investment statements from financial institutions, portfolio statements from investment managers, and other similar reports should be secured and used to establish a balance at the receivership date. Purchases, sales, and transfers of any kind, especially recent transactions, should be reviewed, with special attention to related gains/losses. A focus on related-party or affiliate transactions is important, as it could be helpful to the receiver and attorneys. The receiver should be aware of who has access to the investments and the authority to direct the investment managers/brokers. The receiver should consider changing and restricting this authority.

A review of the investment policies should be made and guidelines and procedures established regarding the future investing of securities. State law(s) should be researched to determine if there are any applicable restrictions. Receivers should take into account how they act in a fiduciary capacity, and any investment decisions and guidelines should reflect that. If an investment management firm is controlling allocations according to the investment policy, the receiver should inform them of any difference in the allocations. Allocation of this function between in-house personnel and independent investment services should take into consideration the current dollar amount of investments, projection of future investments, capability of the company personnel, and the complexity of transactions. The receiver should investigate company ownership of derivative and options instruments (see Schedule DB of the annual statement) and obtain a description of the company's hedging strategy.

The market value of investments as of the date of receivership should be ascertained to determine the realizable value of the assets.

Examples of the various types of investments that may be recorded on the insurer's books include:

- Stock
- Bonds.
- Mortgage or asset-backed securities (ABS).
- Short-term investments (e.g., money markets, overnight deposits). (See cash above.)
- Government securities.
- High-yield, high-risk bonds.
- Mortgage loans.
- Joint ventures.
- Partnerships.
- Investments in subsidiary, controlled, or affiliated (SCA) entities.
- Real estate.
- Companyowned automobiles.
- Other assets, including health care-related receivables (for health-related receiverships).

The receiver should also be aware of the risks associated with the various investments recorded on the books of the insurer and should consider liquidating high-risk investments in favor of more conservative investments. Certain risks can be defined as:

- Credit risk
    - The risk that default may occur on an obligation.
- Market risk
    - The risk that values are affected adversely by changes in interest rates or similar type price changes.
- Liquidity risk
    - The risk that the ability to sell investments readily has diminished, resulting in an inability to generate cash to pay off obligations.
- Off-balance-sheet risk
    - The risk that a potential loss may occur in excess of the amount recorded on the financial statements. This loss may be related to guarantees or commitments entered into by the insurer with respect to a particular investment.

The insurer may have entered into hedge transactions or other sophisticated investment contracts; the receiver should have an understanding of these arrangements before undertaking any transactions relating to them.

C. Real Estate

Determine the existence, the location, and the amount of related mortgage/debt and/or income from properties. Obtain any real estate-related management contracts. Consider obtaining current valuation of the properties through an appraiser or based on current market conditions. Transactions should be identified and quantified with related parties or affiliates on recent transactions within the voidable preference period. Management of existing properties should be reviewed by the receiver. The bank/lender holding related mortgage/debt should be notified of the receivership. If any of the real estate is held in a joint venture/partnership, obtain and review the joint venture/partnership agreements.

D. Reinsurance Recoverables

A present-day evaluation of the collectibility of reinsurance recoverables should be performed by the receiver based on current balances, aging of recoverables, and valuation of allowance for doubtful accounts by reinsurer. The processing of claims by the guaranty funds and the reporting of paid losses should be monitored by the receiver for adherence to protocols regarding completeness and timeliness and the effect of delays on its ability to collect reinsurance recoverables. (See Chapter 2—Information Systems and Chapter 6—Guaranty Funds.) Further, consideration should be given to whether ceded reinsurance premiums should be paid and the legal effect of refusal to pay. In the context of a life and health receivership, the receiver should be mindful of the guaranty associations' right to elect to continue reinsurance in accordance with Section 612 of the *Insurer Receivership Model Act* (#555) and Section 8(N) of the *Life and Health Insurance Guaranty Association Model Act* (#520), as adopted in the states.

A receiver should, as part of their evaluation of all reinsurance contracts, determine if there is a contingent commission component and if so, find out whether the estate qualified and received any present or future contingent commission.

Most reinsurance contracts reward contingent commission by way of the ceding commission; i.e., if the loss ratios are within the contract terms that trigger the contingent commission, it typically would be reflected in an increase in the percentage on the ceding commission.

E. Prepaids

Identify prepaid assets, which could include insurance coverage, taxes, pension benefits, etc. If a prepaid asset relates to property insurance coverage, cross reference the insured property to the real estate section, making sure that the property has been identified and recorded under the real estate section. Focus on any prepaids for services from related parties and affiliates.

F. Agents' Balances

Review agents' balances, focusing on additional information that should be recorded on the books of the insurer versus the agents' books. Examine agreements and commissions, and check for unlawful setoffs, evidence of broker funding, and other netting activities. Investigate any advance commissions, or bonus or delayed payment arrangements with agents. Consideration should be given to lags in the reporting of premium (and thus exposures), particularly when MGAs, TPAs, or multiple agents/brokers are involved. Particular attention should be paid to determine if there are any unearned commissions due to the cancellation of policies caused by the liquidation. Often the agency agreement makes the agent responsible for collection of premium. Under those agreements, if the agent is carrying an account receivable for uncollected premium and the amount of the uncollected premium has not already been paid to the insurance company, the receiver can demand that the agent make payment for the premium even though it has not been collected by the agent. Agent agreements also vary as to the terms for collection of audit premium. Some make the agent responsible for collection of audit premium, while some leave audit premium collection to the insurer. If the audit or audit collection responsibility lies with the agent, the receiver will want to enforce that, at least to the extent that the agent actually collects audit premium. Whether premiums

are to be remitted to the receiver in gross or net of commissions is an issue of state law that should be resolved by the receiver in consultation with counsel.

G. Loans or Advances to Affiliates or Agents

Determine whether any receivables have been written off without an effort to collect.

H. Personal Property

Obtain a complete inventory of all personal property, such as furniture, fixtures, and equipment, including any depreciation schedule. Care should be taken to verify that the insurer is the owner of these assets as opposed to an affiliate or another entity. For example, some assets may be leased as a form of financing. If the company is a staff model HMO, the receiver should also obtain an inventory of medical equipment and a pharmacy or medical supplies inventory.

I. Other Assets

Review other assets, determining existence, location, and amount. Verify expiration dates and adequacy of trust accounts and LOCs posted as collateral by reinsurers, policyholders, and others. Ascertain whether any assets have been sold or transferred for less-than-adequate consideration. Review sales contracts and independent appraisals, and focus on any transactions with related parties and affiliates.

For health care-related receiverships, health care receivables can include items like provider risk sharing receivables, coordination of benefits, provider overpayments, and/or subrogation recoverables among other items.

J. Accounts Payable and Accrued Expenses; Debt

Identify and quantify liabilities outstanding for all general and secured creditors and employee-related expenses. Employee-related expenses include payroll and bonus, severance, vacation, and personal time. Obtain pension and deferred compensation program documentation where applicable. These items can be determined by using the payroll register, personnel policies and procedures, and personnel records. Confirm that all personnel receiving monies are currently employed by the insurer, and review all related-party transactions.

Notify any bank/lender of the receivership, and confirm outstanding balances as of the date of receivership. Review debt agreements, loan files, and collateral files to determine that liabilities are properly recorded on the financial statements as to type of debt and classification; i.e., short-term versus long-term.

K. Claim Reserves and Incurred but Not Reported (IBNR) Claims

Obtain an understanding of the insurer's policy on booking reserves, and determine whether the policy has been consistently followed. Make any necessary adjustments to the financial statements. Continue to monitor claims for ongoing evaluations and reporting of case reserves.

The receiver must consider the use of in-house actuaries or independent actuaries to determine the adequacy of reserves. Consider commissioning a new actuarial study, as of the liquidation date, to establish ultimate losses in a property/casualty (P/C) receivership or to evaluate blocks of business in life, accident, and health carriers. The additional cost of the study may be justified by the receiver's enhanced ability to finally commute reinsurance or to adjust account balances that involve retrospectively rated policies. (See Chapter 5—Claims.)

Determining the adequacy of claims reserves and incurred but not reported (IBNR) claims is especially critical for HMOs. It is also important to identify the inventory and associated liability for claims that are in-house but have not been processed through the HMO's claims system. The receiver may consider hiring

a TPA or other outside claims processing service to process the claims and determine the ultimate liability. The receiver may also consider hiring an actuary to establish the medical loss ratio (MLR) for each of the HMO's product lines in order to determine whether a line of business is profitable.

L. Income and Expense

Examine any unusual income and expense items, including sales to or purchases from related parties or affiliates, significant gains/losses, and unusually high expenses in relation to the size of the insurer and type of business.

M. Equity

Review surplus accounts, and investigate any unusual changes in surplus, statutory to GAAP adjustments, recent capital contributions, recent capital issues, and other activity that appears unusual.

VII. RELATED PARTY TRANSACTIONS

Insurers often enter into many different types of transactions with various related-party entities. Each of these transactions should be scrutinized carefully because of the potential that they were not the result of arm's-length bargaining. Further, even fairly negotiated transactions may not have been carried out according to the terms of the agreement. Finally, the transaction may not be exactly as it appears. For example, a sale of an asset at a huge loss may in fact amount to a fraudulent transfer. Related parties may include a parent company, affiliates or subsidiaries, shareholders, directors, officers, and employees. Transactions with affiliates are required to be disclosed in Schedule Y, Part 2 of the annual statement. Related parties may also include entities or individuals that are not as easily identified, as they may be owned by individuals associated with the insurer (such as directors, shareholders, officers, or employees), or they may be entities that have entered into significant transactions with the insurer. These transactions may be significant as to the number of transactions or as to the amount of money involved. Alternatively, the transactions may be immaterial from the standpoint of assets changing hands, but they may be significant because of the nature of the transaction (guarantees, debt forgiveness, etc.).

It is important to identify related parties and transactions between the insurer and any related party as quickly as possible for many reasons, including to preserve the assets. Often, related-party transactions are not appropriately reflected on the insurer's books; sometimes the transactions may not be reflected at all, therefore misstating the insurer's assets or liabilities. The transactions may be accounted for (if at all) on the incorrect entity's books, and funds or entries may be commingled by management, thinking that all the companies are part of a consolidated group or owned by the same parent. However, the legal corporate entities are important, especially when one or more of them become insolvent. Insurers are subject to the jurisdiction of the insurance commissioner. Other entities are governed by bankruptcy law and are generally not subject to the jurisdiction of the commissioner; however, they may be subject to the jurisdiction of the receivership court in certain circumstances. On Aug. 17, 2021, the NAIC adopted a new provision, Section 5A(6), of the *Insurance Holding Company System Regulatory Act* (#440), which provides that the affiliated entity whose sole business purpose is to provide services to the insurance company is subject to the jurisdiction of the receivership court This applies to affiliates performing services for the insurers that are an integral part of the insurer's operations or are essential to the insurer's ability to fulfil its obligations.[2]

Further, with regard to commingled data and records, the 2021 revisions to Model #440 and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) specify that records and data of the insurer held by an affiliate are identifiable and are segregated or readily capable of segregation at no additional cost to the insurer. The models' reference to "at no additional cost to the insurer" is not intended to prohibit recovery

[2] The full text of Section 5A(6) of the *Insurance Holding Company System Model Act* (#440) is available at https://content.naic.org/sites/default/files/MO440_0.pdf. The 2021 NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

of the fair and reasonable cost associated with transferring records and data to the insurer. Because records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate

Related-party transactions may give rise to culpability on the part of the interested entities or individuals. Preferential transfers, fraudulent transfers, and other bases for liability are discussed further in this chapter and in Chapter 9—Legal Considerations.

Organization charts showing a parent, affiliates, or subsidiaries may be obtained from a schedule within the annual statement (Schedule Y, Part 1), board minutes, or SEC filings. Additionally, relationships with insurance groups and entities that share common ownership can be found on Schedule Y, Part 3. It is more difficult to identify individuals who might have been involved with related-party transactions, and often that list of individuals is much longer. However, the receiver should start with the list of officers and directors of the insolvent insurer; its parent, subsidiaries or affiliates, again listed in the annual statement or SEC documents; and board minutes. Stockholders' names should be listed in shareholder records maintained, possibly, by legal counsel or trustees. Lists of employees may be obtained from payroll registers. When these transactions are reviewed, it may be determined that a significant number or dollar volume of transactions have occurred with one individual or entity. This may indicate that the involved entity or individual is also a related party.

Once an initial list of related parties is established, the types of transactions that may have occurred between these entities can be determined. The types of transactions that may be identified relate to various types of business transactions. An understanding of the related entities and how they are affiliated will help the receiver to identify and formulate the types of transactions that may have occurred between them. Many insurer company groups have established affiliates to act as investment vehicles or managers, brokers, reinsurers, MGAs, TPAs, premium finance companies, and computer service companies, or to accept select types of risks. A parent holding company may have been established. It is important to ascertain the related parties and their affiliation because the insolvent insurer may have claims against affiliates.

The receiver should review the notes to financial statements in the annual statement, the independent auditor's report and the state insurance examiner's report. These reports typically identify and summarize some of the significant related-party transactions. Also, board minutes will frequently contain discussions or resolutions pertaining to specific significant transactions involving related parties.

Brokerage, agency, or management agreements may exist between the insurer and its affiliates. There may also be reinsurance (both assumed and ceded) or pooling arrangements among affiliates. Expense-sharing arrangements may exist. An affiliate may provide data processing services. (The receiver needs to determine immediately if they can continue to obtain these services and how to secure the data.) Leasing arrangements for offices, data processing equipment, and furniture and fixtures may also exist. With respect to all agreements with affiliates, the receiver should be alert to possible differences between the apparent transaction and its real substance.

Holding companies may also provide management expertise for which there is a management agreement and/or expense allocation agreements. Tax-sharing agreements may also exist between all the affiliates and parent.

Insurers may have management agreements with unaffiliated parties, or control may be maintained through interlocking directors of the management company and the insurer. For example, an HMO may be controlled by a provider group such as hospitals. Therefore, these agreements or contracts need to be reviewed to determine if they are arm's-length transactions.

It is important to identify these transactions as quickly as possible, not only for the identification of assets and liabilities that may be recovered by the insurer, but also to determine if alternative data processing, management, facilities, etc., should be obtained, as these services may no longer be available from the affiliate. Alternatively, such services may be available on more favorable terms from nonaffiliated providers.

The types of transactions that may have occurred between the insurer and its directors, officers, employees, and stockholders may be the same as some of the above, but they may also include items such as travel and expense

advances, unsecured loans, or loans secured by personal or real property. Companies owned by any of these individuals may also be responsible for providing services discussed above, including leases, data processing, brokerage, reinsurance, etc.

To determine the existence of these types of transactions, their validity, and the appropriate accounting for the transactions (both in the books and records of the insurer and in cash flow), the tasks described below should be performed.

A. Identify Related Parties

The receiver should obtain or develop organizational charts to identify any and all affiliates and related parties. These affiliates should be identified as: 1) parent companies; 2) subsidiaries; or 3) affiliates (which would be organizations owned or controlled by the same parent company, but not owned by the insolvent insurer). Schedule Y, Part 1 of the annual statements provides an organization chart of the insurance holding company system; Schedule Y, Part 2 includes transactions with affiliates; and Schedule Y, Part 3 includes further information on insurance groups and entities that share common control.

After preliminary identification of these related entities, the receiver should determine the status of these related entities:

- If the related parties are financially troubled, are the parties under the jurisdiction of the insurance regulator of their state of domicile, or are the parties under the jurisdiction of corporate bankruptcy laws?
- Does the insolvent insurer need to file a proof of claim against the related entity to preserve its claim? (The receiver should consult with counsel about the risks of submitting to a foreign court's jurisdiction on issues other than those set forth in the proof of claim.)
- Are the entities affiliated, in which case the insolvent insurer may have access to the assets of the related entities?
- Is cash commingled among the companies?
- Are the entities operating as alter egos?

The receiver should also obtain lists of individuals, as well as their related entities who might also be related parties, beginning with the directors and officers of the insurer listed in its annual statement and the officers and directors of the insurer's subsidiaries and affiliates. The receiver should also obtain a list of all shareholders and employees of the insolvent entity. Each of these individuals may be categorized in a manner similar to that described above for companies that are related entities. Each can be evaluated for the types of transactions that may have occurred between them and the insurer. It should be kept in mind that these individuals may have been involved with other entities that appear not to be related but, in fact, may have had sufficient transactions with the insolvent entity that they, too, become related entities.

B. Find Supporting Legal Documents for Transactions

The receiver should obtain all key documents and agreements entered into between the insurer and its various related entities. As discussed above, these agreements may have been collected through the inventory of documents in the takeover period. If these documents have not been located, a search may be made to locate any agreement or documents that indicate arrangements between the insolvent insurer and the various related entities.

As the receiver completes the procedures described below and in Chapter 4—Investigation and Asset Recovery, identified transactions may indicate the advisability of searching for additional documents.

C. Identify Amounts Associated with the Related Party Transactions

Next, the receiver should review the various accounting records of the insurer, including the chart of accounts, general ledger, journal entry listing, and transaction listings. It must be noted that when dealing with related-party transactions, the receiver should attempt to obtain the corresponding records of related entities to cross-reference transactions and amounts as described in the procedures below.

The chart of accounts may be obtained and reviewed for any accounts that appear to be intercompany receivables, intercompany payables or loans to affiliates, related parties, directors, officers, shareholders, employees, etc. This may be an easier task for some companies than others. Often separate accounts will be established for all related-party transactions. On the other hand, the transactions may be difficult to identify if they were charged to accounts with innocuous titles such as "other assets" or "miscellaneous expense," or if they were netted with other transactions. Some transactions, particularly insurance-related transactions, may be buried in the normal transactions of the insurer. However, if the receiver reviews the chart of accounts to identify preliminarily the accounts that may be with related entities and individuals, subsequent procedures will help identify buried transactions.

After particular accounts have been identified as possibly containing related-party transactions, the general ledger should be reviewed to ascertain the dollar amount in the identified accounts. The receiver may want to prioritize the items reviewed by the dollar magnitude of the balances. However, caution should be taken at this point, as the dollar magnitude alone may not be indicative of the significance of the transaction. Understanding the types of transactions recorded in the particular account is helpful, especially if there is a high volume of transactions that have been netted. A small balance in an account with a significant volume of transactions may have other implications. No cash may have changed hands in the case of guarantees or debt forgiveness.

The next step is to obtain the transaction register by month to see the actual transactions that have been posted to the account. This will be the beginning of the investigation, or audit phase of the review. As mentioned above, depending on the size and type of systems the insurer used, it is possible that the general ledger listing also will provide the listing of transactions posted to the various accounts, meaning that a separate transaction listing is not necessary or available.

It may be beneficial to obtain a listing of disbursements sorted by payee. This can help identify related-party transactions that, as mentioned above, may not appear significant standing alone and that may be buried in other transactions of the insurer.

The above steps are easily accomplished if the insurer had an efficient, effective accounting system. Unfortunately, this is often not the case with many insurers that become insolvent. Frequently, the accounting system may not have been operational as originally designed due to budgetary concerns, cutbacks of manpower, and other problems during the period immediately preceding the insolvency, or there may have been intentional distortion of the system to hide improper transactions. In any case, it may be necessary to reconstruct information.

D. Cross-Reference to Affiliates' Books

If the receiver has access to the related entities' books, they should be obtained from those entities. A receiver who does not have ready access should attempt to obtain access promptly. The reciprocal accounts for those entities may then be reviewed and cross-referenced to see that the amounts recorded on the related entities' books are in fact the reciprocal of the amounts on the insolvent insurer's books. Differences should be investigated. In addition to the cross-referencing, the receiver may also perform all the analytical procedures discussed above for the related entities' identified accounts. Through this process, the receiver may find other transactions that need to be evaluated and analyzed. In the absence of a court order, the receiver will usually be unsuccessful in his/her attempt to obtain the books and records of related entities.

E. Analyze All Transactions

Once related-party transactions have been identified, detailed analyses of most of the transactions can be completed to determine whether they were business transactions entered into at arm's length and for valid business reasons with appropriate support. The arm's-length aspect of some transactions may be difficult to determine (or refute); however, all such transactions should be reviewed with an appropriate degree of skepticism. The analysis of the identified transactions may be completed by the accounting department or by the audit/investigation team.

The receiver may attempt to segregate transactions into types for analysis. Otherwise, the task may seem too large to accomplish. The transaction types may be determined by the accounts that have been identified as including related-party transactions and the relationships of the related parties. For example, if the related-party accounts include advances to or from, or accounts receivable or payable, then one of the transaction types might be cash advances or loans to related parties. The following are some of the transaction types that may be identified for analysis:

- Advances/loans to related parties.
- Reinsurance receivable/payable.
- Premiums due to/from.
- Commissions due to/from.
- Operating expenses receivable/payable (leases, management, computer services, etc.).
- Payment of dividends.
- Purchase or sale of assets from or to related parties.

The receiver should then systematically review the transaction types in each of the identified accounts. This would include noting the description of the transaction in the transaction listing.

It may be necessary for the receiver to search for the underlying documentation for all entries. The journal entry listing and other documents obtained in the document search may be helpful in this effort. Also, the various schedules in the annual statement should be reviewed. In any event, the receiver will have to seek any underlying information that may indicate the substance of the recorded transaction. The receiver may also have access to current or former employees who can shed light on the nature and intent of these transactions, locate documentation, and otherwise interpret such documents. Once the transaction entry has been obtained and the underlying documentation has been obtained and reviewed, the receiver can determine whether the information was recorded appropriately on the insurer's books. At that time, the receiver should add the correct dollar amount of this item to the schedule of items for ultimate determination of action. This schedule should be prepared on a gross basis, without netting of balances, to enable the receiver to see the full impact of the transactions.

The receiver should systematically analyze all significant transactions in all identified accounts, as demonstrated above, until all transactions have been reviewed and scheduled for ultimate disposition.

As each of these transactions is being reviewed and scheduled, it is always necessary to cross-reference to other related parties' books and records, if available.

F. Evaluate All Identified and Analyzed Transactions

After all transactions have been reviewed, analyzed, and scheduled, the receiver will have to evaluate the propriety of the transactions and any action necessary. Some of the transactions might not stand depending

on the type of transaction and when it occurred relative to the date the insurer was declared insolvent. If the related-party transactions result in receivables to the insolvent entity, it may be necessary for the receiver to file a proof of claim in another proceeding if the other party is in some form of receivership. If the related-party transaction resulted in payables from the insurer, the receiver may have creditors that need to be notified of the insolvency.

G. Potential Reconstruction of Records

If the insurer does not have the types of records listed above, it may be necessary to use available records to reconstruct the needed information. In such cases, the receiver should begin with the insurer's annual statement. From this, the receiver may find supporting documents for the numbers entered and filed in this statement. If the underlying information does not agree with the annual statement, the discrepancies should be identified and the reason for the discrepancies determined. The receiver may be able to obtain information from the insurance department or outside auditors, which can be of great benefit when reconstructing records.

If a total reconstruction is required, the receiver should start with all the bank statements for the past year (at a minimum). The receiver should review the receipts and disbursements from the most recent year to determine if there are additional types of transactions that were not previously disclosed in the last filed annual statement. This detailed analysis should include a schedule that categorizes disbursements by type and segregates those related to the payment of claims or reinsurance and other underwriting expenses from those that were pure operating expenses. Disbursements that may have been to related entities should also be segregated and identified. The same type of schedule should also be prepared for all cash receipts.

If available, any financial information regarding affiliates, subsidiaries, or the parent company would be useful in this reconstruction.

H. Data and Records of the Insurer Held by an Affiliate

The *Insurance Holding Company System Model Act* (Model #440 and Model *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450 contain provisions that address data and records of the insurer that are held by an affiliate. While the models have contained provisions since 2010, on Aug. 17, 2021, the NAIC adopted revisions to further clarify owner of data and records.[3]

Specifically, the Model #440 specifies the following:

- The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

- All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. The affiliate may charge a fair and reasonable cost associated with transferring the records and data to the insurer. However, the insurer should not pay a cost to segregate commingled records and data. Therefore, if records and data belonging to the insurer is held by an affiliate (e.g., on the affiliate's systems), upon request, the affiliate shall provide that the receiver can:

[3] Although in 2021 the NAIC adopted revisions to Model #440 and *Model* #450 related to receivership matters including records and data, these revisions may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

- Obtain a complete set of all records of any type that pertain to the insurer's business.
- Obtain access to the operating systems on which the data is maintained.
- Obtain the software that runs those systems either through assumption of licensing agreements or otherwise.
- Restrict the use of the data by the affiliate if it is not operating the insurer's business.

- The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement.
- The revisions to Model #440 and Model #450 also describe that records and data that are otherwise the property of the insurer, in whatever form maintained, include, but are not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate.
- Section 19 of Model #450 lists provisions that should be included in agreements for cost-sharing services and management services between the insurer and an affiliate, which includes certain provisions specific to the insurer being placed in supervision, seizure, conservatorship, or receivership.
  - All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by state law.
  - Records and data of the insurer are the property of the insurer, are subject to the control of the insurer, are identifiable, and are segregated from all other person's records and data or are readily capable of segregation at no additional cost to the insurer.
  - If the insurer is placed into receivership, a complete set of records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable.
  - Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship, or receivership.
  - Specify that the affiliate will provide the essential services for a minimum period of time (specified in the agreement) after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship, or receivership.
  - Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure, notwithstanding supervision, seizure, conservatorship, or receivership.
  - Specify that if the insurer is placed into supervision, seizure, conservatorship, or receivership, and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under certain provisions of Section 19 of Model #450 will extend to such guaranty association(s).[4]

[4] The full text of Section 19 of Model #450 is available on the NAIC website at: https://content.naic.org/sites/default/files/MO450_0.pdf.

VIII. TAX ISSUES

In virtually every receivership, federal tax issues must be considered. The insurer cannot be discharged or liquidated without the filing of federal income tax returns. In addition, consideration should be given to the payment of federal corporate income and other taxes. The receiver can be held personally liable for the payment of certain unpaid taxes if specific procedures are not followed.

Because of the complexity of federal income taxation issues, the potential personal liability of the receiver and the additional complexities associated with receiverships—and the significant impact on the estate from items such as forgiveness of debt, consolidation rules, and other matters—the receiver should hire individuals with expertise in these areas. Such experts could include independent CPAs or counsel with experience in such matters. Furthermore, because of the continuously evolving nature of federal income taxation issues, many of the issues addressed in this chapter may have changed. This is a reason that the receiver should hire individuals that will be as up to date as possible in these areas and why receivers should seek updated guidance on tax matters (both federal income and state premium tax issues) in reference to the issues addressed in this Handbook.

The receiver should ascertain the insurer's tax status as part of the takeover procedure, in addition to securing copies of tax returns and company tax payment records. Foremost, the receiver should learn whether all tax returns due have been filed and any amounts owing have been paid. In addition, the receiver should learn whether the insurer was part of a consolidated group filing or party to any tax sharing or similar contractual agreements. The receiver should also obtain and carefully review and understand the provisions of any tax-sharing agreements between the insurer and any related parties. In almost all receiverships, the receiver takes over the insurer but not necessarily its holding company or other affiliated group with which the insurer may be consolidated for tax purposes. In addition, the insurer may own nonregulated subsidiaries that are taxed differently from the insurer.

Prior years' returns and any correspondence with the IRS also should be reviewed. Discussion may be held with any outside CPAs or counsel who may have been involved in filing the returns or in handling any disputes with the IRS. The receiver should be alert to any contingencies that may exist for payment of taxes, penalties, and interest resulting from failure to file on time, failure to pay tax due on the return, inappropriate treatment of income or deductions on the return, etc. Contingency reserves recorded on the balance sheet of the insurer or its parent should be reviewed and analyzed for purposes of determining tax positions taken by the company that are not "more likely than not." The receiver should consider these contingencies when allocating distributable assets of the estate in light of the priority generally alleged by the federal government and accorded by the applicable priority statute. (See Chapter 9—Legal Considerations.)

The receiver may request an account transcript from the IRS for the receivership entity. The transcript, available by type of tax (Form 1120, Form 941, etc.) and year, may be obtained by filing form 4506-T, Request for Transcript of Tax Return. An account transcript typically contains information on tax payments (amounts and dates) and filing of returns (dates).

Income taxation of insurers is somewhat different from conventional corporations, with additional provisions that are applicable to life insurers contained in Part I of Subchapter L of the Internal Revenue Code (IRC) and specific provisions applicable to other insurance companies contained in Part II of Subchapter L of the IRC.

Even though an insurer may have substantial statutory losses, it is possible that based on its taxable income, federal income taxes may be due. See discussion in this chapter of deferred income that may be taxed when a company loses its status as a life insurance company for federal tax purposes. There also exists the possibility that the insurer is entitled to recover prior years' taxes because of the existence of capital losses, operating losses, or tax credits. Operating losses can be carried back two years and carried forward 20 years by P/C insurers. Prior to 2018, life insurers were allowed to carry back ordinary losses for three years and carry forward losses for 15 years. No carryback is allowed for operating losses of insurers other than P/C insurers for taxable years after Dec. 31, 2017, but these insurers are allowed indefinite carryforwards, which are limited to 80% of taxable income in each year to which the operating loss is carried. All insurers are allowed to carry back capital losses three years and carry forward up to five years to offset capital gains. Tax credit carrybacks vary depending upon the type of credit, so you should

always check with a tax advisor. The insurer may also have made estimated tax payments that can be recovered. Additionally, an insurer may be entitled to a tax recovery because of its inclusion in a consolidated tax filing where its losses were used to set off taxable income from affiliated entities. Tax recovery due to tax sharing agreements will not be recoverable from the IRS but must be recovered from affiliated entities. Therefore, income tax recoverable may not be collectible and, as such, should not be booked. In addition, under Section 848 of the IRC, an insurer must capitalize its estimated acquisition expenses, which are then amortizable (deductible) over the ensuing 10-year period for amounts capitalized prior to through Dec. 31, 2017, and over a 15-year period for amounts capitalized after Dec. 31, 2017 (five years for smaller companies).

The receiver should be aware that IRC Section 6511(a) places a deadline by which claims for credit or refund of taxes must be made. In many instances, this deadline will be three years from the due date of the return for which the claim for refund is being made. However, if the claim for refund results from the carryback of losses to preceding tax years, the deadline will be three years from the due date of the return that generated the loss. Due to the critical nature of properly determining these deadlines, the receiver should consider consulting independent CPAs or counsel with experience with these matters.

In addition to federal corporate income taxes, the receiver also has to be concerned about foreign taxes, state corporate income taxes, federal and state payroll taxes, premium taxes, real estate taxes, federal excise taxes, state franchise and excise taxes, sales taxes, and personal property taxes, along with myriad reporting and filing requirements. The receiver will also need to file final tax returns upon the closing of the receivership estate.

A. Notice

Within 10 days from the date a receiver is appointed, Form 56 (Notice Concerning Fiduciary Relationship) must be filed with the IRS. A certified copy of the court appointment should be attached. This form should be filed for all forms of receivership. The receiver should specify that they are to receive notice concerning income, excise, sales and property, and payroll tax matters. The list of tax forms should include Form 1120L (for life companies) or Form 1120PC (for P/C companies), Form 941 (quarterly payroll tax returns), Form 940 (Federal Unemployment Compensation Tax), and Form 720 (Federal Quarterly Excise Tax Return). If the insurer owns subsidiaries, the receiver should also file a Form 56 notice for each subsidiary.

In addition to the federal filing, many states have similar notice requirements. Even without a specific requirement, sending similar notice to the taxing authorities of those states and foreign countries where the insurer did business or had employees should be considered.

Form 56 is not to be used to update the last known address of the receivership entity. The receiver should file form 8822, Change of Address, with the IRS.

B. Income Taxes

Under Section 1.6012-3(b)(4) of the federal income tax regulations, a receiver or trustee who, by order of a court of competent jurisdiction, by operation of law or otherwise, has possession of or holds title to all, or substantially all, the property or business of a corporation, must file a return in the same manner and form as the corporation.

The due date for filing federal corporate income tax returns for insurance companies is the 15th day of the fourth month (generally April 15) of the year following the year end of the company. (For years beginning prior to 2016, the due date was the 15th day of the third month [generally March 15] of the year following the year end of the company.) A six-month extension to Oct. 15 can be obtained for the filing of the return if the extension form is sent to the IRS prior to the April 15 deadline. This extension, however, is only for the filing of the return and not for the payment of tax liabilities. The April 15 deadline is applicable to calendar-year companies only. There may be certain non-insurance companies under the receiver's authority that have fiscal year-ends.

Once an affiliated group of corporations files a consolidated return, it must continue to do so as long as the group remains in existence. Therefore, consolidated returns must continue to be filed with the insurer's subsidiaries. In addition, the IRS has ruled under PLR 9246031 that an insurer in liquidation under state law generally is required to be included in its common parent's consolidated federal income tax return. The receiver may request approval from the IRS to file separate returns. This permission may be granted on a case-by-case basis for good cause shown. Pursuant to the consolidated return regulations (1.1502-75), the parent of the affiliated group must request deconsolidation for good cause. A deconsolidation may weaken the IRS' position; as such, the granting of a deconsolidation is not guaranteed.

Following is a list of various insurance or insurance-related entities and the federal income tax form that should be filed:

Type of Insurer (Based on Business Written)	**Federal Income Tax Form**
P/C	1120-PC
Life	1120-L
HMO	1120-PC
Staff Model HMO	1120
501(c)(15)(A) - Tax Exempt	990
Title	1120-PC
Blue Cross Blue Shield Association	1120-PC
Health	1120-PC
Health w/Noncancellable and/or Guaranteed Renewable Contracts	1120-L

For a company to be considered an "insurance company," at least half of its business during the taxable year must be the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies.

For a company to be considered a "life insurance company," it must be engaged in the business of issuing life insurance and annuity contracts (either separately or combined with accident and health [A&H] insurance), or noncancellable and/or guaranteed renewable contracts of health and accident insurance. Also, its life insurance reserves plus unearned premiums—and unpaid premiums on unpaid losses and on noncancellable life, accident, or health policies not included in life reserves—must make up 50% or more of its total reserves.

In certain special situations, managed care organizations may qualify for tax exempt status; if so, they would file Form 990.

1. Life Insurance Companies

   Life insurers (whether stock, mutual, or mutual benefit) that meet certain reserve requirements file Form 1120-L. If a life insurer does not meet the reserve requirements, then it must file Form 1120-PC. If a stock life insurer loses its life insurance tax status because its life insurance reserves fall below the minimum requirement, then taxes that were deferred in earlier years may now become due. In Revenue Procedure 2018-31, Section 26.03 provides for an automatic accounting method change when there is a change in qualification as a life insurance company as defined in Internal Revenue Code (IRC) Section 816(a).

   For taxable years ending before Jan. 1, 2018, life insurers with less than $500 million in assets are entitled to a small life insurer deduction of 60% of their "life insurance company taxable income." This deduction is available for income up to $3 million and then is gradually phased out on income from $3

million to $15 million. For taxable years after Dec. 31, 2017, the small life insurer company deduction is repealed, and the alternative minimum tax for corporations is repealed as well.

2. Non-Life Insurance Companies

Non-life insurers (stock and mutual) file Form 1120-PC. Non-life companies generally are taxed on their statutory income with certain modifications, including the discounting of loss reserves and the non-deductibility of 20% of the increase of the unearned premium reserves. The non-deductible 20% of the unearned premium reserve (UPR) gives the taxpayer a tax benefit when the UPR is reduced, but the effect of the reversal of the 80% deductible portion has a greater impact and may create taxable income. As previously stated, the receiver should consult their tax consultant regarding the ramifications of these issues.

Non-life insurers whose written premiums for the year do not exceed $2.2 million (an amount that is inflation-adjusted for each taxable year beginning after 2015) may elect to be taxed only on investment income under Code Section 831(b). The premium limits are based upon the premiums of a "controlled group" of corporations as defined by Code Section 1563(a), with the exception that more than 50% is the definition of control. The fact that an insurer is in receivership does not remove it from a "controlled group." The company also must meet certain diversification requirements with regard to premiums and owners as prescribed in IRC Section (831(b)(2)(B)). Taxation on investment income may not be advantageous to companies that are currently generating or using net operating losses, as the company may lose the benefit of those losses. IRC Section 831(b)(3) prescribes limitations on the use of net operating losses for insurance companies taxed only on investment income.

Prior to Jan. 1, 2005, small non-life insurers with less than $350,000 of premium income could qualify to be exempt from income tax under Code Section 501(c)(15). Many receivers took advantage of this provision to exempt liquidation estates from federal income taxation. In 2004, IRC Section 501(c)(15) was amended to provide tax exempt status only to those non-life insurers with gross receipts less than $600,000, and then only if more than 50% of the gross receipts were from premiums. Because most companies in liquidation have virtually zero premium income after the first couple of years of the liquidation, and because most have annual income exceeding the $600,000 cap, this amendment to Code Section 501(c)(15) generally eliminated its applicability to insurance receiverships.

The impact upon insurance companies in receivership was considered as Code Section 501(c)(15) was being amended in 2004, and the applicability of the exemption to insurance companies in receivership was specifically extended through calendar year 2007. However, as of Jan. 1, 2008, any insurers in liquidation that may have previously been qualified for exemption under the pre-2005 provisions of Code Section 501(c)(15) became ineligible for such exemption and are subject to federal income tax from that time forward unless they met the new requirements.

3. Special Relief

Under Revenue Procedure 84-59, the receiver may apply to the district director of internal revenue for relief from the filing requirements under limited circumstances. In order to request this relief, the insurer has to have ceased operations and no longer have assets or income.

4. Prompt Audit

The receiver may request that a prompt determination be made under Revenue Procedure 2006-24 whether the income tax return is being selected for examination by the IRS or is accepted as filed. The receiver will be discharged from any liability upon payment of the tax shown on the return if the IRS does not notify the receiver within 60 days after the request that the return has been selected for examination, or if the IRS does not complete the examination and notify the receiver of any tax due within 180 days after the request. This procedure enables the receiver to proceed with the receivership, or enhances the possible sale of the insurer, by resolving contingencies relating to taxes due for prior

periods. The prompt audit provisions specifically apply to bankruptcy proceedings, not state liquidations. Certain IRS offices have approved applying the provisions to state liquidations. However, the approval is not automatic. When this is the case, a request for prompt assessment should be made under IRC §6501(d). This will reduce the statute of limitations for assessment to 18 months. The request contemplates a corporate dissolution in 18 months and requires the submission of Form 4810 to the IRS.

5. Carrybacks

An insurer often becomes financially troubled because it incurred operating and/or other losses. Such losses may be deductible for income tax purposes. A review may be made of the deductibility of such losses to determine if the losses were deducted in the correct fiscal year and may be carried back to recover previously paid income taxes. If the losses were not deducted in the correct years, prior years' income tax returns may have to be amended. Under the federal Tax Cuts and Jobs Act of 2017 (TCJA), net operating losses of non-life insurance companies can still be carried back two years and carried forward 20 years (IRC Section 172(b)(1)(C)). However, there is no carryback for life insurance company net operating losses arising in 2018 and later years and an unlimited carry forward period (IRC Section 172(b)(1)(A)). Operational losses of life insurers arising in 2017 and earlier are carried back three years and forward 15 years. A non-life insurance company can use the full amount of its net operating losses to offset taxable income (IRC Section 172(f)). A life insurance company is limited to an 80% net operating loss deduction against taxable income (IRC Section 172(a)(2)).

An example of a restructuring technique used in the liquidation of Reliance Insurance Company to address significant net operating loss carryovers is available in Exhibit 3-4.

6. Carryovers

To the extent that there is a discharge of indebtedness, any net operating loss carryover may be reduced by the amount of the discharge. If guaranty funds or other creditors are entitled to future funds, there may not have been a complete discharge.

Net operating losses are allowed an indefinite carryover period in taxable years beginning after Dec. 31, 2017. The net operating loss deduction is limited to 80% of taxable income (without regard to the deduction) for losses arising in taxable years beginning after Dec. 31, 2017. Therefore, even when there are net operating loss carryovers available, discharge of indebtedness could still result in income tax liabilities due because of the carryover taxable income limitations.

7. Deferred Taxes

The deferred taxes for both deferred tax assets and liabilities should be reassessed. For example, the deferred tax assets that rely on further taxes payable to be realized may no longer be realizable.

C. Premium Taxes

If the insurer is in rehabilitation, the receiver may be required to continue paying state and municipal premium taxes. Insurers are usually required to pay premium taxes that are calculated as a percent of direct premiums written. Many state and local tax authorities require insurers to pay estimated premium taxes. In many cases, a financially troubled insurer may experience a decrease in premium volume, or policies in force may be canceled. This may result in a reduction in premiums written and the related premium taxes. A review may be made to determine whether the insurer is entitled to premium tax refunds. It may then be necessary to refile the most recent returns to reflect the reduction in premium income. In addition, the receiver may attempt recovery of any prepaid or estimated premium taxes. If premium taxes are owed in a liquidation, many states may relegate premium tax claims to a lower or general creditor status.

D. Payroll Taxes

Insurers are required to withhold federal income tax and Social Security tax (as well as state and local income taxes) from the wages and salaries of their employees. All of these taxes are considered trust fund taxes and must be remitted periodically to the various taxing authorities. The receiver should promptly ascertain that all payroll tax payments have been remitted by the insurer. If the receiver finds that taxes have not been paid, the Special Procedures Office of the IRS should be notified. In this way, the taxes or 100% penalty can be assessed against the former officers or persons with the responsibility for paying the taxes. The receiver may be asked to complete Form 4180 or Form 4181, which are questionnaires relating to the payment of trust fund taxes.

If the receiver fails to follow these procedures and funds that could have been used to pay trust fund liabilities are used for other purposes, the receiver may be held personally liable. The receiver should make certain that any plan filed with the court for the distribution of assets provides for the payment of these outstanding federal tax liabilities.

Many states have similar laws relating to withheld payroll taxes, and the receiver should be aware of the responsibilities imposed by these laws. The receiver should continue to file Form W-2, as well as Form 940 and Form 941, for employees of the insolvent insurer.

E. Other Taxes and Assessments

1. Real Estate and Corporate Personal Property Taxes

The receiver should ascertain whether all real estate tax payments have been made, including those that the insurer has been collecting on mortgages it holds or services. The tax collector should be notified of the receivership proceeding and instructed to send any notices to the receiver.

2. Guaranty Fund Assessments

State guaranty funds assess insurers to cover their administrative and claim costs. If the insurer is operating under supervision or rehabilitation, it remains liable for guaranty fund assessments, though a guaranty fund may defer or abate an assessment, in whole or in part, under certain circumstances. In liquidation, guaranty fund assessments are paid in accordance with the domiciliary state's liquidation priority statute.

3. Excise Taxes

Some insurers are required to remit excise taxes to the IRS because of foreign reinsurance premiums. These taxes are also considered trust fund taxes, and the same care should be afforded these taxes as is given to withheld payroll taxes.

4. Commissions and Other Payments

At year-end, insurers are required to file Form W-2 and/or Form 1099 for all commissions and other payments to an individual or partnership in excess of $600 during the year. In addition, the receiver is required to prepare 1099 forms and send them to policyholders of life companies while business is still being serviced by the insolvent insurer. In addition, if the insurer has received interest from mortgages, the receiver is required to prepare and provide Form 1098 to the payer. If more than 250 1099 forms are to be issued, the filing is required to be done electronically. However, relief from this electronic filing may be secured upon request to the IRS. The receiver should be able to demonstrate that an electronic filing would place an undue hardship on the insolvent insurer. The IRS can assess penalties for both the failure to issue the forms to agents and the failure to file the forms with the IRS. If the receiver has not already sought relief and the estate is assessed, the IRS may waive the assessment upon request. Additionally, most states and some localities have filing requirements.

5. Franchise Taxes

Several states have franchise taxes. The tax basis can be the net worth of the insurer, the assets of the insurer, the number of shares of authorized stock, or the amount of paid-in capital. The failure to file and pay these taxes may result in the cancellation of the insurer's corporate certificate of authority.

6. Other State Taxes and Licenses

Insurers are subject to numerous state taxes and assessments, including: workers' compensation; second injury funds; firemen's and policemen's pension funds; medical disaster funds; major medical insurance funds; arson, fire, and fraud prevention funds; fire marshal tax; insurance department administrative assessments; federal Fair Access to Insurance Requirements (FAIR) Plan assessments; and motor vehicle insurance funds. In addition, many localities have licenses and taxes unique to insurers. Comprehensive summaries are published by several insurers groups, including the Property Casualty Insurance Association (APCIA) and the American Council of Life Insurers (ACLI). The receiver should also ascertain if the insurer has any responsibility for filing informational returns and/or paying other state or local taxes such as sales and use taxes, water and sewer taxes, business and occupational privilege licenses, and taxes for employment training funds. Before paying these taxes, consideration should be given to the importance or lack of importance of maintaining state corporate certificates of authority and/or licenses.

All taxes should be reviewed to determine how any liability should be included in the priority scheme. The receiver should consider whether the certificate of authority or licenses have value before they are allowed to expire or be cancelled.

IX. INVESTMENTS

Investments may represent the largest group of assets on the balance sheet of an insurer. The purpose of the investments is to provide the company with resources and a steady flow of investment income to meet obligations as the obligations become due. A priority of the receiver is to take over full responsibility for all investments. This section will attempt to guide the receiver and identify any hidden elements in the following steps: seizure and control, inventory/identification, balancing, valuation, and other considerations.

The investment management function may be delegated to a bank or other professional manager. Depending on the receiver's evaluation of the company's investment manager, that person or entity may be retained with or without additional restrictions on their discretionary authority. Further, the receiver should consider that prior company investment objectives of high-yield, equity-related gains, and acceptance of reasonable risk may no longer be appropriate. Concerns of safety and liquidity may be foremost.

A. Seizure and Control of Investments

To seize investments, the receiver should identify the various custodian institutions, investment brokers or managers, and the pertinent account numbers for the insurer. Most of the essential information may be obtained by review of the annual statement and the workpapers of the last full statutory examination or CPA audit. The examination workpapers will most likely include year-end statements and confirmations from the various institutions that are holding the investments. A review of the last filed annual statement will disclose the brokers that are most frequently used for the purchase and sale of investments.

The receiver may also corroborate all the pertinent information with the chief investment officer of the insurer.

If the investment managing function has been contracted to an outside institution, the receiver should promptly notify the institution of the receivership action. The external manager may be allowed to continue with their duties at the direction of the receiver, but transfers to other non-managed accounts should be restricted. The manager's discretionary authority should be reviewed to determine if additional restrictions should be placed on the manager to maintain investment balances in safe, liquid, and/or insured securities. The receiver should consider the difference between investment goals related to rehabilitation versus liquidation

The receiver should notify all banks, custodians, depositories, brokers, and managers of the takeover as soon as possible and by the most expeditious method practicable under the circumstances. Time may be of the essence in preventing insiders from absconding with company funds. The notification should be specific as to account numbers but not limited to those account numbers. (Include any other accounts that bear the name of the insurer.) The notification should be accompanied by a copy of the court order of receivership. The institutions should be instructed as to their continuing duties and what is expected of them.

As part of the notification, the receiver should instruct the institutions to add the receiver's name as a signatory, deleting all others.

A matter that may need priority attention is the immediate suspension of wire transfers. Today, many insurers are electronically connected to financial institutions. Funds can be transferred by use of a personal computer (PC) or by telephone instructions (wire transfers) in a matter of minutes. Until the receiver has had an opportunity to review the process and change access codes and requirements, wire transfers should be suspended.

To avoid the exchange of good quality investments for lower quality investments, the receiver should review the authority for purchases, sales, and reinvestment of securities. The receiver might choose to impose a temporary restriction that only maturing securities may be liquidated to issuing institutions. This will provide the receiver an opportunity to review the quality of the investment portfolio. The receiver may desire the opinion of an outside service company in the evaluation of the portfolio. If the investment function is internally managed, the receiver may want to consider the economies and expertise of an outside investment management company. The receiver may also consider moving out-of-state assets into the domiciliary state to improve control and lessen the chance the assets may be attached by creditors.

B. Identification and Inventory of Investments

An inventory will help establish control of the investments. A good initial control list may be the investment schedules of the last annual statement, including Schedule A—Real Estate; Schedule B—Mortgage Loans; Schedule BA—Other Long-Term Invested Assets; Schedule C—Collateral Loans; Schedule D—Long-Term Bonds and Securities (which includes bonds, common and preferred stock, SCAs, etc.); Schedule DA—Short-Term Investments; Schedule DB—Financial Options and Futures; and Schedule E—Cash and Cash Equivalents. Also, the General and Special Deposit Schedules found in the annual statement will identify investments on deposit with various regulatory jurisdictions.

The receiver should confirm investment holdings with the appropriate institutions. The insurer should have detailed listings of investments held, transaction statements, bank notices and advices, and broker slips and statements. These documents will assist the receiver in the identification and inventory of investments.

The insurer's financial statements may not disclose all investments in which the insurer has an interest. Subsidiaries of the insurer accounted for on the equity method will have separate listings of investments owned. The equity method (as opposed to the consolidation method) permits the parent company to report the net value of (or the equity in) the subsidiary as an investment. Therefore, the assets and liabilities of the subsidiary are not evident in the books of the parent company. In the case of a pension plan, the assets are owned by the pension plan and will not be listed on the insurer's statutory annual statement. Even though pension funds may come under the receiver's control, these funds should be maintained in a separate account. The receiver should also be aware of significant restrictions that may exist on the investment and

use of the funds. Generally, pension funds are subject to the federal Employee Retirement Income Security Act (ERISA), which imposes severe penalties for mishandling funds and governs the dissolution of the pension plan.

Many states require that purchases and sales of investments be approved by the insurer's board of directors. The board minutes may reflect all purchases and sales. A review of the minutes may assist in the identification of investments.

Insurers from time to time may purchase debt obligations directly from the issuing company, without the assistance or the evaluation of a broker. Private placements indicate that the underwriting of the investment was solely the responsibility of the insurer. The insurer should have an underwriting file containing documentation of matters taken into consideration and copies of correspondence regarding the decision to purchase the instrument. The document of indebtedness may be located on the premises of the insurer, rather than with a financial depository or custodian. If securities that are not publicly traded are to be listed in the annual statement as admitted assets, all insurers must submit to the Securities Valuation Office (SVO) of the NAIC documentation to support the market value of the securities. The SVO will evaluate the documentation and assign a market value and a quality grade to the securities. The receiver should check with that agency to determine if management sought such valuations, possibly indicating the existence of additional assets not otherwise apparent from the accounting records.

An insurer should identify those securities with a high risk as to the potential of a loss of principal. While derivative instruments are reported in Schedule DB, the receiver should also be aware of other securities, such as structured securities, included in Schedule D that maintain significant risk. See the section on audit/investigation of financial statements in this chapter for a listing of risks inherent to certain investments. The receiver should determine whether such securities are consistent with the current investment strategy of the insolvent insurer and conclude whether the insolvent insurer should hold or sell the security and the timing of such action. Often, insurers use derivative instruments as a hedge to reduce exposure to other risks incurred by the insurer. With respect to hedge transactions, the receiver should consider whether the hedge transaction effectively reduces the insolvent insurer's exposure to losses arising from other aspects of the insurer's operations or investment portfolio. A common hedge used by insurers is an interest rate swap. The NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) describes an interest rate swap as "a contractual arrangement between two parties to exchange interest rate payments (usually fixed for variable) based on a specific amount of underlying assets or liabilities (known as the notional amount) for a specified period." Insurers have used swaps for various reasons, including matching returns on assets to contractual obligations. The AP&P Manual provides additional examples, for both life and P/C companies, of complex investment arrangements entered into by insurers. The receiver should consider engaging an investment/derivative expert to review the insurer's hedging program and make recommendations.

State insurance laws differentiate between real estate owned and occupied, and real estate owned for investment purposes. Some state laws require that real estate owned for investment purposes be income producing. If no income is generated within a set period of time, the property must be timely and properly disposed of (sold). Non-income-producing real estate should be investigated for possible alternative, non-investment objectives or accommodations. The receiver should review the pertinent statutes and consult with legal counsel regarding possible improprieties.

The insurer may own property in varied capacities. The insurer should have in its possession documentation for each property owned, including the deed (registered with county clerk), appraisal, survey, title policy, lease agreement (if rented), mortgage agreement (if any), schedule of future payments, hazard insurance policy, evidence of real estate tax payments, correspondence, related real estate management agreements, and other pertinent information.

The insurer may own a share of an investment property or may be part sponsor of a capital venture through a limited partnership, and it should have adequate documentation to support the investment. The

documentation should include the partnership agreement, contracts with project managers, projections of cost and time to complete, projections of future income, expert evaluations and opinions, plans of operation and financing, description of any guarantees or financing commitments, and current status reports from project managers.

The insurer should have an individual file for each mortgage loan that contains the signed mortgage note, trust deed, recorded lien, appraisal report, amortization schedule, documentation of hazard insurance, and evidence of real estate tax payments. The insurer may have mortgage servicing agreements, and the receiver should obtain those servicing agreement documents.

Collateral loans are investments that are covered by other assets of the borrower. For each collateral loan, the insurer should have an instrument securitizing the insurer, a description of the borrower (possibly financial statements of the borrower), description and value of property pledged as collateral, and the repayment schedule.

C. Balancing and Reconciliation

The control list of investments that the receiver has developed can be reconciled to certified listings of brokers, custodians, and other depositories. The insurer should have in its investment files the supporting broker slips and bank advices for all investment transactions. A detailed statement of account activity can be obtained from brokers and custodians. The control list should also be reconciled to the general ledger and investment subledger. All discrepancies should be noted and resolved.

Investment transactions should be audited for possible unauthorized transfers. Reference is made to the chapter on investigation and asset recovery in this Handbook.

D. Location of Investments

Usually, the bulk of an insurer's investments will be on deposit for safekeeping with a custodian (a financial institution) to facilitate the transfer of securities for purchases and sales. The safekeeping also minimizes and transfers the risk of theft or misplacement to the custodian. Securities in the custodian's possession may include bonds and publicly traded stocks, option and future contracts, and, on occasion, stocks of subsidiaries.

Many states require securities to be deposited with the insurance department or the state treasurer's office as a prerequisite for the insurer to write business in that state. Alien insurers may be required to place various assets in a trust for the protection of U.S. policyholders. Deposits may be held by non-U.S. jurisdictions. The receiver should notify all jurisdictions and, where possible, obtain the return of all deposits to avoid costly jurisdictional battles with creditors.

Investment brokers may also be holding securities that the insurer has purchased and not yet settled or that have been pledged as collateral for options.

Other investments—such as real estate, mortgage loans, collateral loans, private placements, common shares of subsidiaries, etc.—may be held in an in-house safe or vault for safekeeping. The receiver should make a complete detailed list of documents in the in-house safe. If any items are marketable, the receiver should take appropriate steps for the safekeeping of the items. Since the receiver may not be able to ascertain who has access to keys or codes for such safes, consideration should be given to changing locks or setting up a new safe deposit box under sole control of the receiver.

The insurer may have rented a safe deposit box at a financial institution. An inventory of the box will be necessary and appropriate safeguards taken against access by others. The receiver should obtain the access log for the safe deposit boxes. If the boxes have been accessed just prior to the receivership order, the receiver should investigate the reasons for entry.

E. Valuation of Investments

The determination of value for securities that are publicly and actively traded should not be a problem because prices are published on a daily basis through various data feeds. The receiver should consider the published market value rather than the NAIC value in the evaluation of the liquidation value of assets. Often, a receiver is compelled to sell investments prior to maturity to generate cash flow. The NAIC value, which generally shows stocks and preferred stock at fair value while bonds are usually at amortized cost, will not necessarily reflect the amount the receiver will receive from the sale of investments.

The market value should approximate the amount of cash that may be generated from the sale of investments. The market valuation reflects an adjustment for current market rates as compared to the fixed interest rate on the investment and for the credit-worthiness of the debtor.

Private placements will be the most difficult to value, and the opinion of outside experts may be necessary. The receiver may wish to employ an investment specialist to determine the values and liquidity of below-investment-grade private placements or non-publicly traded stocks. The financial statements of the borrower may be sought. A review of the financial statements may tell whether the company is in sound financial condition and whether it is able to repay the obligation. Prepayment at a discount may be an alternative for both parties.

Several values may be placed on real estate that is occupied by the insurer. The value may be the cost paid less depreciation, construction cost less depreciation, appraisal value, or market value. The receiver may consider the latest appraisal of the property and determine the possible market value. Economies may warrant the sale of the property and rental of other quarters.

Real estate that is held for investment ordinarily should be income-producing. A large negative cash flow may warrant disposal of the property. An appraisal may be necessary to assess the marketability, which will disclose the sale price of similar properties in the area. If comparable sales are not available to estimate market value, the receiver may consider using a discounted cash-flow approach to valuing the real estate. The receiver may wish to obtain outside professional support in determining proper values, methods of valuing, investments in real estate, mortgage loans, and real estate joint ventures or limited partnerships.

The book value of mortgage and collateral loans is usually the unpaid principal balance. The receiver may also assess the value of the property that has been pledged as collateral. Many states' insurance laws require that mortgage loans be first-lien mortgages. A second-lien mortgage is of greater risk and subordinate to the first-lien mortgage. Insurance laws require the amount of the mortgage, at inception, not to exceed a specified percentage of the appraised value of the property. The receiver should research compliance with the statutes. Possible accommodations given to affiliated parties should be investigated.

F. Other Considerations

The insurer may be the owner of various tangible and intangible assets that may not be apparent on its statutory balance sheet. The receiver should try to identify and value all possible assets of the insurer, including insurance licenses, the value of the shell of the company, assets that have been previously written off, and any assets that are listed in Schedule X of the annual statement.

1. Pension and Deferred Compensation Plans

The insurer's employee benefits may include participation in either a defined-benefit or defined-contribution pension plan. The plan may require or allow that a percentage of the assets of the plan be invested in shares of the insurer. It is not uncommon for the trustees of the plan to be officers of the insurer. Also, the plan administrator may be the insurer itself or an outside financial institution. The regulatory action will create several uncertainties in relation to the plan. The receiver should be familiar with the provisions of the plan and whether a complete liquidation and distribution is required. The provisions of the pension plan agreement and the Employee Retirement Income Security Act of 1974

(ERISA) may clarify some of these issues. It is recommended that the receiver retain the services of a consultant CPA firm to audit and provide independent opinion regarding compliance with IRS and ERISA requisites.

If the insurer is insolvent and the plan is heavily invested in shares of the insurer, then the plan may be insolvent also. The administrator, therefore, may need to liquidate the plan. If the pension plan is solvent, the administrator must continue with its duties. If the insurer is the plan administrator, the receiver may become the plan administrator by succession. If the plan administrator is a third party, the receiver may wish to evaluate the propriety of changing administrators.

The insurer may have hidden equity in other employee benefit plans. A saving plan that requires the insurer to partially match amounts contributed by the employees may be such a plan. The plan agreement will detail the operation of the plan and when the insurer's contributions vest to the employees. The plan should have provisions for possible employee termination on a voluntary or involuntary basis. Depending upon the terms of the plan, the receiver may recover contributions that have not vested to the employees, or the receiver may amend terms, for example, to eliminate employer matching of contributions.

Pension considerations may be further complicated if an employee benefit plan is established to cover the employees of a parent holding company and its many subsidiaries, of which the receiver has authority only for one or more insurer subsidiaries. The desire of the receiver to terminate the plan and attach excess assets (or reduce additional exposure to underfunding) may be mitigated by excise tax issues on termination, ERISA, and other considerations.

It should be noted that under some state liquidation priority statutes, amounts, and priorities due employees may be limited. Compensation and benefits due officers and directors may also be excluded in their entirety.

2. International Considerations

As insurers become part of a global economy, the receiver may be confronted with the issues of investments and other assets held in other countries. The receiver should try to gain control of the investments or assets and bring their value back to the estate. An ancillary receiver may be appointed by a foreign country, which may make that difficult, since the ancillary receiver may need the assets to settle claims in the ancillary jurisdiction. The ancillary receivers will need to cooperate with the domiciliary receiver. The value of the foreign assets will fluctuate with the exchange rate of the foreign currency, and the receiver should try to match in foreign denomination the assets and liabilities (claims) by the foreign country. This should indicate whether any excess assets are held in the foreign country. The receiver should ascertain if the company's Schedule DB contains derivative instruments covering foreign currency exchange risks. Because foreign countries may have currency restrictions for repatriation of assets, the receiver should consult with legal counsel.

Special deposits and general deposits with insurance regulators in other jurisdictions in the U.S. and outside the U.S. may also present problems to the receiver. Many U.S. courts have ruled that the state of domicile has the duty to liquidate the insurer and, therefore, all deposits should be returned to the domiciliary receiver. In the case of a non-U.S. jurisdiction, the foreign receiver may claim the right to the deposits for purpose of distribution in his jurisdiction. In this situation, the receiver should consult legal counsel. The receiver should consider whether they can divest themself of the responsibility for foreign claims.

3. Structured Settlements

In the insolvency of an annuity insurer, special consideration should be given to any single premium immediate annuities that were issued to form the basis of funding periodic or lump sum payments in personal injury settlements, commonly known as "structured settlement annuities."

These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS tax codes (primarily 104 (a)(2)) and various revenue rulings in order to preserve the tax benefit to the beneficiary or payee. However, some older annuities (prior to 1986), although not issued to a QA company, may nonetheless enjoy the same tax benefits. Generally, periodic payments are excludable from the recipient's gross income only if the payee is not the legal or constructive owner of the annuity and does not have the current economic benefit of the sum required to purchase the periodic payments.

When these blocks of business are resolved in the insolvency context (typically through assumption reinsurance), extreme care must be taken to ensure that the resolution does not compromise the tax benefits to the payees. It is strongly recommended that competent and experienced tax counsel be retained to guide the receiver through this potentially complicated process.

X. RECEIVABLES

A. Uncollected Premiums

The amount of uncollected premiums may vary from company to company, but may be a significant asset.

1. Methods of Billing

The billing and recording of insurance premiums differ, depending upon the insurer (e.g., direct billing of policyholders versus billing of agents) and type of insurance (e.g., primary versus reinsurance). Following are four of the more common types of billing methods:

a. Direct Billing

Some insurers bill the policyholder directly for the full amount of the premium. A separate liability is established for any commissions allowed to brokers or producers.

b. Agency Billing

Insurers that use agency billing send monthly statements to their agents, listing premiums written during the month, including any adjustments and endorsements of previously issued policies. Commissions allowed to the agent are deducted on the statement to arrive at the net amount due to the insurer.

c. Account Current Billing

This method is used when the agent submits a statement to the insurer. The account current sets forth premiums written by the producer during the month, less the commissions. This method requires the insurer to maintain a premium difference register to account for differences between the premiums reported by the agent and insurer's records. Differences are usually resolved by communicating with the agent. (Use of the agency billing method will transfer the premium difference reconciliation to the agent.)

d. Item Basis

The item basis of billing is generally used when each item is remitted when collected by the producer, as is the case when business is submitted by many independent brokers. The amount of the bill is usually net of the broker's commission.

2. Different Types of Premiums

   a. Property/Casualty Insurance Premiums

   Most property and liability policies provide for the payment of a single premium for the entire term of the policy (usually one year). Different types of property and liability premiums include:

   - Installment premiums—Some insurers issue policies that are payable on an installment basis. Even though the premiums may be payable on an installment basis, the insurer must record the full annual premium when the policy is issued, except for those policies that are recorded or billed monthly because of changing exposures. Premiums that are due currently are billed using any of the foregoing methods. The billing of future installments is deferred until the due date of the installments.

   - Retrospectively rated premiums—Retrospectively rated policies are used when the ultimate premium is based on the individual policyholder's claim experience. The ultimate claim experience may not be known until several years after the policy has expired. Usually a deposit (estimated) premium is billed using any one of the above methods when the policy is issued. However, the ultimate premium will be developed by applying the retrospective factor set forth in the policy to the policyholder's claim experience. The ultimate premium will not be less than the minimum nor more than the maximum premium set forth in the policy.

   - Audit premiums—Some premiums are based on the amount of the policyholder's payroll or sales (reporting values). For these policies, the insurer will bill an estimated or deposit premium at the inception of the policy and, upon determining the reporting values, the final premium will be billed. Sometimes insurers send auditors to determine and/or verify the reported values. These premium adjustments are called audit premiums. The billing of the deposit and audit premiums may be done by using any combination of the aforementioned methods.

   - An insurer should maintain an inventory of policies with adjustable premium features such as retrospectively rated premiums and audit premiums. Typically, retrospectively rated premiums are popular features of workers' compensation policies and reinsurance treaties. The receiver should be aware of adjustable features included in contracts of the insolvent insurer and ensure that all contracts with such provisions are summarized. In the preparation of financial statements, appropriate accruals should be recognized for these contractual features based on the related claim experience and premiums paid under the agreement as of the date of the financial statements. The receiver should further ensure that appropriate action is taken to collect monies owed the insolvent insurer under these contractual provisions and that proper recognition of liabilities arising from these contractual provisions is provided in the financial statements. If the accrual is significant, a receiver may consider performing a systematic review of the related accounting support, focusing the review on policies with premiums that are substantial to the overall population.

   b. Life and Accident and Health Premiums

   Unlike property and liability insurance policies, life and A&H insurance policies can be guaranteed renewable contracts and are generally accounted for as long-term contracts. Premium payment plans for life, annuities, and A&H insurance vary. Some polices may be payable monthly, as is frequently the case with group insurance. Others may be payable quarterly, semiannually, and/or annually. Some may be fully paid up when issued. For HMOs and health insurers, it is important

for employer groups and government plans like Medicaid that premiums are reconciled monthly to enrollment tapes to ensure that additions and deletion of members are updated promptly.

c. Assumed Reinsurance Premiums

Assumed reinsurance premium billing, recording, and collection methods and procedures primarily depend on the reinsurance treaties, which specify the relationship between the parties.

- Facultative premiums—Facultative reinsurance may be billed and recorded using any combination of the methods described above for direct insurance. It is usually billed and recorded on a direct basis or account current basis.

- Treaty premiums—Premiums due on assumed treaty business are usually reported to the reinsurer either directly by the cedent or by the reinsurance intermediary.

3. Policy Control

An insurer normally prenumbers its policies when printed. A control procedure should be in place routinely to identify and follow up on skipped and missing policy numbers. The receiver should ascertain the insurer's policy control procedures and ensure that missing and skipped policy numbers are properly accounted for because a skipped or missing policy number may represent an unbilled, in-force policy. In the case of multiple offices and multiple agents with policy-issuing authority, there may be several sets of policy numbers.

4. Setoff Against Uncollected Premiums

State insolvency statutes may restrict setoffs that previously were allowed against uncollected premiums due the insurer when it was solvent. In many cases, no setoffs may be allowed, even if:

a. Agents were previously permitted to: (i) deduct commissions from premium remittances; and (ii) return premium owed to one policyholder from an amount owed to the insurer on another unrelated policy.

b. Cedents were permitted to: (i) set off ceding commissions and loss payments from premium remittances; and (ii) settle balances for a variety of assumed and ceded contracts on a net basis.

The propriety of recognizing setoffs should always be reviewed with the receiver's legal counsel.

5. Commission Recoverable on Cancellation of Policies In Force

Agents and brokers are usually prepaid their full commission when the premiums are collected, even though the premiums are earned over the life of the policy. They frequently deduct their commissions from their remittances to the insurer.

Upon cancellation of the policies in force by the receiver, the policyholders are entitled to a return of the premiums applicable to the unexpired term of the policy (unearned premium). Such return may be fully or partially paid by a state guaranty fund. The policyholder may file a proof of claim with the receiver for any amounts not paid by the guaranty funds. In any event, the receiver should look to the agents and brokers for the return of prepaid commissions applicable to the refundable unearned premiums.

6. Summary

A variety of methods and procedures are used by insurers to bill, record, and collect premiums. A combination of methods may be used. Since uncollected premiums are usually a significant asset, it is

important that the receiver become familiar with the insurer's premium billing and recording procedures in order to most effectively marshal these assets. If necessary, new systems and procedures may be required to collect these assets subsequent to liquidation.

Finally, the applicability of federal and state debt collection statutes should be considered by counsel. Receiverships may be entitled to governmental exemption from certain statutes.

B. Bills Receivable Taken for Premium

Insurers sometimes accept a promissory note from the policyholder for a portion of the premium due. The promissory note includes a payment schedule and is subject to interest on the unpaid balance. Some companies record the principal amount of the note, plus the total interest to scheduled maturity, as a receivable and set up a contra account for the unearned portion of the interest. Others record only the principal amount of the note as an asset and separately accrue the interest as it is earned. Statutory accounting treats bills receivable differently than agents' balances and notes receivable. (See *Statement of Statutory Accounting Principles (SSAP) No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers*.) The realizable value of these receivables should be ascertained.

C. Life Insurance Policy Loans

Policy loans usually are a significant asset to a life insurer that writes permanent plan life insurance. Unlike term insurance, permanent plan life policies build cash surrender values that may be borrowed by the policyholder either as a:

- Conventional loan where the policyholder makes an application to borrow all or part of the policy's available cash surrender value.

- Automatic premium loan (APL) where the policy provides, or the insured has elected in the application for insurance, that the policy shall not terminate (lapse) because of the nonpayment of premiums as long as there is adequate cash value to cover the unpaid premiums and any other amounts owed under the policy.

If the policyholder dies before the policy loan is repaid or the policy is surrendered, the proceeds payable by the insurer should be reduced by any outstanding policy loan.

D. Salvage and Subrogation (Property/Casualty and Health)

1. Salvage

Salvage is an amount received by an insurer from the sale of damaged property or recovered stolen property for which the insured was indemnified by the insurer. In the claim settlement process, the insurer will obtain title to the property and sell it for its remaining value. This asset needs to be addressed quickly because property often is stored, and storage fees are being incurred. Salvage on surety bonds (e.g., construction performance bonds) may be of considerable amount. Due to the intricacies of the surety line of business, consideration should be given to the hiring of external experts to manage the salvage of uncompleted projects.

2. Subrogation

Subrogation is the legal right of an insurer to recover from a third party who was wholly or partially responsible for a loss paid by the insurer under the terms of the policy. In the case of a property accident, where there is a dispute between the parties, an insurer will often pay its policyholder's claim and assume the policyholder's right to pursue the negligent third party.

3. Accounting Practices

Until 1992, under statutory accounting practices, an insurer was not allowed to recognize salvage and subrogation recoverables until they were collected. In 1992, the AP&P Manual began allowing accrual of salvage and subrogation recoverables. However, certain states may still disallow the asset. GAAP requires that an insurer recognize an asset or reduce its liability for unpaid claims for the amount of salvage recoverable on paid and unpaid claims. Therefore, an insurer should have records, systems, and procedures to identify and follow up salvage and subrogation recoverables on both paid and unpaid claims.

4. Summary

A receiver should ascertain how an insurer identifies and follows up on its salvage and subrogation recoverables. This becomes more difficult when claim files are turned over to a guaranty fund. Salvage and subrogation practices may vary among the guaranty funds. Salvage and subrogation collected by a receiver or guaranty funds may have to be held in trust for certain beneficiaries (e.g., where the policyholder's claim is subject to a deductible, or the loss is a reinsured loss and the reinsurer previously reimbursed the insurer for the full amount of the claim). The right to the salvage and subrogation proceeds should be discussed with legal counsel.

5. Salvage and Subrogation (Property/Casualty – Deductible Recoveries – Only)

a. Deductible Recoveries

Large-deductible recoveries are amounts received by an insurer from an insured covered under a policy having an endorsement providing that the insured is responsible to indemnify the insurer for losses and certain LAE incurred that are for amounts below the high deductible. The high-deductible definition varies, but it is often for deductibles up to $100,000. While these policies share some characteristics with retrospectively rated policies, the accounting treatment of recoveries under the two types of policies is different. If the policy form requires the reporting entity to fund all claims including those under the deductible limit, the reporting entity is subject to credit risk, not underwriting risk.

b. Accounting Practices

Under statutory accounting practices, reserves for claims arising under high-deductible plans are established net of the deductible. However, no reserve credit shall be permitted for any claim where any amount due from the insured has been determined to be uncollectible. Reimbursement of the deductible is accrued and recorded as a reduction of paid losses simultaneously with the recording of the paid loss by the reporting entity. Therefore, these amounts are not easily identified on the balance sheet. It is important that the receiver examine the records, systems, and procedures to identify and follow up large-deductible recoveries on both paid and unpaid claims. It is also important to understand the insurer's process for obtaining collateral to mitigate credit risk on high-deductible policies. The receiver should examine the scope of the large-deductible business written, as well as the collection and collateral procedures employed by the company. The High Deductible Disclosures, Note 31 in the Annual Statement Disclosure and the related guidance in *SSAP No. 65—Property and Casualty Contracts* should aid the state insurance regulator in this review.

E. Reinsurance

For additional information on reinsurance, see Chapter 7—Reinsurance.

1. Reinsurance Recoverables

For P/C insurers, reinsurance recoverables on unpaid losses are not reported in the cedent's financial statement as receivables, but they are accounted for as a reduction of its gross liabilities for unpaid losses and LAEs. Reinsurance recoverables on loss payments and LAEs are, however, recorded as an asset in an insurer's financial statement. However, GAAP reporting now requires reporting reinsurance recoverables on paid as well as unpaid losses as an asset (FASB No. 113). All insurers—both P/C and life—use a variety of internal accounting procedures to bill and record paid loss reinsurance recoverables. Unfortunately, financially troubled insurers do not always have adequate internal controls and procedures in place to properly quantify and identify their recoverables by individual reinsurer. Consequently, a substantial amount of record reconstruction may be necessary by the receiver's staff, not only to identify all present recoverables, but also to install appropriate systems and procedures to bill and monitor future paid recoverables.

2. Funds Held By or Deposited With Reinsured Companies

The reinsurance treaty between the reinsurer and its cedent may require the cedent to withhold a portion of the premiums owed to the reinsurer and/or the reinsurer to deposit funds with the cedent. The purpose of such an arrangement is to collateralize the reinsurer's obligations for unpaid losses owed to the cedent. Care should be taken by the receiver to ensure that proper credit is taken against invoices submitted by the cedent for any such deposits.

F. Health Care-Related Receivables

Insurers and HMOs may have receivables for provider claims overpayments, pharmacy rebates, provider risk sharing recoveries, capitation arrangements, and loans/advances to providers.

XI. ACCOUNTING AND FINANCIAL REPORTS TO THE RECEIVERSHIP COURT AND THE NAIC

Accounting and financial reports will be required by the receivership court at the date of the receivership and subsequently to monitor the progress and status of the receivership. To prepare these reports, the receiver will need to continue processing and recording transactions and producing related reports. The results of the accounting transactions described in the preceding sections of this chapter should be incorporated into the company's financial information and subsequently produced financial reports. Exhibit 3-1 is a representative summary of the format required to be input into the NAIC's GRID Global Receivership Information Database (GRID) system.

Additional information is often critical to the daily management of the receivership. Perhaps the most needed additional reports are: 1) daily cash reports (Exhibit 3-2); and 2) a budget to monitor costs (Exhibit 3-3).

A. Timing of Preparation

Within 180 days after the entry of an order of receivership by the receivership court, and at least quarterly or annually thereafter, the receiver shall comply with all requirements for receivership financial reporting as specified by existing state receivership laws. The financial reports should include: a statement of the assets and liabilities of the insurer; the changes in those assets and liabilities; and all funds received or disbursed by the receiver during that reporting period. (See Exhibit 3-1.) These reports are also to be filed with the receivership court. Receivers in those states without Model #555 may be required to file some or all of these reports with the receivership court. The receiver may qualify any financial report or provide notes to the financial statement for further explanation. The receivership court may order the receiver to provide such additional information as it deems appropriate. The reports should include claims and expenses submitted from each affected guaranty association.

For good cause shown, the receivership court may grant relief for an extension or modification of time to file the financial reports by the receiver.

In the early stages of a receivership, especially one involving an insurer with limited liquid assets, daily cash reports are critical to determine whether the insurer should be in conservation, rehabilitation, or liquidation. A budget is useful to manage the costs of the receivership and should be produced in the first year after the initial receivership court order.

B. Necessary Sources and Records

The following is a listing of information that may be used to prepare the financial reports:

1. Trial Balance and Detail Subledgers

The trial balance normally is produced on a monthly basis and details all assets and liabilities on a cumulative basis, plus income and expenses for the period. The line items on the trial balance can tie directly to the general ledger or can consist of a grouping of several general ledger accounts. The detail subledgers exist for accounts payable and contain more detailed information about an account, such as individual account information, vendor name, and due date of payment. The totals of these subledgers either tie directly to the general ledger account balances, or they are reconciled and differences are identified. If the corporate structure consists of more than one company, then a consolidated trial balance should be produced that consolidates all individual companies.

2. General Ledger

The general ledger details the account information, showing the activity in an individual account during the period. Totals tie to the trial balance on an individual basis, and sometimes accounts and subaccounts are detailed and grouped into one line item that ties to the trial balance. The general ledger typically gives more detailed information on the transactions that were recorded during the period. An individual general ledger usually exists for each company/legal entity.

3. Bank Reconciliations

Bank reconciliations are useful in reporting on and projecting available cash for the operations of the receivership.

4. Investment Ledger

The investment ledger contains investment activity, investment income, types of securities, and realized and unrealized gains and losses. Totals should tie to the general ledger.

5. Accounts Receivable and Reinsurance Recoverable Aging

The accounts receivable and/or paid recoverable aging contain detail of accounts receivable and paid recoverable balances by account and ages the receivable based on number of days it has been outstanding. Reinsurance recoverable ledgers will also be kept here. Reinsurance recoverables will be included in the aging. The aging will be used in establishing allowances for uncollectible items.

6. Reserves

With respect to P/C insolvencies only, loss and LAE reserves (case, IBNR, and LAE reserves) tend to be the most significant amounts on the balance sheet, as well as the most subjective. If an outside actuary is used to evaluate the existing reserves and to project the ultimate losses, the resulting actuarial studies may be used when preparing the financial statements, and any adjustments should be reflected in the statements. With respect to life insurance insolvencies, there are substantial non-loss reserves for expected future benefit payments on various policies or contracts.

7. Paid Loss Information

Losses paid by the guaranty funds on behalf of the insurer should be recorded as liabilities in the insurer's records.

8. Cash Disbursements and Cash Receipts

A check register of all amounts paid during a given month, including payee and amount, should be maintained. Cash receipts are actual cash items received monthly and deposited into the estate's bank accounts.

9. Budget Versus Actual Report

A receivership budget for expenses and income by department should be established within 12 months of the date of receivership. On an ongoing basis, a report should be generated detailing budgeted versus actual expenditures for the reporting period. All significant variances should be investigated by the receiver.

C. Responsibility

The responsibility of preparing the financial and accounting reports can be assigned to the insurer's accounting and finance departments, the receiver's personnel CPA, or independent CPAs. The use of independent CPAs should be considered if the receiver questions whether the remaining insurer's personnel are capable of completing the report, or the receiver does not have sufficient staff.

A specific individual should be designated as the party responsible for the distribution of the reports to the receiver, attorneys, personnel, applicable state agencies, and other predetermined parties.

The filing of the completed reports with the courts should be assigned to the attorneys handling the receivership.

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CHAPTER 4—INVESTIGATION AND ASSET RECOVERY

I. INTRODUCTION

Insurance receivers generally have two principal duties: 1) marshalling assets; and 2) paying or otherwise disposing of claims. Typically, the marshalling of assets involves selling real and personal property, collecting reinsurance recoverables and/or commuting treaties, collecting earned premium, filing preference and fraudulent conveyance actions, and bringing lawsuits against former owners and management.

In any receivership, the receiver is responsible for maximizing and safekeeping the assets of the insolvent insurer. One of the receiver's early priorities is to examine the insurer's records to identify the insurer's assets, marshal them as necessary or appropriate, and then determine whether litigation should be pursued against any persons or entities liable for causing or contributing to the insurer's financial difficulty.

It is important for the receiver to keep in mind that the receiver's investigation and asset recovery activities may be subject to approval by the receivership court, with notice to guaranty associations and other interested parties. Furthermore, the receiver should take special care to review any applicable state or federal laws.

As a general rule, most state statutes require receivers to seek court approval before they may sell, assign, transfer, or abandon assets having an individual or aggregate value above a threshold dollar amount. Therefore, a receiver seeking to sell an asset or settle a claim of the type described below may need court approval before closing the transaction.

II. DISPOSITION OF ASSETS ALREADY IN THE ESTATE

A. Title to Assets—Legal Versus Equitable Title

The first issue to address before a receiver may dispose of an insurer's assets is whether the receiver is vested with title to those assets. The NAIC *Insurer Receivership Model Act* (#555), also known as IRMA, gives possession of all assets of the insurer to all receivers. Title to an asset may be legal or equitable or both. Legal title is ownership of the asset; equitable title is the right to the benefits or possession of the asset. Normally, both titles are held together, but in some cases, they can be divided. In a trust situation, the trustee is the legal owner of the asset, but the beneficiaries receive the benefits of the trust and so are the equitable owners of the asset. A receiver can only transfer the interest the insurer held. If an insurer had both legal and equitable title, the liquidator has the full power to dispose of the asset. If the title was bifurcated, the holders of the legal and equitable titles must join in the transfer in order to pass full ownership of the asset to the purchaser. Counsel should be consulted to assure that all equitable interests are identified prior to attempting to sell any assets.

B. Payment Terms

The principal reason for entering into a sale transaction is to generate income for the insolvent insurer, with a view to maximizing the distribution of assets to its policyholders and creditors. If creditor distributions will not occur until a later date, the receiver can entertain installment terms, possibly attracting purchasers or an increased purchase price not attainable in an immediate lump-sum sale.

C. Tax Consequences of a Disposition

All disposition of assets will result in tax implications, which will need to be reported on the company's tax returns. Appropriate professional advice should be sought.

D. Other Terms

Most assets are sold on an "as is" basis with limited representations and warranties to prevent the receiver from being exposed to liability for matters for which it has limited knowledge. If the buyer is unwilling to

purchase the asset "as is," the receiver may consider giving limited representations and warranties, but only subject to the receiver's "knowledge" and restricted to facts concerning the asset to be sold that the receiver has learned during the conduct of the receivership proceedings.

An asset sale agreement may also contain provisions designed to maintain confidentiality of its terms. Confidentiality is particularly desirable if the receiver subsequently may enter into similar transactions with other third parties on more or less favorable terms. Venue over all disputes should remain in the receivership court. Finally, the breadth of release given by and to the receiver should be carefully considered in light of the transaction being documented and the receivership proceedings as a whole.

E. Supervising Court Approval

Court approval may be required prior to disposition of an asset.

F. Identification and Collection of Statutory/General and Special Deposits

The receiver should make every effort to identify and collect all estate assets held by other states or entities as statutory/general or special deposits. The receiver should have specific policies and procedures regarding the identification and collection of these assets. These should address:

- Location and current status/value of the deposit.
- Determination of creditors within state holding deposit.
- Discussion with the state insurance department holding the deposit about their intentions regarding:
    - Possible full ancillary receivership.
    - Holding the deposit due to open claims within their state.
    - Releasing the deposit to the receiver.
    - Releasing or assigning the deposit to the guaranty funds.
- Review and execution of release agreement.

G. Disposal of Assets

Once the receiver has identified and inventoried all assets, the focus should turn to the process of sale and disposal of assets. Assets should be sold at the most opportune time to recover their maximum value by approved sales and disposal methods that are transparent and avoid any appearance of a conflict of interest.

III. INVESTIGATION AND PURSUIT OF CLAIMS AGAINST THIRD PARTIES

A. Objectives of Investigation and Asset Recovery

The goal and the scope of the investigative examination should be tailored to fit the specific situation. In all cases, the examination is crucial to analyzing the insurer's financial difficulty. The examination also may reveal corrective actions that the receiver should implement for successful rehabilitation. In all cases, the thrust of the investigative examination is to disclose what went wrong, determine what corrective action is necessary, reconstruct critical data/programs to support asset collection, and identify those legally

responsible for the demise of the insurer. In appropriate cases, life and health guaranty associations may be able to provide support and assistance in connection with asset recovery efforts. In life and health, joint and common interest agreements are commonly used by regulators, receivers, and guaranty associations to preserve protections for privileged communications and work product. Quite often property/casualty (P/C) guaranty funds enter into confidentiality agreements with receivers to exchange information and work towards preparing a company for liquidation if that is the ultimate outcome.

The receiver may retain the services of accountants or examiners who have expertise in determining whether the insurer's financial condition gives rise to any causes of action, as well as marshalling assets and quantifying liabilities. The job of such an examiner goes beyond the role of an auditor. Here, in addition to probing for the cause of the financial difficulty, the examiner must identify for the receiver all transactions or business dealings that may produce assets for the insurer's policyholders and creditors, either by avoidance or rescission of certain transactions or by other legal action. Some state insurance departments may have experts in-house whose services are available to the receiver; otherwise, the receiver should consider retaining appropriate outside consultants.

B. General Conduct of an Investigation or Post-Receivership Examination

The receiver and the examiners should make themselves aware of the state statutes governing insurer receiverships. These statutes frequently detail the elements of causes of action that the receiver and examiners should investigate. For example, certain transactions are deemed preferential and may be voidable. Other transactions may be classified as fraudulent and may be set aside as such. The receiver and the examiners should seek advice of legal counsel on such statutes and, in particular, the applicable statutes of limitation. (See Chapter 9—Legal Considerations.) (Counsel also may be helpful by providing guidelines for examiners to follow in conducting the investigation.) It is crucial that the receiver take the requisite legal action in timely fashion to avoid the bar of such statutes.

The investigative examination of an insurer can start with records maintained by the insurance department. These records may include: transcripts and exhibits from administrative proceedings against the insurer; holding company registration statements; market conduct reports rate filings; recent Form A filings; work papers related to the last statutory examination, including the report thereon; annual and quarterly financial statements; and correspondence files. The receiver should also procure a complete set of the audit work papers of the insurer's certified public accounting firm, including the firm's permanent and correspondence files, as well as a complete set of the work papers from the insurer's consulting actuaries. The receiver should also thoroughly review the minutes of meetings of the board(s) of directors and any board or executive committees of the insurer and its subsidiaries. If possible, the minutes of any related holding company should be reviewed.

These records may provide the receiver with specific areas of concentration for the investigative examination. The examination will be broad in scope with a special emphasis on large or unusual transactions. The insurer's files on any suspect transactions must be reviewed completely; the receiver may need to engage a forensic accountant to assist the receiver's counsel in this review.

Once the examination reveals potential causes of action to pursue, a cost-benefit analysis should be conducted. If the potential benefit does not warrant the anticipated cost of the legal action, administrative remedies may be available. In order to conduct such an analysis, the receiver needs a full understanding of the potential claims, including the legal requirements that must be met in order to prevail on them.

C. Reference to Special Issues Regarding Claims Involving: Federal Home Loan Bank, Life/Health, and Large Deductible

In Chapter 5, there is a section that discusses special issues regarding particular claims, namely: 1) claims of the Federal Home Loan Bank (FHLB); 2) life and health claims; and 3) claims under large-deductible programs. As large-deductible programs involve both policy claims and the collection of amounts due under those policies, both subjects are covered in that subchapter.

IV. VOIDABLE PREFERENCES

The receiver of an insolvent insurer faced with the need to gather the assets of the insurer's estate should bear in mind that many state liquidation statutes authorize the receiver to retrieve property transferred by the insolvent insurer to another party if the transaction constituted a "voidable preference" as defined by statute. In general, these statutes permit the receiver to recover assets that the insurer transferred to a creditor to satisfy prior debts and resulted in the creditor receiving a greater percentage of its claims against the insurer than other creditors in the same class. The statutes in various states differ significantly in substance, scope, and form. Some states may not have voidable preference provisions in their insurance receivership statutes. However, provisions regarding voidable preferences may exist in a state's general laws, and there may be applicable case law on the subject. The receiver should consult the statutes and case law in the insurer's state of domicile to ascertain which voidable preference laws may be applicable and to learn the requirements of those statutes.

The concept and general elements of voidable preferences are discussed in detail in Chapter 9—Legal Considerations of this Handbook. In general, a voidable preference may be found if:

- There was a transfer of the insurer's property.
- The transfer was made during a statutorily specified time period.
- The transfer was made to satisfy an "antecedent debt."
- The transfer results in a "preference."

It may be necessary for the receiver to establish that there was intent to create a preference or that the creditor had reason to believe the insurer was insolvent in order for the transfer to be voidable. It may also be possible for the receiver to recover a voidable preference from persons other than the party to whom the insurer's property was transferred, such as "insiders" of the insurer who were involved in the preferential transaction and, in some cases, subsequent holders of the property. In some instances, however, the receiver's right to pursue such remedies may conflict with the rights of other creditors to pursue the same.

Preferences are dealt with in Section 604 of Model #555. This provision delineates the conditions under which a receiver can avoid a preference and attempt to recover the assets that were given to the antecedent creditor. The preference period under Model #555 is two years. Not all preferences can be avoided by the receiver. Subsection 604(B) provides that preferences can be avoided if:

- The insurer was insolvent at the time of the transfer.
- The transfer was made within 120 days before the filing of the petition commencing delinquency proceedings.
- The creditor receiving it or being benefited thereby had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent.
- The creditor receiving it was:
    - An officer or director of the insurer.
    - An employee, attorney, or other person who was, in fact, in a position to effect a level of control or influence over the actions of the insurer comparable to that of an officer or director, whether or not the person held that position.
    - An affiliate.

Subsection 604(C) states which preferences may not be avoided even if they would otherwise be avoidable under Subsection 604(B). Basically, preferences may not be avoided if they were made in exchange for an item of value to the insurer, if they were made in the ordinary course of business in accordance with ordinary business terms, or if they were in the form of an appeal bond.

V. FRAUDULENT TRANSFERS

Receivers typically have the authority to recover assets conveyed by the insurer in transactions that constitute fraudulent transfers. The receiver's authority to recover fraudulent transfers may stem from any of the following sources: 1) a specific state statute; 2) the Uniform Fraudulent Conveyance Act to the extent adopted in the particular state; and/or 3) the common law of fraud. Fraudulent transfers are covered by Section 605 of Model #555. The receiver should consult counsel to ascertain which theories are available to recover fraudulently transferred assets.

Like voidable preference statutes, rules against fraudulent transfers authorize the receiver to rescind certain transactions and bring previously transferred assets back into the insolvent insurer's estate. Fraudulent transfer laws vary from state to state, but most permit the receiver to avoid transfers for inadequate consideration or transfers aimed at obstructing or defrauding other creditors.

Receivers may be able to recover fraudulent transfers from the person who received the transfer, "insiders" at the insurer who were involved in the transfer, and, in some cases, subsequent holders of the property transferred. Certain additional requirements may be applicable, and special rules may apply to certain reinsurance transactions, such as commutations. The receiver should consult Chapter 9—Legal Considerations for further details.

VI. OTHER SIGNIFICANT TRANSACTIONS

In addition to considering fraudulent transfer laws and voidable preference statutes, a receiver reviewing the reasons for an insurer's financial problems and attempting to marshal its assets should determine whether there have been any suspect transactions. Suspect transactions are unusual transactions that would not normally occur in the ordinary course of business. Some of these transactions may at first glance appear to be ordinary, but upon closer examination, they are found to have not been entered into for the benefit of the insurer. These are transactions that may have deceptively portrayed the insurer's financial condition, delayed discovery of its insolvency, or resulted in actual losses for the insurer. Included in the category of suspect transactions are transactions that did not comply with applicable legal requirements, were not commercially sound, or lacked financial viability.

A receiver may advance various theories to recover funds for the estate regarding losses or damages caused by suspect transactions. For example, causes of action for recovery may be based upon common law fraud, violations of the federal Racketeer Influenced Corrupt Organizations Act (RICO), fraudulent transfers, or breach of fiduciary duty. These and other causes of action are addressed fully in other sections of this Handbook and are not repeated here.

This section focuses on identifying potentially suspect transactions that are not discussed elsewhere in this Handbook. The transactions identified do not frame an exhaustive list of all suspect transactions, nor are the identified transactions necessarily fraudulent. In fact, if properly negotiated and administered, the transactions may be perfectly legitimate. However, the receiver should review the following types of transactions for due diligence. Suspect transactions may be difficult to detect and may consist of combinations or variations of one or more of the transactions described.

A. Reinsurance

Reinsurance balances often represent significant assets and liabilities of insolvent companies, whether from assumed or ceded business. It is commonly the case in a P/C insurer insolvency that these balances will represent the largest asset to be marshaled. Because reinsurance transactions are complex and involve large sums that may have a material effect on the balance sheet, these transactions present numerous opportunities

for fraud, misappropriation, or mismanagement by or upon the insolvent company. The receiver's investigation should, therefore, include a review of the company's reinsurance structure, and especially any extraordinary transactions in the years immediately preceding the company's demise.

1. General Considerations

Delegation of the collection of reinsurance recoverables, without proper accounting and management controls, to managing general agents (MGAs) and other third parties has been a common source of large accruing balances. Therefore, the more common asset recovery activity in this area is in record construction and documentation of the accrual of balances due (see Chapter 7—Reinsurance). Aside from the instances covered below, the larger amount of the receiver's reinsurance recovery work usually should focus on the concepts that: 1) reinsurers respond and pay based on a proper accounting and documentation of the balances due; and 2) because of the frequent mismanagement of these transactions by insurers that have become insolvent, reinsurers are skeptical of information from an insolvent insurer. The receiver must dispel this skepticism.

It is often necessary to conduct a full review or reconstruct reinsurance transactions accruing pre-receivership, as well as documenting post-receivership reinsurance balances. Post-receivership balances include reinsurance balances resulting from claims covered by the guaranty funds and adjudication of non-fund covered claims. See Chapter 2—Information Systems (especially the UDS section), Chapter 5—Claims, and Chapter 6—Guaranty Funds for more on the relationship between post-insolvency accruing liability and reinsurance recoverable balances.

In the context of life and health company insolvencies, state laws generally provide the life and health insurance guaranty associations the right to elect to continue reinsurance and to succeed to the rights and obligations of the insolvent ceding insurer with respect to contracts and policies covered, in whole or in part, by the guaranty association. The election must be made within 180 days of the liquidation date and is subject to certain statutory requirements. This right to continue reinsurance is reflected in the Section 8(N) of the NAIC's *Life and Health Insurance Guaranty Association Model Act* (#520), which has been adopted in most states.

Footnote suggestion: Section 612 of Model #555 similarly reflects the rights of life and health guaranty associations to elect continue reinsurance and to succeed to the rights and obligations of the insolvent insurer under reinsurance agreements, subject to the requirements of state receivership and guaranty association laws.

2. Secured Reinsurance Balances

Reinsurance balances frequently will be secured to ensure collectability and preserve the insurer's statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. The security often includes letters of credit (LOCs) and trust accounts. Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations.

It may be necessary to establish procedures to monitor the security during the receivership. Some LOCs will require renewal, while others will have an "evergreen clause" providing for automatic renewal. Also, some security arrangements may require that the amounts held be increased by the reinsurer. Pre-receivership transactions regarding these security arrangements should be reviewed to ensure compliance with the related reinsurance agreements, security agreements, and statutes.

3. Commutations

A commutation is a mutual release of all obligations between the parties for consideration. Commutations terminate the rights and liabilities between parties, including premiums due, paid losses,

outstanding losses and incurred but not reported (IBNR) losses, loss adjustment expenses (LAE) where applicable, and present or projected profit. There are many valid reasons for commutations. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between insurers and reinsurers, and provide some protection or limitation of exposure from the insolvency of the reinsurer.

Commutations, however, may also give rise to abuses. A commutation may unfairly benefit the reinsurer by relieving the reinsurer of considerable exposure for less than fair consideration. Further, in a rehabilitation proceeding, if the cash payment received from a commutation is less than the loss reserves that must then be recognized by the insurer, then the surplus of the insurer will be reduced.

Statutory accounting principles allow an insurer's reserves to be reduced by authorized reinsurance. If an insurer's net reserves have been carried at nominal value due to a substantial credit for reinsurance recoverable, the elimination of the reinsurance setoff credit as a result of a commutation could have had an adverse impact on the insurer. For example, a related reduction in surplus could have an adverse impact on the insurer's solvency ratios and could exacerbate capacity problems. Under such circumstances, a receiver should carefully review the commutation to determine whether the benefit to the insurer outweighed the disadvantages.

In measuring the surplus impact of a commutation and comparing the assets and liabilities assumed, it should be kept in mind that the assets received are usually easily quantifiable, whereas the reserves are not. Thus, what may appear to be a break-even transaction on the surface may, in fact, result in a large loss to one party because of the way the reserves were determined. It usually is helpful to know if a qualified actuary has reviewed the assumed block of reserves, supplementing case reserve estimates with projections of IBNR development, related LAEs, and use of industry data where necessary. Also, because of the inability of insurers to discount their reserves for statutory purposes, a commutation may appear on the surface to produce a loss to the insurer. The long-term economics of the transaction, however, may be sound when consideration is given to the future investment income to be earned from the commutation process. The receiver should also assess the potential adverse consequences of any commutation. In sum, commutations should be reviewed to determine if they were negotiated at arm's length and were fair and reasonable to the insurer; the receiver may need to engage an independent actuary to assist in this review.

Section 605 of Model #555 addresses the avoidance of reinsurance transactions incurred on or within two years before the date of the initial filing of a petition commencing delinquency proceedings under certain conditions. Section612 of Model #555 relates to the continuation of life, disability income, and long-term care (LTC) reinsurance in liquidation and the right of the GA to elect within 180 days of the liquation to continue that reinsurance subject to the requirements of Section 612 of Model #555. Some states' voidable preference and fraudulent transfer statutes include specific sections dealing with commutations that occur within a short period before the filing of a petition for the appointment of a receiver. The receiver should be aware of these special rules, which may allow the rescission of a commutation for the benefit of the insurer and its creditors.

4. Stop-Loss Treaties

A stop-loss treaty, or aggregate excess reinsurance contract, indemnifies an insurer if in any year the losses on retained accounts exceed a specified amount. The determination of whether the specified amount has been exceeded is usually made after the application of all other reinsurance and the benefits or recoveries under surplus, quota share, and catastrophic excess of loss treaties. The premium for a stop-loss treaty can be based on a fixed dollar amount, or it may be a ratio of annual retained premium (calculated by reducing gross premium income by premiums for other reinsurance, such as surplus treaties, quota share treaties, and catastrophic excess of loss contracts). The purpose of a stop-loss treaty is to protect against an aggregation of losses during a particular period of time.

Stop-loss treaties are also subject to abuse and, consequently, should be carefully evaluated. The amount of loss protected against may be unreasonable in light of the loss experience of the insurer. As a result, there may have been an improper motive in paying a premium for a stop-loss treaty for which the insurer was not likely to receive any real benefit. The premium may have been excessive when compared to similar coverage generally available.

5. Unauthorized Reinsurance

Unauthorized reinsurance is reinsurance placed with non-admitted or unauthorized reinsurers that are not authorized to transact insurance business in the cedent's domiciliary state. Under statutory accounting principles, an insurer's liability for loss reserves is carried net of reinsurance. Generally, unauthorized reinsurance may not be used to reduce loss reserves unless the reinsurer's liability is secured by trust funds, funds held by the cedent, or LOCs. Care should be taken to ensure that these potential estate assets are identified and secured.

Unauthorized reinsurance may be appropriate when placed with a financially sound reinsurer. The placement of reinsurance with unauthorized reinsurers, however, is subject to abuse. For example, it may be a means of diverting funds to an affiliate. The placement of reinsurance with financially weak non-admitted reinsurers may indicate an improper motive for obtaining such reinsurance.

6. Portfolio Transfers/Loss Assumption Reinsurance

Generally, a portfolio is one of the following: 1) an entire book of business; 2) a book of business in force at a certain time; or 3) outstanding losses unpaid at a certain time. Typically, in a portfolio transfer, the reinsurer assumes the reinsureds' obligations to pay losses on the assumed portfolio in return for the payment of a premium and the transfer of related loss reserves and security, as applicable.

Portfolio transfers should be reviewed to ensure that the transfer was entered into for legitimate business reasons and inured to the insolvent insurer's benefit. The receiver should consider whether the business transferred was an integral part of the insolvent insurer's business. Did it represent a highly profitable segment of the business, or was it marginal or even a contributor to operating losses? What were the long-term prospects for the portfolio transferred? How did it fit with the balance of the business retained by the insurer? Did the transfer effect a novation of the underlying insurance policies or reinsurance contracts? Did the transferor's policyholders or reinsureds consent to the novation? Answers to these questions should indicate whether a particular portfolio transfer might be a suspect transaction.

Transfers of a profitable portfolio could temporarily prolong the insurer's life while undermining the long-term financial viability. Transfers between affiliated parties should be carefully reviewed. Because certain bulk transfers require insurance regulatory approval, it should be determined if there was compliance with applicable requirements.

7. Surplus Relief Treaties

Comparing premium income to surplus is a common test of whether an insurer is taking on too much risk. Typically, the desired ratio is 3:1. In other words, annual premium income greater than three times surplus may be a warning signal that the insurer is assuming too much risk. Regardless of the test applied, if an insurer reaches the maximum amount of premium income supportable by its surplus, it either must cease writing new business or shed some of its premium income or liability to maintain its financial health.

One method of reducing premium income is to enter into a reinsurance treaty whereby the insurer cedes premium in exchange for a *pro rata* reduction in its liabilities. This practice allows the insurer to continue to write business. A surplus relief treaty is generally considered to be proper if the liabilities ceded are not set off by commission paid to the reinsurer and if the reinsurer does not protect itself against an adverse loss experience by having the insurer ultimately pay the liabilities. In other words,

if the insurer has ceded the premium for the business and has transferred the underlying liabilities, the treaty likely will not be a suspect transaction. (See Chapter 9—Legal Considerations.)

If scrutiny of the surplus relief treaty reveals that the insurer superficially ceded premium and the business but in reality provided a stop-loss to the reinsurer or otherwise protected the reinsurer from liabilities, then the transaction may have been improper. It may be difficult to trace such a transaction because it can be accomplished in separate documents. This type of arrangement would give a false picture of the insurer's solvency, as it would mask its true premium-to-surplus ratio by understating premium and, at the same time, not relieve the cedent of the risk of loss associated with the underlying business.

8. Finite Reinsurance

Another way that an insurer occasionally attempts to improve its balance sheet is by entering into financial reinsurance transactions. There are many forms of these, but the potential concern behind these types of transactions is to examine whether they were performed simply to shift liabilities off the books of the insurer onto the books of the reinsurer without any real transfer of risk for those liabilities. Any reinsurance contracts that do not appear to have effectuated a real transfer of risk of loss to a reinsurer should be examined closely by the receiver. These contracts may not only be voidable, but there may be additional recourse against the reinsurer for participating in the financial reinsurance transactions. (See Chapter 7—Reinsurance and Chapter 9—Legal Considerations.)

9. Affiliated Reinsurance

In some cases, the insurer cedes its risks to an affiliated reinsurer. The reinsurer then dividends funds to common ownership. There are also affiliated pooling transactions that may be used to inappropriately transfer funds among the pool participants.

B. Large-Deductible Policies

1. NAIC has adopted a *Guideline to Administration of Large Deductible Policies in Receivership*, and the guideline or similar policy has been adopted in several states. Large-deductible recoveries can represent a significant source of recoveries for insolvent companies, especially those P/C companies that wrote workers' compensation insurance. These recoverables may be a significant amount, and the receiver should examine the scope of the large-deductible business written and the collection and collateral procedures employed by the company.

   General Considerations

   a. The receiver's recovery of large-deductible recoverables is dependent on the claims handling and reporting of both claims covered and those not covered by guaranty funds.
   b. The key to effective collection and collateral administration is ensuring that the historical records for paid losses under the deductible policies and the program design are maintained and available. Another key is retaining the personnel that have knowledge and history of the insurer's deductible business operations.
   c. Collateral for Large-Deductible Balances.
      - The importance of collateral cannot be overstated; adequate collateral must be established prior to liquidation and maintained throughout the receivership.
      - Large-deductible balances frequently will be secured to ensure collectability and preserve the insurer's statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. Particular attention should be paid to security arrangements where the insured's collateral is held by third parties, especially affiliates of the insurer.

- Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations

2. Communication

Deductible collection, in addition to requiring collateral, is dependent on communication of all parties (i.e., between receiver and insured, receiver and guaranty association, and guaranty association and insured). It must be quickly established with insureds as to the procedure for ongoing claim processing, continuation of their responsibility to reimburse the deductible payments, and responsibility to maintain appropriate collateral. Guaranty associations must also recognize that they will be required at times to communicate with insureds regarding claims handling. All parties should be mindful of security concerns related to communication of sensitive claims data. The SUDS server hosted by the National Conference of Insurance Guaranty Funds (NCIGF) is a useful tool for communication between receivers and guaranty associations. The collection process should proceed with minimal delay as the passage of time will affect the success of collection efforts. In these efforts, it is imperative that the guaranty associations and the receiver work together and offer consistent messages to the insured regarding any collection issues. It should also be noted that the release of collateral from a receiver to a guaranty association may not fully satisfy the policyholder's obligation for costs related to the claim under a state's guaranty association law.

3. Deductible Collection Procedure

a. A working process must also be established quickly between the receiver and the guaranty associations to provide claim handling, payment information, and all other required claim financials to allow the receiver to bill and collect loss payments.
b. The information would include the receiver providing the guaranty associations all pertinent information to establish the policies that are deductibles along with effective dates, deductible limits, treatment of allocated loss adjustment expense (ALAE), and deductible aggregates where available.
c. Copies of deductible policies should be made available if required.
d. Guaranty associations will provide, through the establishment of a UDS data feed, all financial information regarding deductible claims that they are handling.
e. The receiver will collate data from guaranty associations and review historical billing information to invoice the insureds on a monthly or quarterly basis.
f. The receiver will calculate and track the payment history pre-liquidation and post-liquidation within the deductible and within a deductible aggregate for the policy if applicable. This ensures that the insured is only billed for amounts that remain within its deductible.
g. To assist in the collection process, the receiver and the guaranty association should work to provide sufficient information and explanation to allow the insured to recognize its obligation. In the event where the insured refuses to pay, the receiver will either begin litigation or draw on collateral—or both. This should be coordinated with the guaranty associations.

4. Professional Employer Organizations

a. Policies issued to professional employer organizations (PEOs) often have large-deductible endorsements.
b. Because of the prevalence of abuse in the underwriting of PEOs, post-liquidation collection of deductible payments may be challenging.
c. Clients may have been added without notice (or payment) to the insurer. Client class of business may have been misrepresented or expanded to include riskier classes of business— all of which may lead to inadequate or exhausted collateral.

d. Client companies of PEOs may not have received notice of cancellation, leading to coverage disputes. If collateral is inadequate and the PEO does not have assets to pay the deductible reimbursement in full, the policy terms might make the client companies liable for the shortfall, either for their own exposure or on a joint-and-several basis. However, this might not be a meaningful source of recovery because it could be impractical, inappropriate, or impossible to collect significant amounts from the clients.

5. Commutations
   a. Generally, commutations are negotiated terminations of the rights and liabilities between insurers and large-deductible insureds. A commutation is a settlement of all obligations, both current and future, between the parties for a lump sum payment.
   b. There are many valid reasons for commutations of large deductibles. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between the insurer and the insured, and provide some protection or limitation of exposure from the insolvency of the insured. Commutations of long tail business (i.e., workers' compensation) may be essential for the early termination of the receivership.
   c. Commutations, however, may be a detriment to the receivership if the commutation is consummated for less than fair consideration. A receiver should carefully review the commutation to determine whether the benefit to the insurer outweighs the disadvantages.

C. Inappropriate Investments

Inappropriate investments may have the effect of overstating the insurer's assets on its annual statements and, at the same time, result in an actual loss if the investments are poor. In some instances, earnings from investments are less than they should have been. Investments may be inappropriate for four general reasons: 1) the investments are prohibited and not allowed as admitted assets by insurance laws or regulations; 2) while allowed as admitted assets, the investments are too speculative at the time of investment, given their materiality to the insurer's financial condition; 3) the investments did not meet the insurer's need for liquidity; or 4) the assets do not match the corresponding policy liabilities.

While some states' insurance codes prohibit the acquisition of certain assets, many view such acquisitions as non-admitted assets. However, regulators retain the right to order disposal of assets acquired in violation of law. A receiver should determine whether such acquisitions have occurred and whether the assets still are held by the insurer. If so, the receiver must identify the losses that have occurred on previously acquired assets and losses likely to occur on assets currently held by the insurer. Additionally, a separate inquiry should be made to determine whether the insurer was damaged. If such investments were booked as admitted assets, the result may be an inaccurate financial statement.

It is difficult to evaluate the culpability for making investments in admitted assets that are highly speculative or illiquid. While code provisions require all investments to be sound, an analysis of what are sound investments involves the application of the business judgment rule. This rule protects management, who made informed decisions in good faith without self-dealing, from being judged in hindsight. Insurance codes have prohibitions and limitations on the types and amounts of investments both on an individual and aggregate basis. Insurance codes generally enumerate the types of assets permitted, but that is beyond the scope of this discussion. In general, an insurer first must invest its minimum paid-in capital and surplus in certain defined investments, which generally are thought to be safer than other types of investments. Generally, these types of investments are government obligations. Once the insurer has invested its minimum paid-in capital and surplus in these allowed investments, there are other limitations on investment of an insurer's assets (excess funds investments). The codes are quite detailed with numerous descriptions and limitations, including limitations on the amounts that may be invested in real estate (if any), affiliates, and common stock, as well as the relative percentages of certain investments. (Although affiliates are generally admissible, such assets are usually illiquid if not publicly traded. If they make up a significant portion of surplus, then an investigation should be made into their acquisition and value.) Other

inappropriate investments may include those that, although admitted, are either high-risk, or are not matched properly to the insurer's cash flow needs.

Investments that violate the applicable insurance code or regulations will not qualify as admitted assets on the annual statement. If such investments have been identified, the receiver should determine:

- When the investment occurred.
- Who authorized the investment.
- For what purposes the investment was made.
- The details of the transaction, including cost.
- Whether corporate formalities were followed.
- The broker and other persons involved.
- Whether the investment is with a related party.

It also is important to review how the questionable investments were reflected on the insurer's annual statement. The booking of non-admissible assets as admitted assets may identify a problem affecting the true financial condition of the insurer and may necessitate further investigation of corporate officers and directors. If the investments have already been disposed of, it is important to determine whether this resulted in a gain or loss. If disposed of at a reasonable gain, then a judgment must be made as to whether it is worth proceeding further with the analysis. If losses were incurred or will be incurred, there may be substantial questions of legal responsibility.

A review of recent transactions should reveal realized losses, and an evaluation of investments still held should reveal where unrealized losses exist. In the event that realized or unrealized losses are identified, a case-by-case evaluation should be made as to whether there is any culpability surrounding the acquisition or disposition of these types of investments. Once again, all the details surrounding the acquisitions should be thoroughly reviewed, particularly focusing on any close or suspicious relationships between the insurer's management, officers or directors and the management, officers or directors of the acquired investment, or with any brokers or agents involved in the sales transaction.

To identify investments that violate insurance laws and, consequently, are not admitted assets, a receiver should begin with a review of examination reports and work papers. Examiners tend to be thorough with respect to identifying assets or investments that are not admitted assets. If no examination report has been prepared, accountants or auditors should review the most current annual statements and supporting schedules to identify and list all investments that are not admitted assets. The following exhibits and schedules should be reviewed:

- Exhibit of Net Investment Income.
- Exhibit of Capital Gains (Losses).
- Exhibit of Non-Admitted Assets.
- Schedule A – Real Estate.
- Schedule B – Mortgage Loans.
- Schedule BA – Long-Term Invested Assets.

- Schedule D – Bonds and Stocks (including valuations of subsidiary, controlled and affiliated companies).
- Schedule DA – Short-Term Investments.
- Schedule DB – Derivatives.
- Schedule E – Cash, Cash Equivalents, and Special Deposits.

General Interrogatories (which could contain information concerning cryptocurrency and other assets). Other sources include internal and external audits, U.S. Securities and Exchange Commission (SEC) periodic reports (such as annual and quarterly reports on Forms 10-K and 10-Q), and investment committee minutes.

D. Dividends and Intercompany Transactions

State insurance codes have strict limitations on how much money can be paid out as dividends from insurance companies. Some insurance codes provide for the recovery of dividends paid within a certain time period prior to the insurer's insolvency. Accordingly, all dividends should be reviewed to determine compliance with these statutory limitations. The receiver also should determine whether the financial statements were manipulated to make otherwise impermissible dividends possible. Regulators who had responsibility for reviewing the dividends may be contacted to determine what representations were made by company personnel when the dividends were approved.

As part of this process, intercompany transactions should be reviewed to look for disguised dividends. Many companies will have been part of a holding company structure. Oftentimes, a company will have entered into cost-sharing agreements, tax-sharing agreements, investment management agreements, marketing agreements, and other such transactions with affiliates. These transactions should be reviewed closely. When a company is precluded from paying dividends, it may try to disguise what, in fact, are dividends under transactions pursuant to these agreements.

Illegal dividends may be recovered in fraud actions or breach-of-fiduciary-duty actions. The failure of the company's outside accountants or auditors to detect illegal dividends also may form the basis of an action in negligence against the accountants and/or auditors.

E. Management by Others

Another area of suspect transactions is the management of insurers by other entities, including MGAs or third-party administrators (TPAs) acting pursuant to management contracts, as well as corporate or individual attorneys-in-fact. A close examination of the overall relationship, including all contracts, should be made since there is a potential for abuse of these relationships. In some instances, the management contract may be arranged so that, in essence, the insurer fronts for the MGA or the attorney-in-fact, who retains all the profits, and the insurer retains all the liabilities. It may raise a difficult question as to whether there was proper compensation for services or if the MGA or attorney-in-fact misappropriated corporate opportunities. Another abusive practice is causing the insurer to pay the MGA, TPA, or attorney-in-fact for services that it did not provide but were provided by the insurer's employees at the insurer's expense. This, in effect, results in double payment. Detection requires a thorough review of the contracts and an analysis of which entity pays for which function, which may be especially difficult when the operations are all in one facility.

VII. RECEIVERSHIP INVOLVING QUALIFIED FINANCIAL CONTRACTS

Section 711—Qualified Financial Contracts (or Similar Provision) of Model #555 addresses stays termination, transfers of netting agreements, or qualified financial contracts (QFCs).

When financial markets are uncertain, it causes heightened scrutiny in the capital markets and among financial institutions about identifying, managing, and limiting risk, as well as the need for adequate capitalization and for understanding the interdependency of the different financial sectors. One source of risk to financial market participants that rises due to the lack of certainty in the financial markets is the treatment of QFCs and netting agreements in the event of the insolvency of state regulated insurers.

A. Definition of Qualified Financial Contract

Model #555 defines a QFC as "any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the commissioner determines by regulation, resolution or order, to be a qualified financial contract for purposes of this Act."

- Commodity contract is defined by reference to the Commodity Exchange Act (7 U.S.C. § 1) (Commodity Act) and is a contract for the purchase or sale of a commodity for future delivery on or subject to the rules of a board of trade or contract market subject to the Commodity Act; an agreement that is subject to regulation under Section 19 of the Commodity Act commonly known as a margin account, margin contract, leverage account, or leverage contract; an agreement or transaction subject to regulation under Section 4(b) of the Commodity Act that is commonly known as a commodity option; any combination of these agreements or transactions; and any option to enter into these agreements or transactions.

- Forward contract, repurchase agreement, securities contract, and swap agreement shall have the meanings set forth in the Federal Deposit Insurance Act (FDIA), 12 U.S.C. § 1281(e)(8)(D), as amended from time to time.

It should be noted that an insurance contract is not a derivative or a QFC because an insurance contract includes the indemnification against loss. Therefore, reinsurance agreements would not be considered a swap agreement.

B. Insolvency Treatment of Qualified Financial Contracts Under the *Insurer Receivership Model Act*, Section 711 Provision[1]

Model #555, Section 711 provides a safe harbor for QFC counterparties of a domestic insurer. The provision largely tracks similar provisions in the Federal Bankruptcy Code and the FDIA, as well as laws of other

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[11] Except where the state has adopted *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (*#1556).

Guideline #1556 Drafting Note: State receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration, or close-out obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition, or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The FDIA also provides for a 24-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC. 12 U.S.C. § 1821(e)(9)-(12). States that permit the termination and netting of QFCs may want to consider adopting a similar stay provision following the appointment of a receiver for certain insurers—generally larger entities that may be significant in size but outside of being subject to a potential federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) receivership.

States that consider the enactment of a stay should take into account the relevant federal rules. In 2017, the Board of Governors of the Federal Reserve System (Federal Reserve), the Federal Deposit Insurance Corporation (FDIC), and the Office of the Comptroller of the Currency (OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB). The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a "stay" under several defined resolution regimes, including Title II of the federal Dodd-

foreign jurisdictions. These safe harbor provisions for QFCs were adopted to avoid disruptions resulting from judicial intervention that can cause unintended chain reactions and significant systemic impact. Section 711 applies in both rehabilitation and liquidation proceedings.

Section 711 states that a right to terminate, liquidate, or accelerate a closeout under a netting agreement or a QFC with an insurer either due to the insolvency, financial condition, or default of the insurer or the commencement of a formal delinquency proceeding is not prevented by any other provision of Model #555. Section 711 allows a counterparty to net different contracts and realize on collateral without a stay.

Section 711 addresses transfer of a netting agreement or QFC of an insurer to another party. In a transfer, the receiver has to transfer all of the netting agreement or QFC and all of the property and credit enhancements securing claims under the agreement or QFC. This prevents "cherry-picking" and requires the transfer of everything; i.e., all of both the "in-the-money" and "out-of-the-money" positions.

C. Considerations of Qualified Financial Contracts Held by an Insurer Receivership

- Although the *Investments of Insurers Model Act (Defined Limits Version)* (#280) does not include limits on the amount of collateral an insurer is allowed to post, some states have restrictions on derivatives use, including quantitative limits, and limits on the pledging of collateral, based on type and credit quality. The receiver may also need to determine if a derivative use plan, if required, is in effect and if it dictates any collateral requirements.

- If the ability to net exists and there is no stay requirement, it is important that the regulator understand the QFC portfolio before the insurer's failure, either through a recent or ongoing financial examination or through an assessment made during regulatory supervision that precedes a receivership order, while recognizing that the market value of the derivatives positions can vary substantially over relatively short periods of time. The receiver also needs to have a good understanding of the relationship of the QFC contracts to the rest of the insurer's balance sheet. Because most derivatives transactions are used for hedging purposes, if those contracts are terminated as a result of netting, the assets and liabilities will no longer be hedged. It is important

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Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) and the Federal Deposit Insurance Act (FDIA), as well as comparable foreign resolution regimes. Notwithstanding the NAIC's request for inclusion, stays under the state insurance receivership regime (state receivership stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize state receivership stays, if a state implements a stay as contemplated by the Guideline, insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for qualified financial contracts (QFCs). Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, the FDIC, and the OCC have been amended to recognize state receivership stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize state receivership stays.

References: *Restrictions on Qualified Financial Contracts of Systemically Important U.S. Banking Organizations and the U.S. Operations of Systemically Important Foreign Banking Organizations*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 42882 (13 November 2017), available at https://www.federalregister.gov/d/2017-19053; *Restrictions on Qualified Financial Contracts of Certain FDIC Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 50228 (30 October 2017), available at https://www.federalregister.gov/d/2017-21951; *Restrictions on Qualified Financial Contracts of Certain FDIC-Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definition, 82 FR 61443 (28 December 2017), available at https://www.federalregister.gov/d/2017-27971; and *Mandatory Contractual Stay Requirements for Qualified Financial Contracts*, 82 FR 56630 (29 November 2017), available at https://www.federalregister.gov/d/2017-25529.

to quantify the effect of the loss of the contracts if possible. The receiver may wish to engage outside resources to assist in evaluating the QFC portfolio.

- The receiver should be aware that there may be areas of contention and disagreement by parties in the netting, termination, and closeout of QFC agreements—for example, disagreement over the valuation or in the resolution of transactions where the parties wait too long to terminate the contract.

- Some counterparties may have been accepting less liquid assets, such as private placements based on the relative financial strength of the insurance company; typically, collateral for a QFC will be cash and U.S. Treasury bonds. The moving of over the counter (OTC) derivatives to centralized clearinghouses (CCHs) will gradually eliminate less liquid assets, as well as assets with more volatile market values being used as collateral. It is also worth noting that it is possible to have non-admitted assets eligible as collateral. Where assets exceed concentration limits, the excess can be collateral without being an admitted asset.

- The impact of CCHs will be to standardize documentation and collateral requirements. The standard rules for collateral will be more restrictive and be applicable to all parties. These rules will generally allow for only high-quality assets that are more liquid and are expected to have less market value volatility. In addition, all parties will be subject to the same rules for both initial margin and variation margin. In the past, it was not uncommon for counterparties to not require initial margin from their higher quality clients. This will not be the case going forward.

D. Recommended Procedures for State Insurance Regulators/Receivers

To the extent possible, in a pre-receivership situation:

- To the extent a company has a small number of large QFC contracts that are important to the overall investment portfolio and operations of the insurer, in pre-receivership and in rehabilitation, the state insurance regulator or receiver should reach out to the counterparty to determine if the counterparty is agreeable to continuing the contract and performing on the contract when the insurer enters receivership.

- Consider practical strategies for successfully managing the netting agreements and QFCs, not only at the inception of the receivership, but also ongoing during the receivership process.

- Evaluate if the insurer is engaged in netting agreements and QFCs through a market-facing affiliate or non-affiliate, whereby the insurer's contract is with that market-facing entity and the market-facing entity has the contracts with the counterparties.

- Consider the applicability of any federal master netting agreement rules and regulations to the insurer's netting agreements and QFCs. (See the references to applicable federal rules in the preceding footnote in this chapter [2].)

- Evaluate the need to consider the use of a bridge financial institution to transfer and manage the netting agreements and QFCs in a pre-receivership proceeding; i.e., administrative supervision. See Chapter 11—State Implementation of Dodd-Frank Receivership of this Handbook for guidance on the use of bridge financial institutions for a federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) receivership.

- Carefully review the most recent financial statement filings and interim company records to identify the netting agreements and QFCs active at the time of receivership; understand the terms of the agreements and the valuation of the QFCs; and identify the securities held as

[2] See footnote 1 of this chapter.

collateral and counterparties to the contract. See the Appendix for a Summary of Statutory Annual Statement Reporting of QFCs or the most current Statutory Annual Financial Statement and Instructions.

- Consider how ongoing hedging of obligations and assets can be accomplished during and following a receivership.

Once a rehabilitation or liquidation order has been entered:

- Provide notice of the receivership to counterparties, as appropriate under state law.

- Consider implementing a 24-hour stay on termination of netting agreements and QFCs, if allowed under state law. (See the *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts* [#1556] and the accompanying drafting note in the preceding footnote in this chapter[3].)

- It is important for the receiver to keep track of which transactions have been terminated validly and which have not so that appropriate action can be taken when the validity of the termination is contested.

- Once the set off has occurred, if the receiver disagrees with the counterparties' valuation of either the collateral or the QFC transaction, the receiver would take the next steps to try to negotiate the correct amount and, if unsuccessful, pursue legal action.

- Consider engaging an investment expert to assist in the auditing, investigating, and management of the netting agreements and QFCs within the investment portfolio. Refer to Chapter 3.VI of this Handbook for more guidance on auditing and investigating the investments of the receivership estate

E. Exhibit—Qualified Financial Contract Annual Statement Reporting (As of 2021)

The subsequent information provides a general description of how and where QFCs are reported within the *Accounting Practices and Procedures Manual* (AP&P Manual) and the statutory financial statements.

Derivative Instruments—*Accounting Practices and Procedures Manual* Disclosure

- *Statement of Statutory Accounting Principles (SSAP) No. 27—Off-Balance-Sheet and Credit Risk Disclosures*
- *SSAP No. 86—Derivatives*
- *SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees*

Derivative Instruments—Annual Statement Disclosure

- Schedule DB – Part A, Section 1 – *Open Options, Caps, Floors, Collars, Swaps, and Forwards*
- Schedule DB – Part B, Section 1 – *Open Future Contracts*
    - Within Part A and Part B, Section 1 identifies the contracts open as of the accounting date, and Section 2 identifies contracts terminated during the year.
- Schedule DB – Part C – Replication (Synthetic Asset) Transactions
    - Section 1 contains the underlying detail of replicated assets open at the end of the year. Section 2 is reconciliation between years of replicated assets.
- Schedule DB – Part D, Section 1 – *Counterparty Exposure for Derivative Instruments Open*
- Schedule DB – Part D, Section 2 – *Collateral for Derivative Instruments Open*
- Schedule DB – Part E – *Derivative Hedging Variable Annuity Guarantees*
    - Specific to derivatives and hedging programs under SSAP No. 108
- Schedule DL – Part 1 & 2 – *Securities Lending Collateral Assets*
- Notes to Financial Statement – *Investments*

[3] See footnote 1 of this chapter.

- Notes to Financial Statement – *Derivative Instruments*
- Notes to Financial Statement – *Debt* (*FHLB Funding Agreements)*
- Notes to Financial Statement – *Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk*
- Notes to Financial Statement – *Fair Value Measurements*

On a quarterly basis, the insurer only reports derivative instruments that are open as of the current statement date. Schedule DB – Part A – Section 1 lists the insurer's open options, caps, floors, collars, swaps, and forwards. Open futures are reported in Schedule DB – Part B – Section 1, replications are reported in Schedule DB – Part C – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D.

Repurchase Agreements—AP&P Disclosure

- *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*

Repurchase Agreements—Annual Statement Disclosure

- Notes to Financial Statement– *Investments*
- Notes to Financial Statement – *Debt*
- Repurchase agreements are disclosed in various investment schedules within the Annual Financial Statement depending on the type of investment (Schedule D, DA, E, Supplemental Investment Risk Interrogatories). The Investment Schedule General Instructions provide the following list of codes to use in the appropriate investment schedule code column regarding investments that are not under the exclusive control of the reporting entity, and also including assets loaned to others. For example, a bond subject to a repurchase agreement would be detailed in Schedule D Part 1 – *Long-Term Bonds Owned* and use a code of RA in Code Column.

Codes
LS – Loaned or leased to others
RA – Subject to repurchase agreement
RR – Subject to reverse repurchase agreement
DR – Subject to dollar repurchase agreement
DRR – Subject to dollar reverse repurchase agreement
C – Pledged as collateral – excluding collateral pledged to FHLB
CF – Pledged as collateral to FHLB (including assets backing funding agreements)
DB – Pledged under an option agreement
DBP – Pledged under an option agreement involving "asset transfers with put options"
R – Letter stock or otherwise restricted as to sale – excluding FHLB capital stock (Note: Private placements are not to be included unless specific restrictions as to sale are included as part of the security agreement.)
RF – FHLB capital stock
SD – Pledged on deposit with state or other regulatory body
M – Not under the exclusive control of the reporting entity for multiple reasons
SS – Short sale of a security
O – Other

VIII. POTENTIAL RECOVERY FROM THIRD PARTIES

As noted above, a number of persons inside and outside of the insolvent insurer may have caused or contributed to the reasons for the insurer's insolvency. Such acts or omissions may be unintentional, but the result is harm to the insurer and thus its policyholders, claimants, and creditors. This section and the next identify by category the acts and omissions of such persons, the causes of action that may be brought, and the foundation that the receiver must establish to prevail in such causes of action.

Not all actions listed here may have contributed directly in the insurer's problems, and inclusion of an action in the following list does not necessarily indicate that a receiver will find a basis for seeking legal remedies from identified persons. Each situation must be evaluated on its own merits and circumstances. For example, the facts may clearly indicate that an agent wrongfully withheld funds due the insurer, but an investigation of the agent's financial condition might show that there would be little hope of collecting any judgment resulting from successful civil

litigation. Therefore, the cost to the estate of pursuing this particular agent may outweigh the ultimate benefit, if any, to the estate.

A. Breach of Fiduciary Duties

Any person empowered to collect and hold funds on behalf of another has a fiduciary duty with respect to any funds collected. MGAs, TPAs, reinsurance intermediaries, brokers, and others may have violated this obligation by:

- Failing to maintain a premium trust account where required by law.
- Skimming premiums.
- Withholding funds without authorization.
- Failing to collect and remit premiums.
- Paying affiliates more than market rate for services.
- Deducting excess commissions and/or fees.
- Taking improper set-offs.
- Improperly using funds to make loss payments.

The investigative examination initiated by the receiver may indicate the presence of these problems. The receiver may need to conduct a more intensive investigation of transactions arising from the suspect MGA or TPA agreement, reinsurance treaty, etc., to determine whether a violation has occurred and the extent of injury to the insurer. Some examples of the information that may suggest a need for further investigation are:

- A significant decline in reported premium volume from one period to the next.
- Gaps in policy number sequence.
- Sharp increases in agents' balances receivable.
- Inordinate delays in collecting reinsurance balances receivable.
- Increase in consumer complaints.

B. Abuses Related to Risk Selection

An insurer may have delegated the authority to bind risks to an MGA or TPA, or may have given a reinsurance intermediary the power to cede or assume reinsurance on behalf of the insurer. Delegation of authority carries with it the duty to perform on the underlying agreement that binds the agent or intermediary to adhere to the insurer's articulated underwriting guidelines and limitations. To the extent any agent exceeded these limits and caused the insurer to suffer financially, the receiver may be entitled to appropriate remedies.

Some of the ways in which underwriting authority may have been abused are:

- Accepting excluded classes of business.

- Violating territorial limits.
- Exceeding premium and/or product mix limits.
- Using binders improperly.
- Misrepresenting risks.
- Placing reinsurance with insolvent reinsurers.
- Improperly placing reinsurance with affiliated or unauthorized reinsurers.
- Failing to obtain adequate security for balances due the cedent.
- Misrepresenting reinsurance coverage.

As noted above, the takeover investigation may indicate that these problems exist and that a more intensive examination of performance under specific agreements may be in order.

Some examples of information that may suggest a need for deeper investigation in this area are:

- Unusual line codes or state codes in statistical reports or state pages of reports.
- Variances from sales plans and volume projections.
- Schedule F or S problems, mismatches, and unexplained differences.
- Reinsurers' resistance to or questions regarding claims presented.

C. Loss Settlements

As with risk selection, the insurer may have delegated claims settlement authority to a third party, be it an MGA, TPA, or loss adjuster. The third party has the duty to adhere to any guidelines and limitations stipulated in the delegation agreement, as well as to comply with fair claims settlement practices. Typically, these agreements will stipulate the third party's settlement authority, reporting practices, reserving practices, and use of outside experts.

Potential abuses include exceeding the claims settlement authority and establishing inadequate loss reserves in order to maintain a relationship with the insurer. Other indicators of problems are:

- Fluctuations in reported incurred losses.
- Unusually high LAEs.
- Unexpectedly high losses.
- Late development of reported losses.
- Policyholder complaints.
- Low salvage recoveries and/or high ratio of salvage costs to amount recovered.
- Low subrogation recoveries and/or high ratio of subrogation cost to recovered amount.
- Negative market conduct examination report comments.

- Claims payments exceeding clean claim guidelines in health insurance.

To the extent that an agent's actions caused the insurer's financial suffering, the receiver may wish to pursue litigation or other available remedies.

D. Abuses Relating to Premium Computations

This area is closely related to risk selection in that the parties to whom underwriting authority has been delegated may also have the authority to compute the premium for the risks, as well as compute, collect, and remit premium adjustments.

The compensation of the party in question, especially an MGA, is generally a commission based on premiums written. Consequently, the agent may deliberately underprice the premium or fail to compute additional premiums in order to write the risk and generate a commission.

Similarly, the insurance broker, the policyholder, and intermediary (if reinsurance is involved) might deliberately suppress information relating to compensation. The receiver should look for:

- Change in pattern of premiums audit activity.
- Unusual lag in reporting losses.
- Unexpectedly high incurred loss ratios.
- Uncollectible adjustment premiums.
- Captive cell arrangements

E. Professional Malpractice

Insurers frequently retain outside professionals, including attorneys, auditors, certified public accountants (CPAs), investment advisors, actuaries, and loss reserve specialists. The receiver should retain an expert from the same profession to review the activities of the insurer's professionals and to determine if their actions met the minimum standards of the profession.

Types of actions that may result in litigation or other proceedings against such persons include:

- Incompetence or failure to meet professional standards.
- Failure to divulge conflicts of interests.
- Billing abuses.
- Failure to timely discover or disclose insolvency or other deficiencies of the insurer that prolonged the insurer's operations and increased its debts.

Many professional organizations promulgate a code of ethics and technical performance standards that the receiver may wish to obtain as a source of professional standards against which a breach may be measured. This is an area of considerable complexity, however, so the receiver should consider retaining the services of knowledgeable legal counsel.

It is particularly important for the receiver to review whether certain professionals who were responsible for reporting on the financial condition of the insurer, such as auditors and actuaries, performed their duties in accordance with their applicable standards. Even in cases where the actual cause of insolvency was due

to misfeasance or malfeasance by the directors and officers (D&O), other professionals may be liable for not discovering and disclosing the problems. If an auditor breached and/or failed to meet its duties of care, such breach and/or failure may be the proximate cause of damages to the insurer and its policyholders, creditors, and shareholders by reducing the value of the insurer and deepening the insurer's insolvency. For instance, if an auditor gives a clean opinion on an annual statement, reporting an insurer to be solvent when it should have detected and reported the insurer's insolvency if it had properly performed its duties, then the insurer's financial condition may continue to deteriorate, causing an even greater loss of surplus or increase in insolvency.

Some jurisdictions have awarded damages against auditors for what is referred to as the "deepening of the insolvency." This theory of damages was initially used in bankruptcy cases but has been applied to the insurance insolvency settings. Some courts have found "deepening of the insolvency" to be a separate cause of action even though it would still primarily be based upon some kind of professional negligence action. However, this theory is not universally accepted. In most states, auditors are required, as a condition of providing annual audit services to insurers, to provide a letter of qualification to the commissioner of insurance stating that they understand that the annual audited financial statements of the insurer and the auditor's own report with respect thereto will be filed and that the insurance commissioner intends to rely on this information in the monitoring and regulation of the financial position of the insurer. Such reliance may form the basis of a claim. Examples of professional malpractice of an auditor may include the failure to detect and disclose:

- Risks and accounting errors associated with an insurer's insurance program.
- Dissipation and misspending of funds by the insurer's officers and directors or controlling companies.
- Inadequacy of an insurer's reserves.
- Diversion of audit premiums or other assets.
- Existence of retroactive reinsurance or other reinsurance that could not be counted as an asset.
- Any significant deficiencies in the insurer's internal controls.

If such failures mask the true financial condition of the insurer so that the insurer continued to operate and slide further into insolvency, the auditor could be liable for the increase in insolvency from the date of that failure (i.e., the failure to report the insurer's deficiencies or insolvency) and the date when the insurer was actually placed into an insolvency proceeding.

Similarly, other professionals, such as actuaries, may be liable for the deepening of the insolvency if they breach their standards of performance and understate the insurer's reserves to the extent that, had they properly stated the reserves, the insurer would likely have been put into an insolvency proceeding sooner.

F. Income Tax

Insurance companies placed into liquidation often have net losses for federal income tax purposes. They are required to file federal income tax returns. (See Chapter 3—Accounting and Financial Analysis.) In addition, they may carry back the net operating losses and capital losses for a three-year period and recover prior years' federal income taxes. If the company is included in a consolidated return, the losses may be used to offset income from other companies in the consolidated group.

As part of the receiver's investigation, it should be as certain whether the company has entered into a tax-sharing agreement. A tax-sharing agreement provides for the allocation of tax among members of a consolidated group may enforce the insurer's rights to tax recoveries. The receiver should determine

whether any tax obligations or refunds due the insurance company have been paid and should be aware that intercompany tax allocations are frequently not recorded.

See *Exhibit 4-1* for a chart of potential recoveries from third parties.

IX. POTENTIAL ACTIONS AGAINST MANAGEMENT (DIRECTORS AND OFFICERS), SHAREHOLDERS, AND POLICYHOLDERS/OWNERS

A. Directors and Officers

The receiver may seek to recover damages from an insurer's D&O under one or more of the following theories:

1. General Mismanagement

In most states, case law requires that corporate officers and directors exercise ordinary or reasonable care and diligence in discharging their duties. The standard varies by jurisdiction. In most states, officers and directors are protected by the "business judgment rule" for their good faith actions. (See Chapter 9—Legal Considerations.)

The receiver should focus on what the D&O did or did not do. Accordingly, the receiver should begin the investigation by identifying the D&O and examining their qualifications to serve in their respective capacities. Such persons are held to minimum requirements of background, experience, and skill for each position. These prerequisites may be defined by statute or contained in the company's bylaws. The receiver should ascertain that the minimum requirements were met. The statutory remedy for an officer or director failing to meet qualifications is removal. However, willful failure of other officers and directors to enforce timely action may lead to their liability if it contributed to the insurer's insolvency.

The receiver should pay attention to the directors' and officers' actions during the time leading up to the commencement of the receivership. If, prior to initiation of receivership, the D&O knew or should have known that the company was hopelessly insolvent, their failure to take remedial actions may be considered mismanagement. That is, continuing operations of the company may result in a larger dollar amount of the insolvency than would have occurred had management taken remedial actions, such as ceasing to write new business, going into run-off, or voluntarily consenting to receivership. In some jurisdictions, this "deepening of the insolvency" is considered an element of damages in an action against the D&O.

An officer or director is accountable for the results of the operations of the insure. Whether accountability translates into liability in directors' and officers' litigation would appear to be dependent on answers to the following questions:

- Did the officer exercise reasonable and ordinary care in monitoring the behavior of subordinates?
- Did the officer act promptly to take appropriate corrective action?
- Did the officer attempt to conceal the failings or wrongdoing?
- Was the officer an active co-conspirator?
- Did the officer obtain adequate information before making a judgment?

The receiver should review all minutes of the board, board committee meetings, and related activity. Records of attendance at board meetings should be scrutinized. Particular attention should be given to officers' compensation and directors' fees, as well as to excessive travel or preferential use of company property. The receiver also should examine investment transactions for improper or self-dealing in ventures in which officers and/or directors had an interest. An absentee or empty-headed/pure-hearted director is not absolved and may incur additional liability because of continuous absences or non-feasance.

2. Racketeer Influenced Corrupt Organizations

The availability of the federal RICO Act to receivers is discussed in-depth in Chapter 9—Legal Considerations.

At least some causes of action under RICO require demonstration of fraud. In such cases, the concern expressed below regarding collectability of reinsurance and errors and omissions (E&O) liability coverage would apply to these RICO actions as well.

3. Fraud

Civil liability is not the only remedy available to a receiver. In appropriate cases, consideration should be given to referring the matter to local, state, or federal law enforcement authorities for criminal enforcement. Alleged fraudulent or criminal activity may involve only one or two persons. It is not necessary to prove a pattern of activity, and it should include a comprehensive evaluation on impact to the estate. Fraud is often used as a defense or basis to deny coverage by liability insurers covering D&O of the insurer and may be used as a defense by reinsurers.

4. Voidable Preferences and Fraudulent Transfers

As discussed earlier, statutes prohibiting voidable preferences and fraudulent transfers often allow the receiver to pursue insiders who knowingly participated in the prohibited transactions. A forensic analysis will help identify potential voidable preferences or fraudulent transfers.

5. Activities that Give Rise to Potential Recoveries

Recoveries from the directors and/or officers may be founded on a variety of acts or failures to act that may be difficult to uncover. Major things to consider are outlined in the following paragraphs. Refer to Chapter 9—Legal Considerations for more detail.

a. Self-Dealing

All transactions between the insurer and vendors owned or controlled by D&O and/or their immediate family members should be examined for propriety. Leases of office space, data processing equipment, and furniture and equipment can be used to skim funds from insurers for the improper benefit of owners/officers. Similarly, there have been instances in which the insurer paid excessive management fees to organizations controlled by related parties. Other possible areas for abuse are claim service organizations, software vendors, auto repair shops, attorneys, consultants, and shared office space.

b. Executive Compensation

Travel and expense reimbursements to officers and directors should be examined for abuses, such as travel with no clear business connection, travel to resort areas accompanied by family members, etc. Special facilities, such as leased or company-owned luxury cars, boats, or residences maintained for executives may also be suspect.

Some scandals have identified artworks, antiques, oriental rugs, or other high-end items purchased with company funds for the primary benefit of its officers.

c. Investment Transactions

Real estate owned by D&O may have been sold to the insurer at an inflated value or exchanged for other property of greater value. Mortgage loans may have been granted to family members based on overstated appraisals or in violation of company investment policies.

Other areas of potential abuse include secured loans in which the collateral may be improperly secured or below investment quality.

d. Underwriting Transactions

Poor underwriting results may have been the result of actionable misconduct, such as:

- Accepting risks in violation of the insurer's published underwriting guidelines.
- Failing to prevent or correct over-lining (writing prohibited classes of business).
- Failing to obtain motor vehicle records on automobile risks and safety, and engineering reports on commercial property risks or workers' compensation risks.
- Taking on additional risk when the premium is insufficient to cover the risk.
- Placing reinsurance with unacceptable reinsurers and/or failing to obtain adequate security (LOCs, trust funds, or funds withheld) to cover unauthorized reinsurance.
- Failing to keep new business writings within prescribed limits.
- Failing to monitor the activities of MGAs and TPAs.

e. Claim Operations

Claim operations are vulnerable to liability for unlawful conversion of funds, which usually requires active participation by an employee or agent of the insurer. Persons in senior management positions may be culpable and subject to litigation to the extent that they were aware of activities, such as:

- Improper payments to claimants.
- Payments made to non-existent claimants.
- Payments to non-existent providers or service vendors.
- Inflated invoices for LAEs linked to a kickback scheme.
- Deliberate and material under-reporting of incurred losses.

The degree of culpability will be determined by answers to at least the following questions:

- Did the officer exercise reasonable and ordinary care?
- Did the officer take prompt corrective action?
- Did the officer attempt to conceal the failings or misconduct?

- Was the officer an active co-conspirator?

f. Actuarial and Financial

An officer may have negligently or intentionally misstated actuarial data, either through improper valuation of policy reserves or case reserves for P/C losses, or by negligent or intentional failure to maintain sufficient data on which to base a reasonable estimate of loss reserves. The degree of culpability would appear to hinge first on intent and then on the qualifications of the officer. Alternatively, a group of officers and/or directors acting in concert may have intentionally tampered with reserve data or deliberately filed false financial statements.

g. Failure to Act in the Best Interests of the Company

A corporation's officers and directors have a common law duty of loyalty to that corporation that precludes, among other things, seeking private profit or advantage from their office. In most cases, the standards of conduct are clearly defined. The officer or director must not place his or her private gain above the best interests of the company and its survivability as a going concern. The receiver should carefully scrutinize insider stock trading, employment contracts, "golden parachutes," "poison pills," bylaws, etc., to verify that key personnel did not breach this duty.

6. Directors and Officers Indemnification

Consideration should be given to the existence and effect under applicable law of indemnification provisions in the company's bylaws and in state corporate laws.

7. Errors and Ommissions, and Directors and Officers Insurance

Many companies purchase E&O and D&O insurance that may provide coverage for certain types of conduct described above. As part of the receiver's investigative examination, all such policies should be identified and examined. These policies will almost certainly be claims-made policies that should be reviewed to determine the deadline for notifying the carrier concerning possible claims. Additionally, the policies may provide for the purchase of "tail coverage," which could extend the time in which to file a claim. In most cases, the receiver should purchase the tail coverage if his/her investigations have not been completed. The presence of insurance may be a factor in the cost/benefit analysis with respect to assessing causes of action against officers and directors. If insurance does exist, consideration should be given as to whether causes of action are covered by the insurance. Certain causes of action may be excluded by the policy, and it is important for counsel to review the policies before any suits are filed. One common exclusion that should be considered is the "regulatory exclusion" clause, which will likely be present in the policy under review. Another common exclusion is the "insured versus insured" clause, which may be in the policy under review.

B. Shareholders and Policyholders/Owners

Some jurisdictions permit alter-ego actions against shareholders, usually in closely held corporations, under common law or by statute. It may not be necessary to establish that management was negligent or guilty of fraud to recover from the shareholders. Where permitted, such recoveries may be limited, as in Arizona, to the par value of the outstanding shares.

In certain situations, it may be possible to assess policyholders or shareholders. Reciprocal inter-insurance exchanges and some old-line mutual insurers may have issued assessable policies that required policyholders to pay amounts over and above their premiums. Impairment to surplus usually is sufficient to trigger assessment.

Recoveries from shareholders and policyholders are special situations not likely to be encountered in most receiverships, and the amounts to be recovered and the procedures for recovery are specific. Thus, the receiver's attention is directed to the statutes and other authorities.

C. Significant Developments in the *Insurer Receivership Model Act*

In litigation between the receiver and affiliates of the insolvent insurer, Section 113 of Model #555prohibits the affiliate from using any evidence that was not included in the records of the insurer at the time of the transaction. As an example, it is not unknown for inter-affiliate loans from the insurer to have side agreements excusing repayment under various circumstances. Under Section 113, if the side agreement is not fully documented at the time of the loan in the records of the insurer, the borrowing affiliate may not present that agreement as a defense to the receiver's collection efforts.

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CHAPTER 5—CLAIMS

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I. INTRODUCTION

Claims processing is the most visible, tangible part of a receivership proceeding. Because policyholder protection is the basic goal of any insurance receivership, the adjustment and adjudication of claims is closely monitored by interested parties. Accordingly, the claims process should be carefully developed and administered.

A receiver should consider the different circumstances under which claims are adjudicated. There are several variables that may affect the way the claims process is handled, each of which, as well as state law, will have an impact on the type of claims procedure that must be established:

- Whether the insurer has any assets.
- Whether the insurer is a primary carrier, an excess carrier, a professional reinsurer, or a primary carrier that assumed reinsurance obligations.
- Whether the insurer underwrote property/casualty (P/C); fidelity/surety; a health maintenance organization (HMO) or a preferred provider organization (PPO); or life, accident, and health risks.
- Whether guaranty associations are involved.
- Whether the proceeding is judicial or administrative.
- Whether the proceeding is a conservation, rehabilitation, or liquidation.
- Whether the claim arises under an insurance policy or other contract.
- Whether the insolvency crosses state or international borders.
- Whether the insurer handles claims adjudication internally or outsources this function to third parties.

For a discussion of the legal aspects of claims processing and payment, see Chapter 9—Legal Considerations.

The following discussion is ordered chronologically and, unless indicated otherwise, assumes that the insurer is insolvent and that the receivership proceeding is a liquidation. One of the first tasks for any receiver is to establish a claims procedure and publish the procedure to potential claimants. Once established and published, the claims procedure is implemented. It may be prudent to file the claims procedures with the receivership court and seek the court's approval of the procedures prior to implementation of the procedures. The receivership court ultimately approves the claims that the receiver has adjusted and recommended for payment or denial. Establishing appropriate reserves is an integral part of the process. The final step is payment.

This section addresses the timetable for the filing of claims, the different types of creditors and their claims, and provision of notice to claimants. The receivership court's order defines the required notice to potential creditors and establishes deadlines for the filing of claims.

A. The Fixing Date

One of the first steps in any insurance insolvency proceeding is to establish the exact date upon which the rights, obligations, and liabilities of the insurer and its creditors are determined or "fixed." Most states use the date of entry of the liquidation order or, in some cases, rehabilitation order, for this purpose. (See

Section 501(B) of the *Insurer Receivership Model Act* [#555], also know as IRMA.) However, as to some policyholder claims, the fixing date is often required to be the date when the statute or court order terminates the insurer's policies. The effect of the fixing date is significant: It provides a reference date upon which the insurer's liability and creditors' rights are determined. The most common legal distinction made is that between contingent and absolute claims. In essence, a claim is contingent if a liability-imposing event has occurred, but it is uncertain that the claim will be made or coverage and liability established. An absolute or non-contingent claim is one of certain liability. Although there may be a question as to the ultimate amount of the liability or when it may be due, there is no doubt that some debt will be due. An example outside the liquidation context helps to illustrate these distinctions. Assume that A negligently drives his car into the rear of B's automobile. As a result of the incident, B has a contingent claim against A. If B sues A, and B is awarded a final judgement, B as an absolute claim against A. In short, a claim remains contingent until liability is certain.

Identification of the fixing date may be subject to statutes applicable to both life/health and P/C insolvencies in several states that require continuation of coverage for a specified period after liquidation, usually 30 days. Most state statutes require that a life insurer's policies continue in full force and effect, at least until the receiver reinsures or transfers the policy liabilities to another insurer.

B. Claim Filing Deadlines

1. What Is a Claim Filing Deadline?

A claim filing deadline is the deadline for filing proofs of claim against the estate. (See Section 701(A) of Model #555.) The purpose of the claim filing deadline is to enable the receiver to: identify existing or potential claims against the estate; adjust and adjudicate claims; make distributions; and eventually close the estate. A claim received after the filing deadline should be classified as a late claim. Timely filed claims may be amended or supplemented subject to certain limitations provided notice of the loss or occurrence giving rise to the claim was provided on or before the claim filing deadline. Late-filed claims may be accepted but may not be paid until all timely filed claims of the same priority have been paid in full, or it will be moved to a lower priority of distribution within the estate. Under Model #555, late-filed claims are assigned to Class 9, provided that the claim was late due to certain specified criteria (Model #555, Section 701 and Section 801(I)). Other claims filing dates may apply.

In some circumstances, claimants need not file a claim to preserve their rights (e.g., policyholders of a life insurance company). Unearned premium claims may be treated similarly in P/C liquidations. It is recommended that the receiver discuss with the guaranty association which claimants are required to file a proof of claim. It is the receiver's responsibility in such circumstances to develop a list of claimants who are deemed to have filed claims prior to the claim filing deadline. As always, it is imperative to check local statutes for the appropriate procedure and rule of law.

a. Effectiveness as Against Federal Claims

Whether claim filing deadlines cut off untimely claims of the federal government pursuant to federal super priority statute 31 U.S.C.A. § 3713 remains unsettled. For a more extensive discussion of this and other claims issues, see Chapter 9—Legal Considerations.

b. Applicability in Rehabilitations

Whether a claims deadline date will be established in a rehabilitation proceeding depends upon the specific circumstances and applicable law. In rehabilitations of a limited or set duration, a claim filing deadline may enable the rehabilitator to ascertain the amount of outstanding claims and implement a plan to return the insurer to solvency. A deadline may also allow the rehabilitator to conserve liquid assets to pay current obligations while a rehabilitation plan is

being developed or the amount of outstanding claims is being assessed. In other rehabilitations, it may be appropriate to set no claim filing deadline until a final dissolution plan has been settled.

2. How Is a Claim Filing Deadline Established?

A court order is required pursuant to the applicable statutory requirements to establish the claim filing deadline for a particular receivership. (See Section 701 of Model #555 and Chapter 6—Guaranty Associations for claim deadlines applicable to guaranty associations or ancillary receiverships.) The claim filing deadline established for claims against the receivership estate will also apply to the claims against a guaranty association.

Some state statutes specify the maximum period of the period of time for the claim filing deadline bar date. If there is flexibility within the statute, the length of this period often will depend upon the complexity and size of the receivership and the type of business written. The assumption of blocks of business by a solvent insurer may eliminate the need for many claims to be filed at all. There can be a general correlation between the length of the claim filing deadline and the amount of the estate's administrative expenses.

3. Deemed Filed Claims

In circumstances where the insurer has better information about claims than the policyholders have, the receiver may be able to avoid the administrative expense of handling some or all proofs of claim by establishing a "deemed filed" procedure. Under such a procedure, the receiver may establish a list of policyholders and claimants based on the insurer's books and records, which shall provisionally state the amounts claimed. Each person whose name appears on such a list shall be deemed to have filed a proof of claim in a timely manner. Claimants are given notice and provided an opportunity to correct errors and prove their claims before final allowance. This procedure works well for unearned premium claims and claims for investment values in life insurer insolvencies. Most state statutes do not require holders of life or annuity contracts to file claims.

D. Developing the List of Creditors

The first step in this process is to develop a master mailing list of creditors from the insurer's books and records and other interested parties.[1] Most state statutes or receivership courts require notice by first class mail to the last known address of the known claimants, as well as by publication. In some states, notice shall be given in a manner determined by the receivership court.

The following persons usually will be included in the insurer's mailing list:

- Guaranty associations.
- Policyholders.
- Third-party claimants.
- Secured creditors.
- Government agencies.
- Wage claimants.

[1] See *Elmco Properties, Inc. v. Second National Federal Savings Ass'n*, 94 F.3d 914 (4th Cir. 1996) for a receivership involving a savings association.

- General creditors.
    - Reinsurers and reinsureds.
    - Intermediaries.
    - Managing general agents (MGAs) and third-party administrators (TPAs).
    - Claims adjusters.
    - Defense attorneys.
    - Vendors.
- Equity (stock or share) holders.

E. Proof of Claim Forms

Once the list of claimants is developed, the receiver typically sends a proof of claim form to each person identified. The proof of claim form, which is the basic prerequisite to the allowance of a creditor's claim, serves a number of useful purposes. First and foremost, it identifies the claimant and the nature and extent of the claim. The receiver also may use the form to calculate the extent of the insolvency, to identify any obligations the claimant may owe the insurer (e.g., through the identification of any setoffs), to set reserves, and to determine the estate's right to collect reinsurance. In some cases, health claims may not have to file a proof of claim. An example is where the health insurer uses a TPA and is covered by the guaranty fund; there should be no need for the TPA to adjudicate the same claims twice.

Many proof of claim forms have been developed over the years. Claim forms to be used in any particular proceeding should be tailored to the circumstances presented. For example, the receiver should consider whether claims forms must be filed by all claimants. Most state statutes permit the receiver to dispense with the issuance of claim forms in a life receivership. The receivership simply draws a list of creditors from the insurers' books and records. In some states, filing with a guaranty association may constitute filing with the receiver for purposes of satisfying a claim filing deadline, but the receiver may need additional information from the claimant that the guaranty association did not elicit. Guaranty associations and receivers should coordinate their respective claim filing procedures to the extent possible. With receivership court approval, receivers may deem open claims as reflected on the books and records of the delinquent insurer as timely filed. In such circumstances, proofs of claim need not be filed by insureds or third-party claimants for such claims.

Before a proof of claim form is created, the receiver may wish to determine the number and types of claim forms that will be needed. The first task is to identify in broad categories the various classes and types of claimants. Then the receiver can determine what information is required for each type of claim. With this information, specific proof of claim forms can be developed for each category of claimant based on the type of business written. Some receivers use only one claim form but use control numbers (such as an alphanumeric system) to designate the type of claim presented in the form. This saves the cost of developing separate forms. Receiverships involving surety business may necessitate the use of a separate proof of claim form for each type of surety bond. The objective is to facilitate the exchange of information between the claimant and the receiver in order to adjust and later adjudicate a claim.

The more specific the information that can be elicited in the initial proof of claim form, the less follow-up will be required. Receivers should be encouraged to request submissions from creditors that the company in receivership has reinsured in accordance with the format of reporting under the reinsurance contracts in question. This should just be complemented by a comprehensive overview and breakdown of the total claimed by such reinsured creditor. The receiver, however, may require the claimant to present

supplementary information or evidence, may take testimony under oath, may require production of affidavits or depositions, or may otherwise obtain additional information or evidence. (See Section 702(C) of Model #555). The class determinations should be subject to a right of appeal by the claimant. The prompt determination of creditor class permits a faster wind down, as well as facilitates more prompt calculations and distributions for creditor claims. It may be unnecessary to determine the amount of receivership claims for a creditor class if receivership assets are unavailable for that creditor class.

Most statutes require claimants to provide certain basic information. (See Section 702 of Model #555.) The following information typically is required:

- The nature and particulars (e.g., the who, what, when, where, and amount) of the claim asserted.
- The consideration for the claim.
- The identity and amount of any security held on the claim.
- Any payments made or received on the claim.
- A copy of each written instrument upon which the claim is founded or a statement of the reasons a copy of the instrument(s) cannot be provided.
- The amount and a description of the source of any salvage or subrogation collected or that may be collected.
- An affirmation (notarized) that the insurer justly owes the sum sought and that there is no setoff, counterclaim, or defense to the claim (Section 702 A of Model #555).
- The name and address of the claimant and any attorney representing the claimant.

Additionally, Model #555 requires that the claimant provide: 1) its Social Security number (SSN) or federal employer identification number; and 2) any right of priority of payment or other specific right asserted by the claimant (Section 702 A of Model #555).

The receiver may decide to use the same claims and policyholder service forms that the insolvent company previously employed because the information required is fairly uniform, and the use of different forms could be confusing to the service providers and policyholders. Additionally, many estates make proof of claim forms available for easy access via the receiver's office website.

The receiver decides what additional supporting documentation will be required to prove a claim and in what form it should be submitted. (See Section 702 C of Model #555.) Different documentation will be needed for different types of claims. For example, death benefit claims require the furnishing of a death certificate. Accident and health (A&H) claims may require a physician's certification and copies of medical bills. Return premium claims may be established simply by submitting a bordereau of all cancelled policies and return premium amounts attributable thereto, while computer summaries may be required to prove cumbersome or complicated claims. When policyholders claim return premium, the receiver may require additional documentation, such as copies of cancelled checks. Reinsurance claims may require yet another form of documentation. Life insurance claims usually require the policyholder to furnish the original policy. If the original cannot be provided, a copy thereof may suffice. If neither the original nor a copy of the policy can be furnished, a lost policy form should be executed and submitted to the receiver.

The level of detail required in the proof should conform to industry standards and statutory guidelines, as well as make it convenient for the receiver to communicate with the claimant and add the information to its database for claims management. Some estates may not process a claim that does not include all the

requested information. One of the most critical needs of general creditors involves financial information on an insolvent ceding company. Providing regular financial statements of the company would be beneficial to interested parties, such as guaranty associations, reinsurers, and other receivers or regulators. It should be noted that whenever a reinsurer of the company in receivership has claims against the estate or where a reinsured creditor at the same time is a reinsurer of the estate, receivers should use the guidance provided in Subsection F—Coordination and Communication With Reinsurers.

The receiver must determine who may submit a proof of claim on behalf of an entity and what form of verification is required. Because corporations can act only through their designated agents, it is best to determine and inform corporate claimants who may sign on their behalf (e.g., officers, directors, MGAs or attorneys). Generally, a director does not have authority to act for a corporation because directors must act as a body unless otherwise authorized by the company's bylaws. In most instances, the notarized signature of an individual who attests to his authority to do so will suffice. The signature of a trustee should be received when dealing with trust claims, and the trust document should be provided to the receiver to verify the identity of the trustee. If in doubt as to the capacity or authority of an individual who submits a claim on behalf of a corporation, partnership, or trust, the receiver may require that the claimant provide a certificate of incumbency, signed by another authorized officer or representative, as to the signer's authority to bind the entity. In the case of a corporation, partnership, trust, or individual, the receiver may also require a signature guarantee if in doubt as to the identity of the individual executing the claim. Careful drafting of the attestation will ensure that such authorization has been given to the signatory. Note that the availability of notarizations may depend upon the residence of the claimant. Although most foreign countries maintain their own systems for verification, notaries may be found at most American embassies. Consideration should be given to electronic signatures and proof of claims submission

When developing proof of claim forms, it is helpful to have in mind the volume, type, and class of claims that creditors may submit. Claimants, including guaranty associations and reinsured creditors, may have hundreds of outstanding claims against the insured. Some claimants may be permitted to file a single omnibus proof of claim for all claims against the receivership estate. Section 702(D) of Model #555 allows a single omnibus claim to be filed by guaranty associations, which may be periodically updated without regard to the claim filing deadline, and the guaranty association may be required to submit a reasonable amount of documentation in support of the claim. Also, for reinsured creditors, the receiver will want to decide whether these claims need to be submitted individually or on a bordereaux basis. There are certain advantages to bordereaux submissions, which are dictated by the sheer volume of claims, the requirements of the treaty, and the receiver's need to efficiently process reinsurance recoveries. Ceding treaty retrocessionaires may only be able to file claims on bordereaux. There are other claims submission methods that might be used for reinsurance recoveries, depending upon the complexities of the situation. In the final analysis, the preferred submission approach ordinarily is the one that permits an orderly and efficient administration of claims on a computer system and often closely follows the procedures formerly in effect when the company was in operation.

In some states, if applicable, claims must be submitted on the liquidator's proof of claim form unless the liquidator grants an exception. Therefore, one approach to the claims filing process for reinsurers would be to allow for claims to be submitted in any format acceptable to the receiver; if the receiver (or the court) agrees, a claim would not have to be submitted on a proof of claim form.

To the extent omnibus proof of claims by reinsurers/intermediaries are allowed under your state's law, another consideration to expedite the filing of certain types of claims would be to allow reinsurers/intermediaries to file "place holder" claims, like those of guaranty associations, whereby the reinsurers/intermediaries timely file claims but are permitted to supplement their claims as additional information becomes available later in the receivership process. When appropriate, deem filing practices would be allowed for certain claims in receiverships. Generally, such orders are only sought in situations involving claims for which adequate claims documentation/proof exists within the records of the insolvent insurer.

III. NOTICE

Once a receivership order has been entered, whether it is for rehabilitation or liquidation, one of the first actions taken is to mail notices of the receivership to the company's agents, policyholders/members, reinsurers, and other parties related to the receivership. These notices should contain information regarding the claims processing filing process and references to the receiver's office website. The website should be kept updated with receivership information relevant to interested parties. The receivership website should not only provide information for consumers, but also provide an overview of the current status of the receivership, including past and upcoming deadlines, as well as provide access to court orders relevant to the receivership. To simplify the administration of the website, such information can be provided in the format of a simple table as some receivers' websites already do. Similar receivership notices are also provided to insurance departments of other states where the company is licensed.

Once a claims procedure has been established, the next step is communicating the procedure to all creditors. The receiver should check the domiciliary statute for any applicable time constraints in sending notice.

Ideally, in the case of surety bonds, insureds, their agents, and obligees should be advised of the status of their policies and of the procedures to be followed to make a valid claim. Among other things, the notice typically will inform them of the insurer's insolvency, whether policies have been or will be cancelled, and the procedures for presenting claims. The notice also may be used to describe, in general terms, the anticipated course of the liquidation. Some states require the notice to describe the guaranty association's involvement, if applicable. If a guaranty association is or may be involved, the receiver may want to jointly draft the notice with the association. The receiver should be cognizant of the effect of the receivership on guaranteed renewable and non-cancellable business.

The form of notice should be adapted to the circumstances. The notice may consist of the actual proof of claim form, with appropriate instructions for its use. The notice should identify the rights fixing date and claim filing deadline and its significance. Highlighting the penalty for failing to file by the claim filing deadline may help to avoid problems later. Posting notices, proof of claim forms, and claim filing deadines on the receiver or estate's website is a best practice.

In multistate receiverships, notices to life insurance policyholders and annuity or investment contract holders should be coordinated with affected guaranty associations through the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA). The receiver also may consider coordinating with the National Conference of Insurance Guaranty Funds (NCIGF) in multistate receiverships on the issuance of notices sent to P/C policyholders. Guaranty associations may request that the receiver include appropriate guaranty association information in the receiver's notice.

A. Contents: Plain Language

Most people will be receiving a receivership notice and proof of claim form for the first time. It is important that all forms be written as simply and clearly as possible. When appropriate, bilingual or multilingual notices can be issued.

B. Service

For the initial mailing of proofs of claim, receivers may send notices and proofs of claim as claimants are identified or initiate the mailing process once all potential claimants are identified. For ease of reference

and tracking, proofs may be numbered either before issuance or upon receipt, and a procedure may be implemented for recording the mailing, undelivered return, receipt and processing of all proofs. Notice commonly is given by mail and occasionally by publication. The receiver should be aware that there are constitutional issues with respect to the deprivation of property rights. Specifically, identifiable creditors of the estate, who have a known or reasonably ascertainable address, may be entitled to mailed notice of the proceedings affecting their claim. *Elmco Properties Inc. v. Second National Federal Savings Association*, 94 F. 3d 914 (4th Cir. 1996). (See Chapter 9—Legal Considerations.) Mailing should be done in the manner and form prescribed by the domiciliary receivership statute (e.g., certified, first class, bulk), with appropriate documentation and records to demonstrate issuance, in case a challenge arises later. Publication may be required by law and is advisable for unknown claims. In most cases, the court order establishing a claim filing deadline will also require published notice of the receivership. Refer to applicable statutes or the court order to determine the timing, media, and frequency of published notice.

Proofs of claim themselves may be issued by mail or through the receiver's website. A copy of the entire proof of the claim distribution list should be maintained and supported by verification by the individual(s) handling the distribution.

IV—CLAIMS PROCESSING

The receiver should make decisions at the commencement of the liquidation about proof of claim filing requirements and the claim evaluation process. Making these decisions upfront affords timely notice to claimants prior to the expiration of any claim filing deadlines and permits the development of claim forms and procedures consistent with such decisions. Each of these topics are discussed below:

A. Filing Methods

State laws typically permit the presentation of claims by a variety of delivery methods, including U.S. mail, personal delivery, or private delivery service. The receiver may also allow claimants to present their claims by facsimile or electronic (i.e., computer) transmission. The receiver should determine in advance whether to require original or electronic signatures, verification under oath, and acceptable forms of supporting documentation—whether actual receipt, postmark, or receipt of delivery to a courier by the claim filing deadline.

State law may provide the receiver with discretion to exempt preexisting claims from the proof of claim requirement. In exercising such discretion, a receiver would notify claimants with pending claims reported prior to the entry of the receivership order that their claims are deemed on file. Upon finalizing such decisions, the receiver should develop clear and timely communication protocols that address the requirements for presenting claims against the estate.

In developing claim filing protocols, the receiver should be cognizant of information-sharing requirements with other stakeholders, such as state insurance regulators, guaranty associations, and reinsurers.

1. Documenting Receipt of Proofs of Claim

As noted, the receiver should determine at the outset what constitutes "receipt" of a claim; i.e., whether proofs of claim are considered received on the date they are mailed or on the date they are actually received at the designated address. This determination will affect whether claims are timely filed or late. Documenting the date of receipt of proofs of claim is a critical receivership function that should follow established business protocols.

2. Guaranty Association Claims

The receiver should establish effective communication with the affected guaranty associations at the earliest possible date in the insolvency. (See Section 303 and Section 405 of Model #555.) This is the essential first step to efficient referral of claims to the appropriate associations. After claims have been referred to the guaranty associations, claimant inquiries can be directed to the appropriate guaranty association or claim handler. The receiver may also need to monitor claims where more than one guaranty association is involved. If guaranty associations are unable to commence claim payments shortly after the liquidation date of the insolvent insurer, the receiver may want to establish a transitional prepayment plan for hardship categories, such as workers' compensation claims, pharmacy benefits, or impounded automobiles. Such payments may be appropriate for subsequent treatment as early access distributions to or direct reimbursement by affected guaranty associations. See Section 802(D) of Model #555. (Note: Section 802(D) of Model #555 relates specifically to workers' compensation payments in P/C cases). In the case of a life and health multistate insolvency, such payments may be used to provide funding to support assumption transfers of business or to provide initial funding for covered claims. In either event, the funding would be considered early access in accordance with Section 803 of Model #555. The referral of a claim to a guaranty association does not terminate the receiver's involvement with the claim. The receivership estate may have responsibility for claims that are excluded from guaranty association coverage or for portions of claims that exceed the applicable guaranty association coverage limit. A collaborative approach to the resolution of such claims between the receiver and guaranty association should be considered. Where guaranty associations administer covered claims, it is also critical for the receiver and guaranty association to coordinate information sharing so that the receiver is able to notify, cede, and recover losses from reinsurers. Many state laws exempt guaranty associations from proof of claim requirements and claim filing deadlines. Model #555 permits guaranty associations to file a single omnibus proof of claim for all claims of the association, which may be updated periodically without regard to the claim filing deadline. (See Section 702(D) of Model #555.)

B. Proof of Claim Evaluation

This section outlines the general steps a receiver usually takes when reviewing claims filed against an insurer. It also identifies policy or administrative questions the receiver should consider at the beginning of the claims evaluation process. Model #555 provides that the liquidator may adopt, with the approval of the receivership court, procedures for the review, determination, and appeal of claims that will be preliminary to review by the receivership court. (See Section 707(A) of Model #555).

Prompt and efficient resolution of claims should be management priorities for the receiver. Model #555 provides that the liquidator shall review all duly filed claims and shall further investigate as the liquidator considers necessary. However, a liquidator is not required to process claims for any class until it appears reasonably likely that assets will be available for a distribution to that class. (See Section 703(A) of Model #555). If there are insufficient assets to justify processing all claims for any class, then the liquidator shall report the facts to the receivership court and make appropriate recommendations for handling the remainder of the claims. (See Section 703(K) of Model #555.) The liquidator may allow, disallow, or compromise claims that will be recommended to the receivership court unless the liquidator is required by law to accept the claims as settled. (See Section 703(A) of Model #555).

The receiver should manage the claim staff to achieve these goals. To the extent that the ultimate claim resolution is dependent upon the outcome of a guaranty association's claim administration, the receiver should consider coordinating with the applicable guaranty association on ultimate claim resolution when closure of the receivership estate is in view.

Completion of the claims evaluation process will enable the receiver to effectuate distributions to policyholders and creditors; generatere insurance recoverables; and resolve subrogation and salvage, coordination of benefits, and loss-sensitive underwriting recoveries. The receiver in a health insurance insolvency should evaluate coordination of benefits owed from other parties, as well as

subrogation recoverables. Inquiries to be made include whether collateral is being held by the creditor in connection with the claim and whether there are other third parties who may be pursued, such as indemnitors. Proof of claim forms can be a source of such information.

Receivers and guaranty associations may need to coordinate on entitlement to collect and retain salvage and subrogation recoveries. The decision in *Cal. Ins. Guarantee Ass'n v. Superior Court*, 64 Cal. App. 4th 219, 220-21 (Ct. App. 1998) resolved whether the receiver or the California Insurance Guarantee Association (CIGA) was entitled to the sums CIGA recovered through subrogation actions after it had paid covered claims. The Court held that to the extent CIGA pays covered claims, it was entitled to retain the amounts it recovers through subrogation actions. Conversely, to the extent CIGA pays covered claims with "early access distributions" or other assets from the insolvent insurer's estate, the estate is entitled to proceeds of any subrogation action. Id. at 229. In instances where pre-receivership payments were made by the insurer prior to guaranty association assumption of a claim, those payments typically constitute subrogation of the receivership estate under state law. In the case of surety claims, the receiver will need to review the underwriting file to determine subrogation or salvage potential and the identity of any third-party indemnitors. The estate should notify third-party indemnitors and solicit their involvement and support in settling the claims. Failure to properly and timely notify third-party indemnitors can result in the loss of indemnification through failure to give the indemnitor reasonable opportunity to minimize loss.

1. Review of Timely Filed Claims

Timely filing of a proof of claim may determine whether a claimant receives priority payment and, if so, at what level of priority. The receiver accordingly must determine whether each claim is timely filed.

Determinations of timeliness are made with reference to the claim filing deadline and the receipt or postmark rule. Claims received thereafter are categorized as late and subordinated in priority under state law. State law may provide a limited exception to the claim filing deadline for late claims. The receiver should review the applicable state law to determine whether a claim qualifies under the limited exception. (See Section 801 of Model #555.) For example, in some states, a late-filed claim may be a deemed timely filed claim if the claimant can show that they were entitled by virtue of an open claim on the books and records of the company to receive actual notice of the receivership and claim filing procedures but was not sent such notice. In one jurisdiction, a court held that the claims filing deadline should not be extended as a remedy for a receiver's failure to give notice of the appointment of a receiver. (See *In re Liquidation of American Mutual Liability Insurance Company*, 802 N.E.2d 555, (Mass. 2004.)

Although the law on this point is fact-intensive, a receiver may not be able to rely on constructive or published notice in circumstances where the existence of a claim was contained in the insurer's books and records.

Other examples of deeming late claims timely may include: 1) creditors who received transfers that were subsequently voided by the receiver or surrendered assets transferred to them; 2) secured creditors whose security was valued below the amount of their claims (Section 701(B) of Model #555); and 3) reinsurers whose reinsurance contract is terminated by the liquidation, giving rise to a termination claim under Section 701(C) of Model #555.

- Post-Deadline Maturity of Timely Filed Claims

Certain timely filed claims may not be absolute for a variety of reasons. The receiver may request the Court to set an absolute, or final, or contingent claim deadline, by which timely filed claims must be made absolute or fixed. Claims not made absolute, liquidated or mature by that deadline are date would be denied.

2. Review as to Form

- Policyholder Protection Claims

Some jurisdictions permit policyholder protection claims by first party insureds for claims that are incurred but unreported or not known at the time of the claim filing deadline. Such claims may be allowed if they are amended or supplemented consistent with statutory or judicial rules and procedures. The receiver should consult applicable law to determine whether to allowsuch claims. Other states expressly prohibit policyholder protection claims. (See Chapter 9—Legal Considerations.) Statutes in some states either provide expressly, or courts have decided, that such claims may be allowed. Absent such guidance, some receivers require that the initial proof of claim be specific and may not be amended in any material respect after the claim deadline expires. Other receivers allow proof of claim amendments of all types until assets are distributed. Receivers should consult their local statutes and applicable court decisions on this issue.

- Contingent Claims

Most states provide for the filing of contingent claims by first-party insureds, subject to an additional deadline for liquidating such claims. Contingent claims may be allowed if the claim is liquidated and the insured presents evidence of payment of the claim on or before the contingent claim filing deadline established by the Court. A contingent claim is a known loss or occurrence that is presented by an insured prior to the entry of a judgment or a determination of the insured's liability. Contingent claims do not include, and should be distinguished from, claims presented by third parties where liability or damages had not been established prior to the filing of the claim. (See Section 705 of Model #555.)

Model #555 and most state laws provide third-party claimants with a direct right to file claims with the liquidator prior to the expiration of the claim filing deadline. (See Section 706 of Model #555.) In such instances, an insured may also file a contingent claim for the same occurrence raised by the third party. Section 706 of Model #555 provides that the liquidator may make recommendations to the receivership court for the amount allowable on insured/third-party claims, basing this recommendation on the probable outcome of third-party claims against the insured. But distributions will be withheld and reserved pending the outcome of such a dispute or litigation between the insured and the third party. When the third-party claim is resolved, the reserved distribution will be paid to the insured or third-party claimant, as appropriate, and any excess amount reserved will be redistributed pro rata to other claimants in the receivership.

Section 706 of Model #555 provides a procedure for resolving multiple claims filed by different parties against an insured that may exceed policy limits. In the case of multiple claims and irrespective of the Model #555 provisions, it is imperative to apportion the varying claims without preference to the policy proceeds, and it is important to file for claim approvals with the receivership court before any claims are paid under the insurance policy. The receivership court claim approvals should be filed with due and proper notice to all parties that may be affected by such claim payments. It is recommended that defense costs be paid pro rata, even before all claims have been resolved and settled against a policy, provided that proper notice is sent to all affected and interested parties.

Section 706 of Model #555 provides that the third-party claimant waives certain rights against the insured by filing a claim against the liquidator for the insured's insurance policy benefits, but the waiver will be ineffective if the claimant withdraws the claim or the liquidator avoids insurance coverage.

- Amendment and Supplement of Claim Information

Amendment and supplement of information supporting a previously asserted timely filed claim can assist the receiver in the disposition of a claim that was contingent, unliquidated, or immature at the time of its filing. Consistent with the applicable statutory requirements, the receiver may determine the types of amendment or supplement that will be allowed. Amendments may include, but are not limited to, correcting or updating the amount, correcting technical defects, and providing sufficient documentation supporting payments or damages. Some states may allow insureds to file contingent claims that include reasonable attorneys' fees for services rendered after the date of receivership in defense of approved claims, provided the insured has actually paid the fees and evidence of payment is presented prior to applicable deadlines established by the Court or before assets are distributed.

- Assumed Reinsurance Claims

As for the policies of a P/C insurer, the liability for claims that a P/C reinsurer has assumed generally are limited to those arising out of reinsured events that occurred on or before the liquidation date (unless the court or statute directs otherwise). A receiver should decide at the beginning of the receivership how to evaluate the claims of ceding companies under reinsurance contracts. This decision will dictate the form of notice to ceding companies and the form of the proof or documentation cedents must use to file claims against the insurer. The receiver may opt to let the insurer's assumed reinsurance business run off and have cedents file their current claims against the insurer, allowing the cedents to amend their claims from time to time.

Another option that receivers have proposed is to require all ceding companies to file a proof of claim against the insurer as of the date of the receivership order (or a reasonably close date) for all reported and unreported losses. Under this alternative, the receiver takes a snapshot at the fixing date. Paid losses are recognized as reported if covered under the reinsurance contract. Outstanding claim reserves and incurred but not reported (IBNR) claims reserves are actuarially calculated and discounted to present value. This method allows the receiver to evaluate cedents' claims at an earlier stage in the receivership. Because the receiver will want to employ consistent evaluation methods for all claims that include IBNR, the proof of claim form may require that the claimant report the basis for the IBNR calculation. It is important for the receiver to determine the existence and extent of retrocessional reinsurance that might be available to cover assumed claims. This reinsurance can represent a significant asset of the estate. (See Section 3(b).)

- Claims Under Occurrence Policies Under the *Insurer Receivership Model Act*

Model #555 provides insureds the right to file a claim for the protection afforded under the insured's policy, irrespective of whether a claim is then known or if the policy is an occurrence policy. Further, any obligee shall have the right to file a claim for the protection afforded under a surety bond or a surety undertaking issued by the insurer as to which the obligee is the beneficiary, irrespective of whether a claim is then known. When a specific claim is made by or against the insured or by the obligee, the insured or the obligee shall supplement the claim, and the receiver shall treat the claim as a contingent or unliquidated claim. (See Section 704 of Model #555.)

Having concluded that a proof of claim was timely filed (or properly amended), the receiver should next review the claim to determine if all required information has been provided and if the form has been completed in accordance with the applicable instructions. Model #555 provides that the liquidator need not review or adjudicate any claims that do not contain all applicable information and may deny or disallow any such claims (subject to notice). (See Section 703(I) of Model #555.)

If additional information is required, the receiver should specify a deadline for its submission, advising that the claim will be denied if the information is not submitted by that date. Review of applicable statutes for guidance on this point is suggested.

3. Review of Claims Based on Contract Provisions

The next step in the review process often consists of a substantive review of the claim. Here the receiver determines whether the claim may be allowed on its merits. This section presumes that the receiver has claim files to review (i.e., that the files are not in the possession of a guaranty association). The initial issue is the review of coverage: Is the claimed loss covered under the terms and conditions of the insurer's policy or contract, or is it excluded from coverage? The issue is resolved by referring to the policy or contract, the insurer's claims manuals, and underwriting files.

- Policyholder Claims

The starting point in the review of any policy claim filed against an insurer is the insurance policy or contract. The receiver treats the claim as if the insurer were reviewing it in the normal course of business prior to receivership. The receivership process and the procedures required by the receivership statutes and court are not a substitute for the sort of policy examination and initial claim review that the insurer followed before receivership.

The receiver first determines whether the policy was in force at the time of the loss. If not, the receiver will ascertain why the policy was not in force. Did the policy expire because of the insured's failure to pay premium? Did the term of the policy expire prior to the loss? If the insurer or insured cancelled the policy before receivership, the receiver must decide whether the applicable statutory or contractual procedures for cancellation were satisfied. The receiver also must determine whether the loss occurred before any cancellation of the policy by court order or by operation of law as a result of entry of the order of receivership. In the case of surety bonds, the receiver needs to determine that the bond was in force at the time of the occurrence upon which the claim is predicated. The receiver should be aware that some bond forms cover events that may have occurred prior to issuance of the bond, as well as during the term of the bond. In addition, the receiver will need to determine whether the obligee (claimant) has adequately discharged its obligations under the contract to both principal and surety in such a fashion as not to have prejudiced the surety's position.

Next, the receiver reviews the terms of the policy to ascertain whether the claim is within the scope and limits of coverage of the policy and not otherwise excluded. Model #555 provides that no claim shall be allowed in excess of the applicable policy limits or otherwise, beyond or contrary to the coverage provided. (See Section 703(A) of Model #555.)

In the case of a policy with aggregate limits, the receiver should determine how many claims have been filed against the policy and whether the aggregate limit has been exhausted. (See Section 706(D) of Model #555). If guaranty associations are paying claims under the policies, they should be notified of the extent to which the aggregate limit has been eroded. The receiver also will want to determine if the policy's terms provide procedural defenses to the claim, such as late notice, lack of cooperation, coinsurance, or coordination of benefit provisions (e.g., in a health insurance policy).

The insurance policies under which the claims arise must be read in conjunction with the insolvent insurer's reinsurance agreements. A reinsurer's obligation to pay may only be triggered if the claims under a policy exceed a specified retention point. In some instances, the retention point may only be met if claims under a policy can be characterized as a "single incident" under the terms of the reinsurance agreement. The receiver must determine when claims under a policy constitute a single incident for reinsurance recovery purposes. As the reinsurer may argue that the claims at issue involve multiple incidents, the receiver should carefully review case law from the applicable jurisdiction when making this determination.

In the case of claims under policies of life insurance, the receiver should be sensitive to contestability issues. For example, some claims may be contestable because of misrepresentations contained in the policy application. Suicide claims may not be payable if the death occurred within the policy's contestable period, typically two years. In the case of A&H claims, the receiver should be alert to preexisting conditions that might render a policy claim void. Other areas to watch for are work-related claims that could be covered under a workers' compensation policy or claims resulting from automobile accidents that could be covered by the insured's auto policy.

Model #555 provides that a judgment or order against an insured or insurer entered after the date of the initial filing of a successful petition for receivership, or within 120 days before the initial filing of the petition, and a judgment or order against an insured or the insurer entered at any time by default or by collusion need not be considered as evidence of liability of the amount of damages. (See Section 703(E) of Model #555.)

- Assumed Reinsurance Claims

Most states accord cedent claims the same priority as claims of general creditors. (See Chapter 9—Legal Considerations.) In cases where there are insufficient assets to satisfy all policyholders' claims, the receiver should determine whether a review of general creditor claims is necessary. If it appears that the insurer's assets will cover only a portion of policyholder priority claims, there may be no need to evaluate general creditor claims unless the insolvent company has retroceded a portion of its reinsurance business. In such case, the receiver will need to evaluate and fix the amount of all or at least certain ceding company claims in order to pursue available reinsurance recoverables.

Assuming reinsurance recoverables are available or that assets are available to distribute to general creditors, the receiver will review all such claims. Review of the individual reinsurance contract ensures that the reinsurance contract covers the claim being asserted. The receiver should verify that the contract was in force at the time of the receivership, because the cedent and the insurer may have entered into a commutation agreement terminating the reinsurance agreement or some other agreement that establishes the rights of the parties (such as a novation, loss portfolio transfer, assumption, assignment, or settlement). If so, then the receiver should determine whether the commutation should be honored or whether there is some basis for setting it aside (such as the creation of a voidable preference). If the commutation is determined to be valid, no other claims should be allowed against the insurer under that reinsurance agreement.

As with a direct policy claim, the receiver should determine whether reinsurance claims are covered, proper notice of the claim was provided, and premium and other amounts due under the reinsurance contract have been paid. The receiver should also offset claims due from the cedent (e.g., for unpaid premium, salvage, etc.).

- Certain Other Types of Contracts

The receiver may need to review the terms of the employment contracts with directors, officers or other individuals. Model #555 provides that claims under employment contracts should be limited to payment for services rendered prior to the receivership order unless explicitly approved in writing by the commissioner prior to receivership or by the receiver post-receivership. (See Section 703(F) of Model #555.) The receiver also should carefully review the terms of all leases. Model #555 provides that the claim of a lessor for termination of a lease shall be disallowed to the extent the claim exceeds the rent reserved by the lease (without acceleration) for the greater of one year, or 15% (not to exceed three years) of the remaining term of the lease following either the date of the filing of the petition or

the date of repossession or surrender of the leased property (whichever comes first), plus any unpaid rent due. (See Section 703(L) of Model #555.)

The receiver also should carefully review the terms of all netting agreements or qualified financial contracts (QFCs). Model #555 provides suggestions for the receiver as to how to deal with these types of contracts. (See Section 711 of Model #555.)

4. Review of Guaranty Association Claims

When a receivership triggers guaranty association coverage, the receiver should coordinate the approval and disapproval of claims with the guaranty association(s). Consulting the applicable statutes may enable the receiver to determine whether guaranty association payments bind the receiver. Coordination affects, among other things, the amount recovered under the insurer's reinsurance treaties or reinsurance agreements.

The receiver should establish appropriate procedures at the beginning of the receivership in order to accommodate guaranty association claims. For example, receivers often allow guaranty associations to file an omnibus proof of claim form that can be amended from time to time. Typically, the receiver's forms for guaranty associations will include sections asking the guaranty association to segregate its claim by administrative expenses, allocated and unallocated loss adjustment expenses (LAEs), unearned premium payments, and policy loss payments. The receiver should review the guaranty association's claim for validity of liability and reasonableness of amount claimed. The receiver should be cognizant of the operational differences between life/health guaranty associations and P/C guaranty associations. P/C guaranty association claims are typically related to terminated policies, whereas life/health guaranty associations obligations can also include claims related to the continuation of benefits under the insolvent insurer's contracts.

Life/health guaranty associations may satisfy coverage obligations by transferring those obligations to a different insurer through an assumption reinsurance agreement negotiated by the NOLHGA or through ongoing administration of policies and claims in run-off where assumption reinsurance is not available. Consequently, the nature of the claims and expenses incurred by life/health guaranty associations can differ from the claims and expenses of P/C guaranty associations. In addition, life/health guaranty associations have statutory and subrogation claims to assets of the insolvent insurer to assist the association in satisfying its obligations. Early access agreements frequently permit the receiver to audit the guaranty association's records concerning the association's handling of claims.

The level of scrutiny given to a guaranty association claim depends on the circumstances. When the guaranty association provides complete coverage for affected policyholders, the receiver in cooperation with guaranty associations may wish to so notify policyholders (or have the associations do so) and thereafter deal only with the omnibus proof of claim filed by the association. Most state guaranty association statutes provide that a guaranty association's adjustment of covered claims usually binds the receiver, up to the amount the guaranty association has allowed, subject to statutory limitations. Although Section 703(A) of Model #555 obligates the liquidator to accept claims as settled by a guaranty association when required by law, it prohibits the allowance of any claim in excess of the policy limits or contrary to the coverage provided under the terms of the insurance policy.

In other situations, limitations on guaranty association coverage—including caps, crediting rate limits, copayments, deductibles and net worth—may make it necessary for the receiver to undertake a separate review of claims. The receiver should keep accurate records for, and coordinate with, all affected guaranty associations concerning the tracking of per-occurrence and aggregate limits of coverage under policies where there are multiple claims and claimants. Coordination with guaranty associations is essential.

Claims covered by guaranty associations may be reinsured. It is important for the guaranty associations to report development on these claims so that reinsurance notice requirements can be met. Lack of reporting can hinder the collection of reinsurance recoverables. Because guaranty associations ultimately benefit from reinsurance collection, the receiver and the guaranty associations have a common interest in collaboration.

5. Review Claimant Standing

A claimant's standing to file a particular claim against a receivership estate should also be reviewed by the receiver. Model #555 provides that with respect to claims of co-debtors, if a creditor does not timely file a proof of the creditor's claim, then an entity that is liable to the creditor together with the insurer (or that has secured the creditor) may file a proof of the claim. (See Section 709 of Model #555.)

C. Claims Valuation

All claims should be assigned a value for allowance. In general, the determination of a claim's value is subject to the contractual agreement under which it arose and any statutory limitations. However, the receiver may be inhibited by statute from valuing claims in the same manner as the insurer did before receivership. In a typical surety insolvency, for example, the receiver and the receiver's legal counsel may face myriad issues as to what must have occurred prior to the fixing date for the bond claimant to pursue a claim in the receivership (e.g., how the bond claim is to be valued when the receivership order has interrupted the normal surety repair/completion of a bond principal's default, etc.). Model #555 permits the liquidator to apply to the receivership court for approval to disallow *de minimis* claims. A *de minimis* amount shall be any amount equal to or less than a maximum *de minimis* amount approved by the receivership court as being reasonable and necessary for administrative convenience. (See Section 703(H) of Model #555.)

1. Secured Claims

Generally, the value of security held by secured creditors can be determined by converting the security into money according to the terms of the security agreement, by agreement with the receiver or by the supervising court. Model #555 allows the value of security to alternatively be determined by agreement or litigation between the creditor and the liquidator. (See Section 710(A) of Model #555.) The value of the security is then credited against the claim. Valuation of secured claims may affect the overall recovery and distribution of assets to the other creditors of the estate. Model #555 provides that the claimant may file a proof of claim for any deficiency, which shall be treated as an unsecured claim. If the claimant surrenders the security to the liquidator, the entire claim must be treated as unsecured. The liquidator may recover from property securing an allowed secured claim, the reasonable, necessary costs and expenses of preserving, or disposing of, the property to the extent of any benefit to the holder of such claim. (See Section 710(C) and (D) of Model #555.)

A receiver should proceed with caution when valuing secured claims. The value of the security may be overstated on the books and records of the insolvent insurer.

2. Claims Estimation

The long-tail nature of certain claims, such as workers' compensation or mass tort, in a P/C receivership can present special issues for receivers. Under some rehabilitation plans, claims may be permitted to develop in a normal fashion. In other rehabilitation proceedings and almost all liquidation proceedings, however, the receiver may be ready to distribute assets before all claims are fully developed. In addition to the typical issues of coverage, liability, and damages, the receiver should have a plan for valuing long-tail claims that complies with applicable state law.

Before a claim may be allowed, the receiver needs timely and accurate evidence:

- That the policyholder has, in fact, sustained a loss within the coverage of a valid policy and in a specific or determinable amount. The receiver evaluates the merits of the underlying claim. Under many states' statutes, a judgment against the policyholder entered after (and, in some states, even before) the date of liquidation may not be binding evidence of either liability or the amount of the loss. Nor does an insured's settlement bind the receiver, unless the insured can demonstrate that it is both bona fide and fair to the insurer as well as the insured. Collusive or side agreements between the insured and one or more of the claimants, consent judgments, and covenants not to execute should be reviewed to determine whether the judgment or settlement is reasonable.

- That a third party has asserted and proven a claim against the policyholder on a timely basis, in an amount that can be reasonably determined. Again, judgments should be evaluated by the receiver for reasonableness. Each claim must be evaluated on its merits.

  Some claims will fail to meet the requirements for proof and liquidation set out above, even though, were it not for the receivership's requirements, the claims would eventually have matured into enforceable claims. Late-maturing and even "contingent" claims are nevertheless an important component of the company's liabilities, both because of the significance of the claims themselves and because, when allowed, late claims may generate reinsurance recoverables for the estate.

- The receiver's flexibility in dealing with late-maturing claims may be limited by statute. Nevertheless, a procedure to deal with late-maturing claims should be developed in any estate involving long-tail exposures or where reinsurance recoveries are a consideration. The methodology used by the receiver will depend upon the individual estate, applicable state law, and the nature of the claims and the records available. A number of alternative approaches are available to the receiver:

  - The receiver might deny all claims that have not matured within a specific period after entry of the liquidation order. This "cut-off" approach may be appropriate where the insolvent insurer wrote simple, short-tail business or where the estate has few assets and recoverables. However, if the insolvent insurer wrote more complex business with a longer tail, the cut-off approach may defeat policyholder expectations and limit the receiver's right to collect from reinsurers.

  - Extensions of a claim filing deadline may ameliorate, but not eliminate, the risk that a policyholder with a legitimate claim will be left without a remedy. It sometimes helps and may be statutorily required to establish a second claim filing deadline, prior to any distribution to stockholders, in order to afford late claims an opportunity for recovery. Where permitted by state law, some receivers have obtained approval for plans under which a claim deadline is extended and policyholder claims are allowed for distribution as they mature. This "run-off" approach may delay the distribution of assets and/or closure of the estate.

  - Model #555 provides that a claim that is not mature as of the coverage termination date may be allowed as if it were mature, except it shall be discounted to present value. (See Section 703(D) of Model #555.)

  - The receiver should determine whether the law in the domiciliary state would allow a plan to estimate and pay claims pro rata. While some states' receivership statutes (e.g., Illinois, Missouri, and Utah) expressly permit the estimation of policyholder claims, receivers in other jurisdictions might seek receivership court approval for a claims estimation plan with proper notice to interested parties. Case law that allows for claims estimation when a state statute permits estimation for the payment of

claims or recovery of reinsurance proceeds includes *Angoff v. Holland-America Ins. Co.*, 937 S.W.2d 213 (1996), providing that "the Missouri insolvency statutes grant the receiver considerable discretion in evaluating the determining claims by estimation using actuarial evaluation or other accepted methods of valuing claims with reasonable certainty, including determinations for IBNR losses to the extent that those types of claims can be determined with reasonable certainty." State law may provide that estimated contingent claims may be allowed, but at a lower priority level than non-estimated claims (e.g., Illinois). Case law in another state provides that the receiver should not pay receivership distributions based on actuarial estimates of claims. See *In re Liquidation of Integrity Ins. Co.*, 2006 WL 2795343 (N.J. Super. A.D.). (The court rejected the holding in the *Holland-America Insurance Company* case that permitted claims estimation because it was based on Missouri statute, whereas New Jersey had no such provision.)

Assuming that a claim estimation plan is in accord with state law, the receiver should be aware of the following:

- Some state statutes have been amended to address the handling of contingent and unliquidated claims by providing an opportunity for estimation of contingent claims without lowering the priority of distribution of the claim. These few state statutes specifically allow for the estimation of claims, but some (e.g., Illinois) provide a separate priority of distribution level for holders of such allowed claims.

- Another approach to estimation assumes that each policyholder is assigned a case reserve established in the policyholder's name and a proportionate share of the total projected IBNR. Although largely untested in this country, this technique has worked well in other countries in the liquidation of reinsurers.

- Even if IBNR estimations are acceptable for purposes of distribution from the estate, estimation may not be a valid basis for recovering reinsurance. (See Section 611(I) of Model #555.)

- . Claims in a Life/Health Insolvency

Few receivership statutes directly address the issue of valuing life and annuity claims, but there is a well-developed body of case law on the subject. In any event, it often will be necessary to assess the type of policyholder claims at issue to evaluate whether groups of policyholders are being fairly treated in any rehabilitation, liquidation, or assumption reinsurance transaction.

- Mature Claims

Life insurance claims have the advantage that, in most cases, the condition precedent to claim liability is fairly clear: The policyholder is either alive on the relevant date or not. If the events triggering the insurer's obligation to pay on a life policy have occurred on or before the fixing date, then the receiver's claims process is substantially similar to that of a going concern, centering on proof of death, premium and cash value accounting, and beneficiary designation. Immediate annuities present slightly different problems, but essentially the claim of the owner of such an annuity ought to be the present value of the future stream of payments.

- Immature Claims

Challenges can arise in connection with policies for which the principal liability-creating event has not yet occurred at liquidation. Few such claims would be considered contingent

because the policyholder usually has significant rights at the liquidation date, including surrender rights or rights to unearned premium. Court decisions, going back to the early 1800s and ending in the 1940s as the assumption/guaranty system developed, support the allowance of claims based on these immature policies in the amount of a fairly adjusted reserve, or alternatively in the amount of the difference between premiums expected to be paid in the future and claims expected to be recovered by the policyholder—all discounted to present value.

In evaluating policyholder claims against life insurers, the receiver should look at the company's own reserves, after suitable investigation, to quantify individual policy claims. These reserves will typically equal or exceed cash or surrender value on the policies. Cash or surrender value, being the sum that the policyholder could obtain at any given moment from a solvent insurer, is usually the largest component of such a reserve and establishes a minimum number for the receiver's valuation. Other policy features are usually captured in the company reserves as well, including special premium considerations, renewal commitments, advantageous mortality charges, and above-market crediting rates. Annuity contracts may have features that affect the actual value of the contract. There may be a cash value, an account value, a surrender value, or other valuations used by the company to represent the amount payable to a claimant at a given point. Also, tax consequences may be incurred by a contract holder if their tax-qualified retirement contract is paid out and not rolled over into a qualifying contract within the time allowed by the IRS.

On the other hand, statutory reserves usually do not reflect the likelihood that some policyholders, had the insurer continued in business, would have permitted their policies to lapse. One approach to lapse issues would be to consider that because lapse is an election completely within the control of the policyholder, it would not be appropriate to reduce the claim in respect of an election that, at the date of liquidation, the policyholder had not made. Other analyses, however, are also possible.

In a life/health receivership, the receiver will frequently conclude that traditional proofs of claim are either unnecessary or irrelevant. The company's records often form a better base for a claim valuation than anything the policyholder could construct. The actuarial techniques that ought to be employed in the valuation are outside the competence of most policyholders. Finally, application of a single actuarial method to all claims will permit them to be evaluated on a consistent basis. Part or all of the policyholder claims arising from life insurance policies and annuity contracts will be covered by guaranty associations. State guaranty association statutes typically require a pro rata distribution of receivership assets to guaranty associations based upon the reserves that should have been established for the covered policies. In addition, guaranty associations may have other creditor rights. Accordingly, the receiver should coordinate with the affected guaranty associations as to valuation issues.

D. Notice of Claims Determinations

Once the receiver has completed the review of proofs of claim, the claimants should be advised of their claim determinations. In some states, the receiver will not send a determination letter if the claim has been resolved by a guaranty association. Some receivers merely file with the supervising court a report or recommendations as to the allowance or disallowance of each claim and require claimants to file any objections with the court. Other receivers give claimants notice and an opportunity to object before reporting to the court. As discussed below, Section 703(B) of Model #555 follows this procedure. If the latter procedure is used, notice of the full or partial allowance of a claim should inform the claimant of the amount that the receiver will recommend to the supervising court for adjudication and the class of the claim for priority of distribution purposes.

In the case of the partial or total disallowance of a claim, the notice should state the reason for the disallowance and inform the claimant of the amount of time (specified by statute or court order) that the claimant has to object to the determination. Many states provide that claimants be given 60 days from the date the notice was mailed to submit written objections to the receiver. Model #555 provides 45 days. (See Section 703(C) of Model #555). Model #555 allows the liquidator to accelerate the allowance of claims by obtaining waivers of objections. (See Section 703(C) of Model #555.) Model #555 also provides that preliminary notice of the amount of the claim determination may be given to any reinsurer that is or may be liable with respect to the claim at least 45 days before the notice is given to the claimant. If the reinsurer does not object to the claim determination, it is bound by the determination. (See Section 703(B) of Model #555.) Advance notice to reinsurers may not be practical under some circumstances, such as where the case is settled at mediation on the eve of trial or where the reinsurer has expressed disinterest in the claim determination because it intends to dispute liability. Notice to a reinsurer can help establish proper documentation when a reinsurer denies having been notified of the loss.

Once an objection is received, the receiver should consider whether the determination should be altered before proceeding to a court hearing on the objection. Model #555 provides that whenever objections to the liquidator's proposed treatment of a claim are filed, and the liquidator does not alter the determination of the claim as a result of the objections, the liquidator shall ask the receivership court for a hearing. (See Section 707(B) of Model #555). However, there is case law supporting the proposition that the commissioner may not have a statutory obligation to provide claimants a formal hearing when determining a claim (*Garamendi v. Golden Eagle Insurance Company*, 128 Cal. App. 4th 452, 27 Cal. Rptr. 3d 239 (Cal. Ct. App. Dist. 1. Div. 1. 2005)). Because it may be cost-prohibitive to have hearings on every claim objection, the receiver may settle or otherwise resolve an objection without the need for a hearing. The procedures for hearings on claim objections are discussed further below.

Prior to the court's approval, the receiver may revise the determination. This enables the receiver to correct any errors that were made and to amend the determination in light of any subsequently provided information or negotiations. The receiver should remind the claimant to advise the receiver of any change of address or the information provided in the proof of claim. Naturally, if the receiver changes an initial denial of a claim to an allowance or partial allowance determination, the receiver should notify the claimant of the amended determination.

In addition to policy claimants, the receiver should give notice of claim determinations to other directly affected persons, such as reinsurers. (The reinsurance contract contemplates the reinsurer receiving notice and an opportunity to participate prior to the court approving the claim.) The receiver should pay particular attention to the requirements contained in the insolvency clauses of applicable reinsurance agreements. Similarly, if the insurer underwrote surety bonds (such as contract performance or payment bonds), then the receiver will want to provide notice of the determination to indemnitors of the bonds, any collateral depositors, and the bond principal. Notice will enable the receiver to obtain any information those persons have with respect to the claim and will put them on notice that the receiver may be looking to their collateral or indemnification agreements for reimbursement of the insurer's liability under the bond. If not established by statute, the receiver should set a deadline for the claimant to respond to the claim determination. If a timely response is not received, the claim determination should become final, subject to court adjudication.

E. Judicial Review of the Receiver's Claims Determinations

Depending upon the degree of oversight exercised by the supervising court, the receiver may be expected to account to the court for all claims processed. Model #555 provides that the liquidator shall present reports of claims settled or determined by the liquidator to the receivership court for approval. The reports will be presented from time to time as determined by the liquidator and shall include information identifying the claim and the amount and priority of the claim. (See Section 708 of Model #555.) After the receiver makes the claims determinations, those decisions may be presented to the supervising court in the form of a recommendation for allowance or disallowance, in whole or part. This next section outlines

the procedural steps that may be taken in making, filing, and presenting recommendations for final court approval.

1. Documenting the Recommendation

The first step is to make sure that claims determinations have been properly documented. The receiver may want to have a separate file for each claim filed in the receivership, containing the proof of claim and other relevant information. Files may be organized numerically either on a date of loss or policy basis. A status sheet or checklist may be attached at the front of each file detailing the status of the claim, including the recommendation to allow or disallow the claim, the priority of the claim, status of reinsurance, and other notes. Information in the status sheet should be entered into an electronic claims system. After the recommendation has been documented, the receiver then presents the claim (depending upon its status) to the court for approval or for a contested hearing, if the claimant filed a timely objection to the receiver's determination.

2. Presenting Recommended Approvals to the Supervising Court

The receiver may obtain court approval of recommended claim allowances, or the receiver may obtain advance approval for the payment of claims within a specified claims priority. In the event of advance approval, the receiver may report back to the receivership court if there is uncertainty as to whether claims fall within the approved claims priority class.

If the receiver does not seek advance approval for payment of claims within a creditor class, claims may be presented to the court by listing the claims and amounts approved or, if required, by a full financial accounting. The court usually will enter an order confirming the allowed claims. When the court approves a claim and all possible appeals have been exhausted, the receiver's staff should be notified that the legal action has concluded so that the allowed claims may be placed in line for eventual distribution.

3. Review of Recommended Rejections

This section outlines a general procedure for the denial of claims in a receivership. Model #555 provides that disputed claim procedures are not applicable to disputes with respect to coverage determinations by guaranty associations as part of their statutory obligations. (See Section 707(C) of Model #555.) Some states follow the practice of conducting individual hearings on denied or disallowed claims. The receiver's goal is to complete the process as quickly and smoothly as possible. The receiver may use in-house counsel or retain outside counsel to handle hearings, depending upon the complexity of the receivership and the disputed claims. The receiver should consider the potential expense involved in contested claims proceedings in deciding whether to force a hearing or pursue settlement or arbitration.

The claims hearing process begins when the receiver files a notice with the supervising court and notifies the claimant and other directly affected persons. Various courts require different notices, and legal counsel should be consulted to assure that the receiver is following the correct procedure. Usually, the notice sets forth: 1) the time and date of the hearing; 2) the procedure to be followed at the hearing; 3) the amount claimed; 4) the relevant priority status of the disputed claim(s);5) the reason for the denial or priority status assigned; and 6) whether an objection was filed. In some instances, due to the volume of claims, a special master may be appointed to hear the disputed claims rather than the judge of the supervising court. If a special master is appointed, the parties should meet as soon as practicable to establish the exact procedure to be followed. The receiver's staff should work closely with the legal counsel conducting the proceeding.

Assuming all notice requirements have been satisfied and any special procedures have been implemented, claims hearings typically follow a routine procedure. If permitted, multiple hearings should be scheduled at the same time to conserve estate assets and resources. Depending upon the

complexity of the hearing involved, the receiver's staff and other resources may be needed. The receiver's counsel generally will need testimony from members of the claims staff or the receiver, along with production of relevant records. Expert witnesses also may be required. Receivers should take care to discuss the need for expert witnesses with legal counsel due to the costs involved.

At the close of a claims hearing, the court typically issues a report or decision. Assuming the receiver's recommendation is upheld, the receiver should note the deadline for appeal of the order. If there is an appeal, it is best to complete the appeal process as soon as possible. If the decision is not appealed (or an appeal is concluded), the final order of the court can be entered into the receiver's records, along with any change in claim status. The final disposition by the receivership court of a disputed claim is deemed a final judgment for purposes of appeal. (See Section 707(D) of Model #555.)

4. Arbitration

Judicial review of the receiver's determinations is not always mandatory. Depending upon the nature of the legal right or claim involved and the applicable law, arbitration may be required. Although the arbitration provision contained in a policy or reinsurance agreement may be unenforceable against a receiver (review of applicable law on this point is essential), careful review of these contracts is necessary to determine whether arbitration may benefit the receiver or the estate and, if not, whether arbitration can be avoided. Legal counsel may assist the receiver make this determination. If arbitration is an attractive option or cannot be avoided under applicable law, then the receiver should become familiar with the specifics of the arbitration clause in each contract.

Arbitration is a contract-based proceeding, subject to statutory and case law in the particular jurisdiction whose law may govern the proceeding. Careful review of the agreement with legal counsel is essential. Numerous legal questions arise in the context of arbitration proceedings, and no receiver should enter into arbitration without the assistance of competent counsel. For example, the choice of arbiters can be critical. The receiver may wish to consult with other receivers to identify arbitrators for recommendation. If one party refuses to name an arbiter, however, the other may seek court intervention to facilitate the process.

Section 105(E) of Model #555 recognizes the propriety of arbitration to resolve reinsurance disputes. (See Chapter 7.)

F. Establishing Claim Reserves

Establishing appropriate claim reserves may be just as important to an insurer in receivership as to a solvent company.

1. Why Reserve?

The nature of the receivership will dictate if, how, and when reserves should be established. A rehabilitator is particularly concerned with the company's reserves in assessing the company's prospects for a successful rehabilitation. It may appear that a liquidator should not be concerned with reserves because the insurer usually has been adjudged insolvent, and the liquidator's charge is to adjudicate the claims and close the estate. However, the liquidator will be concerned about reserving from the standpoint of reinsurance claims. Reinsurers need data from which to establish IBNR loss reserves, as well as reserves for existing claims. The receiver's failure to furnish this information on a timely basis may lead reinsurers to attempt to avoid their obligations.

Accordingly, the receiver should determine the reporting requirements established in the insurer's reinsurance contracts and other reserve requirements imposed by the court or by law. Accurate reserve information is equally important for determining the prospects for attracting a potential purchaser or investor and for calculating the availability of assets for early access distributions to

guaranty associations. It is frequently possible to bring significant assets into the estate of a P/C company by negotiating commutations with reinsurers, but such an effort is difficult without reliable, credible, and current reserves. The receiver also should determine when reserve information must be presented to the court, if at all. And there also may be deadlines imposed as to when reserve information must be submitted. This often is the case where receiver reports must be submitted to the court, guaranty associations. or regulators within a specified period. In other words, it is important for the receiver's staff to know the needs of the different users of reserve information.

Further, it may not be useful to obtain an actuary's estimate of IBNR claims and applicable reserves more than once per calendar year, as there may not be enough new data or developments to change the earlier reserve estimate for IBNR. This also means that to the extent that the receivership's claims payment rate is affected by estimates of IBNR claims, the claims payout rate may not be adjusted more than once per calendar year.

Whether a receiver can use actuarial estimates of IBNR for the purpose of collecting reinsurance proceeds from reinsurers depends upon the applicable statutes and case law. (See *Angoff v. Holland-America Ins. Co.*, 937 S.W.2d 213 (1996); *Quackenbush v. Mission Ins. Co.*, 62 Cal. App. 4th 797 (1998)). In *Holland-America*, claims estimation for reinsurance recoveries was permitted on the basis of a state statute that authorized claims estimation for that purpose. In the *Integrity* and *Quackenbush* cases, claims estimation of future IBNR losses would not be permitted for collection of reinsurance proceeds because, in those cases, the applicable state statutes required that unliquidated or undetermined claims could not share in the assets of the insolvent insurer.

IBNR claims will arise in two contexts, namely: 1) IBNR losses from policyholder protection proof of claims in which the actual claim is unknown and has not been submitted to the receiver; or 2) further IBNR loss development from known claims, but the amount or extent of the future IBNR loss development is unknown. A final bar date by which all claims must be presented should be established so that the estate can determine the universe of claims and wind down its affairs over time, thereby saving the costs of keeping a receivership estate open indefinitely. Although the final claims deadline may resolve whether IBNR claims may be presented for policyholder or protection claims, the final claims deadline is likely to allow, as timely filed and proper claims, known claims for which there may be continued IBNR loss development.

How IBNR loss development on known claims may affect reinsurance recoveries, recoveries by insureds, and third parties from guaranty associations or recoveries by guaranty associations from receivership estate assets are important issues. For example, at the closure of the receivership, there may be many known claims for which the future stream of benefit payments could be calculated by the receiver, guaranty association, and/or claimant, such as the value of future benefit payments for workers' compensation claims. If the receiver or guaranty association purchased an annuity in settlement of all future benefit payments due a claimant (including an IBNR component), would the *Integrity* and *Quackenbush* courts reject the settlement because it included IBNR loss development? Or would a claim settled in this way be considered liquidated and non-contingent? The settlement payment should satisfy the court's concerns about having a liquidated and determined claim, but this would be a case of first impression.

Without any accommodations being made for future loss development, guaranty associations may still have obligations to the aforementioned claimant after the receivership is closed but will not receive any distributions from the receiver for these losses. Similarly, claimants will receive no payments for their post-receivership loss development if such development is not allowed by the receivership court or guaranty associations.

Receivers should address IBNR claims before making final receivership distributions and closing the receivership estate, bearing in mind: 1) whether the applicable state statute permits IBNR claims; and 2) whether IBNR loss development can be made liquidated and certain under different alternatives

(e.g., an annuity in settlement of all known and unknown losses as described above). Receivers should also evaluate the extent of reinsurance recoverables available for IBNR losses, and the reinsurers of the insolvent insurer should be given notice and an opportunity to participate in the settlement of claims involving IBNR.

In the case of a life insurer, an actuarial evaluation may be necessary both to value the business (within a positive or negative range) and to estimate total liabilities so that the guaranty association or the receiver can effectuate assumption of the in-force blocks of business by a solvent insurer. The evaluation should be done for each line of business. Life, annuity, and A&H blocks should be considered separately. Proper liability reserving is necessary in any receivership to project ultimate distribution amounts to various creditor classes. Caution must be exercised in establishing loss reserves, however, as reserve reductions that do not reflect actual liabilities can trigger negative tax consequences.

2. Reserve Adjustment

It may be appropriate to adjust outstanding case or claim reserves. In some cases, case or claim reserves will be adjusted continually as additional information becomes available. Reserve adjustments may be required if, for example, amendments to proofs of claim are permitted after the claim filing deadline or the supervising court extends the claim filing deadline. Such adjustments typically affect the amount of a letter of credit (LOC) that a reinsurer must post, early access distributions, tax liabilities, and the future payout rate for other claims. The receiver should also estimate the future administrative costs to pay all claims and to wind up the receivership, including the cost of concluding litigation to recover assets.

Notice of reserve adjustments should be disseminated as necessary. The receiver may be required to report the adjustments to reinsurers and the supervising court, among others. The timing of these reports will depend upon the court's requirements and applicable law. The receiver's staff should identify the needs of the different users of information and determine when information should be provided.

G. Assignment of Claims Issues Considerations and Guidelines

There has been an increase in the number of assignments of claim that are presented to receivers. The development of best practices for administering the assignment of claims was undetaken by the NAIC's Receivership Technology and Administration (E) Working Group, which drew upon the experience of receivers, state insurance regulators, and interested parties to develop best-practice guidance. [RTAWG GUIDANCE attached as reference. Note to publishing link to guidance on NAIC web-site in electronic version.]

V. PAYMENT OF APPROVED CLAIMS

Theoretically, distribution of the insurer's assets to claimants in a liquidation proceeding is different from normal business practice. While claims against an insurer in rehabilitation may be paid either in the normal course of business as they become due or pursuant to a rehabilitation plan, in a liquidation proceeding, the insurer's assets must be distributed to creditors in the order set forth in the priority of distribution statute. This section addresses some of the many issues the receiver must address once the claims evaluation and approval process has been completed and the asset distribution process begins. See generally Article VIII of Model #555.

A. Priority of Distribution in Receiverships

All state receivership statutes and Section 801 of Model #555 provide a priority of distribution scheme. The liquidator must become familiar with the priority of distribution scheme of the domiciliary state's

receivership statute at the outset of the receivership process. Typically, statutory priority schemes require that claims in a higher priority class must be paid in full or funds reserved to pay them in full before any payment may be made to lower priority claims. Also, the statutes typically require that all claims in a class must receive substantially the same *pro rata* distribution.

The receiver must keep in mind that the same claimant may hold several claims, not all of which have the same priority. There also may be different types of claims within a particular class of creditors (e.g., landlord claims, vendor claims, and assumed reinsurance claims are different types of general creditor claims). A receiver must avoid creating subclasses within a priority class. (See In re Conservation of Alpine Insurance Company, 741 N.E. 2d 663 (Ill. Ct. App. Dist. 1. Div.4. 2000).) The following discussion is based on the scheme of priorities established by Section 801 of Model #555. Secured creditors and special deposit claimants are outside the scheme of priorities established by Section 801. Secured creditors are covered by Section 710 of Model #555, and special deposit claimants are covered by Section 1002(C) of Model #555.

1. Secured Creditors

Secured creditors include anyone holding a perfected security interest in or lien against the property of the insurer (e.g., mortgages, trust deeds, pledges and security interests perfected under applicable law, excluding special deposit beneficiaries). Once determined, the value of the security is applied against the creditor's claim, with the deficiency, if any, treated as an unsecured claim. The priority of the deficiency claim depends upon applicable state law. Model #555 also provides guidance to the receiver for the disposition of specific types of secured claims; i.e., claims involving surety bonds or undertaking, and obligees or completion contractors. (See Section 710(B) of Model #555.)

2. Special Deposit Claimants

Some states require deposit or trust accounts for the benefit of policyholders as a condition to authorization of the insurer to transact business in that state. Although owners of special deposit claims often are loosely referred to as secured, they do not, strictly speaking, have a "security interest." Some special deposits are made for the benefit of all policyholders, while others specially protect residents, property, or lines of business in the state where the deposit is established.

States differ in their treatment of special deposit beneficiaries' claims in the domiciliary receivership. Some apply the rules applicable to holders of partially secured claims; i.e., treating the deficiency as an ordinary policyholder claim. Another method gives effect to the special deposit arrangements, but it applies the "hotchpot" principle to payment of any deficiency. Under this method, special deposit beneficiaries receive no additional payment on their claim until all other claimants in the same class have received assets sufficient to make their percentage distribution equal to that of the special deposit claimants. The treatment to be accorded special deposit claimants may be articulated in the receivership statute.

There has been litigation in various state jurisdictions regarding the handling of special deposits for insurance company liquidations. A Massachusetts case provides that an insurance commissioner, acting as ancillary receiver of a foreign insurance company, cannot take any action to remove special deposit funds until all special deposit claims have been satisfied. (See generally, *Commissioner of Ins. V. Equity Gen. Ins. Co.*, 191 N.E.2d 139 [Mass. Sup. Jud. Ct. 1963].)

In North Carolina, a "special deposit claim" has been defined as any claim secured by a deposit pursuant to statute for the security or benefit or a limited class or classes of persons. (See *State ex rel. Ingram v. Reserve Ins. Co.,* 281 S.E.2d 16, 20 [N.C. 1981]. N.C. GEN. STAT. § 58-30-10 [19]). Special deposits are expressly excluded from general assets. *Id.*

In most receiverships, it is difficult for receivers to collect special deposits posted in other state jurisdictions without a court order and provision having been made for the payment of all

policyholders in such state jurisdictions. Thus, the receiver will need to develop a claims distribution plan that takes the special deposits into account and avoids unlawful preferences, being mindful that the state jurisdiction in which a deposit is posted may use the special deposit to satisfy unpaid policy claims in that state jurisdiction.

3. Class 1—Receiver's Administrative Expenses

The expenses of the receiver in marshaling and distributing the insurer's assets are paid out of the unencumbered assets before any other claims are paid. Most statutes treat administrative expenses as claims having a first priority. Some statutes accord the same priority to a guaranty association's administrative expenses. However, some guaranty association expenses may be classified as policyholder benefits, which is an area of disagreement between guaranty associations and receivers. As will be discussed below, Section 801 of Model #555 provides two alternatives as to classification of the priority of guaranty association claims. Reinsurers may argue that if the receiver is making reinsurance recoveries under reinsurance treaties, then all premiums due under the treaties should be treated as an administrative expense. Under general contract law, ratification of a contract may be found under a variety of circumstances, such as: intentionally accepting benefits under the contract after discovery of facts that would warrant rescission; remaining silent or acquiescing in the contract for a period of time after having the opportunity to avoid it; or recognizing the validity of the contract by acting upon it, performing under it, or affirmatively acknowledging it (17A C.J.S., Contracts § 138). Reinsurers' claims should be evaluated on a case-by-case basis, but there may be benefits to the estate from treating the reinsurers' claims as administrative expenses. The reinsurance contract obligations may be binding on the receiver as administrative expense obligations if the receiver has legally "ratified" the reinsurance contract. The assets available to pay all other creditors are those remaining in the estate, net of the cost of recovering and administering them. The process of estimating administrative expenses is a difficult one, as it will depend on many factors, some of which are beyond the control of the receiver. The receiver should establish a contingency reserve for administrative expenses before recommending any payments on claims of lower priority.

4. Class 2—Guaranty Association Expenses

Guaranty associations may have several types of expense claims, not all of which may have the same priority. Model #555 provides two alternative priority schemes depending on how a state wishes to classify certain expenses of guaranty associations. The first alternative places expenses of the guaranty associations, including defense and cost containment expenses of a P/C guaranty association, in Class 2; i.e., after administrative expenses of the receiver. The second alternative places the defense and cost containment expenses of P/C guaranty associations in Class 3 with other policyholder-level claims, while the remaining expenses of the guaranty associations are placed in Class 2. No significance or deference should be given alternatives under Model #555 based on whether an alternative is labeled as alternative one or two. Receivers should note case law providing that however a guaranty association's claims are classified, the claims of an out-of-state guaranty association should be of equal priority with the claims of the guaranty association in the receivership state (in *re Liquidation of American Mutual Liability Insurance Company*, 747 N.E.2d 1215 [Mass. 2001]).

5. Class 3 and Class 4—Claims for Policy Benefits

Many state statutes accord priority status to claims for policy benefits behind only the administrative expenses of receivers and guaranty associations. This status applies not only to the claims of policyholders, but also to those claiming through them, including guaranty associations and liability claimants whose claims were covered under one of the insurer's policies. Claims under life insurance or annuity policies include claims for investment values, as well as death benefit and annuity payments. Premium refunds and unearned premium claims, however, are treated as general creditor claims under the former Model Act, and some state statutes, although guaranty associations often

cover such claims, at least in part. Some states and Model #555 accord the same priority rank to policy loss and premium refund claims. A review of the applicable receivership statute generally will inform the receiver as to how to treat such claims. As sub-classifications within a priority level should be avoided, case law provides that the receiver cannot divide policyholders into those who were insured only by the insolvent insurer and those who had additional insurance through other carriers (in re *Conservation of Alpine Insurance Company*, 741 N.E. 2d 663 [Ill. Ct. App. Dist. 1. Div. 4. 2000]).

a. Deductible and Limits

The policyholder's claim is for the amount that the insurer should have paid. The insurer's liability attaches after the deductible has been paid by the insured (non-advancement policies). However, for some policies (e.g., some workers' compensation policies), the insurer is required to pay the claim and seek the deductible from the insured (thereafter, known as large deductible policies). It is common for insureds to post collateral with the insurer for deductible payments that may be made by the insurer, for which the insurer then seeks reimbursement from the insureds. There are three available model alternatives that provide for the disposition of large deductible policy recoveries between receivers and guaranty associations: 1) Section 712 of Model #555; 2) the *Guideline for Administration of Large Deductible Policies in Receivership* (#1980); and 3) the NCIGF Model Large Deductible Act (NCIGF Model). Individual state statutes based on the NCIGF Model or Guideline #1980 may differ from Section 712 of Model #555 in certain respects. See Section ---- for more information on large-deductible programs.

b. Previous Guaranty Association Payments

A guaranty association that pays all or part of a policyholder's claim acquires the policyholder's rights in the receivership estate (with occasional additional privileges, such as an exemption from certain filing deadlines). The policyholder's claim (or the claim of the liability claimant under the policy) is reduced proportionately, but it usually is not expunged. In some states, a guaranty association may make payment directly to the liability claimant if the claimant waives any further claim against the insured. The receiver should remember, however, that guaranty associations only process "covered" claims and that insureds with claims that the guaranty association does not cover will be instructed to handle their own claims and then seek reimbursement from the estate.

c. Cut-Through

As an enhancement to security, insurance policies or reinsurance agreements sometimes obligate a reinsurer to pay the policyholder directly in the event a covered loss cannot be paid due to the insolvency of the direct insurer, pursuant to a cut-through clause or endorsement. A number of controversies have resulted from these provisions, including the issue of the validity of such agreements. Insofar as the arrangement purports to affect the obligation of the reinsurer to the cedent, or of the cedent to the insured, the receivership estate may be affected. The receiver should seek the guidance of legal counsel concerning rules applicable in the local jurisdiction. Some jurisdictions have allowed insureds direct access to reinsurers even in the absence of a cut-through clause or endorsement. In such cases, courts will look to the relationship among the parties. (See *Koken v. Legion Insurance Co.*, 831 A.2d 1196 (2003), where the court allowed a cut-through where the insolvent insurer had fronted the reinsurance arrangement.)

d. Assignments

Policyholders sometimes assign to a third person their rights to recover from the insurer. Although the general rule is that the assignee stands in the shoes of the assignor, the receiver should determine the validity of any assignment with reference to applicable law.

e. Separate Accounts for Life and Annuity Policyholders

A special form of assets is separate account assets. Separate accounts are accounts established by life and annuity insurers in association with specific types of policies or other business, such as pension plans. Generally, separate accounts are created and administered in accordance with specific regulatory or statutory guidelines. Typically, such statutes provide that assets properly maintained in separate accounts will not be chargeable with liabilities arising out of any other business of the insurer. It has been held that the status of separate account assets is preserved in receivership.

6. Class 5—Federal Government

In general, claims of the federal government may be paid after administrative and policyholder claims. However, the receiver is well-advised to obtain a release from the federal government prior to making any final distributions. This is because the federal government may not be bound by the receivership court's claim filing deadline or the estate's classification and payment of certain claims, and it could seek to hold the receiver personally liable if, for instance, it takes the position that it should have been paid in the place of other creditors.

For a discussion of the federal super priority statute and the 1993 U.S. Supreme Court decision in *U.S. v. Fabe*, see Chapter 9—Legal Considerations.

7. Class 6—Employee Compensation

Most priority of distribution statutes assign a higher priority to certain claims for employee compensation earned pre-receivership. This priority generally applies to wages limited in amount and earned within a specified time, but it may not apply to the wages of the insurer's officers and directors, including stockholders who are employed in such positions.

8. Class 7—General Creditors

The populace of general creditors is often large and diverse. It frequently includes the persons described below.

a. Brokers, Agents and Intermediaries—Personal Versus Agency/Derivative Claims

These categories are considered together, since the primary problem arising in connection with broker balances and similar claims is a tendency of all concerned to lose track of the capacity in which the obligation is incurred and to attempt to lump together amounts that derive from quite different sources. A distinction should be made between the divergent and often conflicting interests of the intermediary (especially a broker) acting as the insurer's agent for the collection of premiums as the representative or subrogee of the insured, and acting on his own account, notably for commission. Identifying the capacity in which the broker served is essential for the receiver to determine the relative priority of the broker's claims and the extent to which such claims may be combined (if at all) for purposes of setoff.

b. Cedents

In the relatively few cases where creditors of this class receive a distribution, the receiver may be able to set off interest deemed received by cedents on premature draw-downs of LOCsagainst the

distributions due them. Legal counsel should be consulted on the issue of setoff. (See Chapter 9—Legal Considerations.)

c. Certain Claims of Directors and Officers

Model #555 provides that, except as expressly approved by a receiver, expenses arising from a duty to indemnify the directors, officers, or employees of the insured should be excluded from the class of administrative expenses and, if allowed, are Class 6 claims. (See Section 801 of Model #555.) (But see *Weingarten v. Gross*, 563 S.E.2d 771 [Va. 2002]). Here, fees and costs incurred by directors in their defense of an action brought by a receiver were held to be entitled to payment as an administrative expense under applicable statutory law.)

d. Reinsurers

Reinsurers may be creditors of insolvent ceding insurers for premiums or other contract-based financial obligations, such as salvage and subrogation recoveries. Receivers should be aware of the fact that such recoveries may be held in trust and, thus, would be payable in full, not *pro rata*. Similarly, the cedent may hold as the reinsurer's trustee funds withheld and the proceeds of drawn-down security until such time as the funds are applied to appropriate claims. Excess amounts then may have to be returned directly to the reinsurer instead of merged with the general assets of the estate, and the reinsurer's claim to such amounts may be considered the claim of a trust beneficiary, not a general creditor. Depending on the terms, express or implied, of the instrument creating the relationship, the reinsurer's claim for interest on these amounts may not be valid. Setoff is an issue when addressing reinsurers' claims, and legal counsel should be sought. Before making payments of salvage, subrogation, or other amounts due the reinsurers after the receivership commences, it is advisable to obtain written assurances from reinsurers that they will honor reinsured claims submitted by the receiver.

e. Other General Creditors

This category includes: trade creditors, landlords, and utilities (for pre-receivership debts); bondholders (excluding surplus noteholders); secured creditors with deficient security: and, in some jurisdictions, late-filing insurance creditors and claimants for unearned premium.

9. Class 8—State and Local Government Claims and Some Legal Fees

State and local government claims that are not included in another class are placed in this class. Some examples of non-Class-8 governmental claims are policy benefit claims under policies issued to the government entity or current sewer or water bills on the insurer's office.

Class 8 also includes the legal expenses incurred by the management of the company in defending against the receivership proceeding. There are significant limitations on these claims.

10. Class 9—Claims for Penalties, Punitive Damages, or Forfeitures

If the policy issued by the insolvent insurer specifically covered punitive damages, penalties, and forfeitures, these claims would be in the policy benefits class.

11. Class 10—Unexcused Late-Filed Claims

Under Model #555, if the claimant can show that there was good cause for the delay, claims filed after the claim filing deadline (as discussed above in Section II(B)) are evaluated in the class they would have been in if timely filed. If there is no good cause, the claims are placed in Class 10. Most receivership statutes have standards for good cause. (See Section 701(B) and (C) of Model #555.) In some state receivership statutes, there may be some ambiguity on the treatment of late-filed claims.

12. Class 11—Surplus Notes

Model #555 provides that claims within this class will be subordinated to other claims in this class if there is a pre-receivership subordination agreement in existence.

13. Class 12—Interest

Interest is not often allowed on claims in receivership after the date of entry of the receivership order, on the general theory that if interest were allowed, it would run equally in favor of all claimants and simply result in a proportionately greater deficiency. Special cases, however, do exist: Holders of secured interests may be allowed interest to the extent their security is sufficient, and creditors in general sometimes may collect interest on their debts before any distribution to shareholders, on the theory that the receivership is to be conducted as if there were no insolvency. Many state laws are silent on this point, but others provide that interest on a given class of claims should be paid or provided for before such payment is made to any lower class. A review of the state's receivership statute may indicate whether interest should be paid as part of any claim. Model #555 allows interest on claims in Classes 1—11 if the liquidator proposes and the court approves a plan to pay interest. (See Section 801(K) of Model #555). Even if the contract upon which the claim is based allows for interest, legal precedent provides that interest shall not be allowed if statutorily prohibited. (See *Swiss Re v. Gross*, 479 S.E.2d 857 [Va. 1987].) Also, legal precedent provides that if claimants are entitled to post-allowance interest on claims, such interest should not be paid at the same priority level of the underlying claim (in re the *Liquidation of Pine Top Insurance Company*, 749 N.E.2d 1011 [Ill. Ct. App. Dist. 1. Div. 4. 2001]).

14. Class 13—Equity Interests

After all higher priority classes are paid, any remaining funds are paid to the owners of the insolvent insurer. Like surplus notes, any pre-liquidation subordination agreements among the owners will be honored. Before making a distribution to the owners, the liquidator should be sure to reserve adequate funds to pay any post-discharge expenses, such as the cost of responding to future inquiries from claimants and the costs associated with disposal of estate records.

B. Setoffs

In general terms, the claim of a creditor or debtor in a receivership is defined as the net amount due after the application of any permissible setoff. Section 609 of Model #444 addresses setoff. As the subject of setoffs in an insurer receivership is complex and often the subject of litigation, the receiver should consult legal counsel. For a detailed analysis of this subject, see Chapter 9—Legal Considerations.

C. Currency Conversion

Variations in foreign exchange rates can become a problem in the distribution of the insurer's assets if the insurer has creditors in foreign countries. The receiver may need to evaluate foreign currency in three situations:

- An insured incurs a loss in a foreign country under a policy denominated in dollars. In issuing such a policy, the insured may be deemed to have assumed a certain degree of foreign exchange risk for foreign currency exposures. However, the insured did not assume the risk of exchange variation during the period when the insurer's insolvency delays payment of the claim.

- An insured incurs a foreign currency loss under a policy denominated in the foreign currency. In this case, the insured may have assumed the risk of currency variation either between loss and payment or pending the insurer's receivership.

- At the time of receivership, the insurer holds funds or other assets in foreign currency. Some can readily be converted to dollars while others (such as reinsurance assets and outstanding premium receivables) cannot.

Foreign exchange risk characteristically is quite random and runs both ways. Prudent financial management does not attempt to predict the direction of future currency variation, but it only plans to match anticipated foreign debt with foreign assets. Unfortunately, this matching produces difficult problems that the receiver must sort out.

Receivers are forced, sooner or later, to restate the value of all assets and claims in a common currency; otherwise, they cannot calculate a distribution. The only question is when they should do so. The English Insolvency Rules still automatically use the date of liquidation, which is certainly the most straightforward technique. American law does not generally contain direction on this point. Applying a differential standard is likely to seriously complicate the claims process without appreciably improving the fairness of the result. Where the foreign exchange balances are significant, the prudent course may be to accept claims denominated in foreign currency, converting them to dollars at a date shortly before distribution, and planning the conversion of assets to occur at or near the same date.

The actual process of conversion of claims valuation may not be as complicated as it sounds. For example, the receiver might announce a suitable benchmark standard, such as the average of bid and asked prices for the relevant currency as published in The Wall Street Journal or offered by major banks. The U.S. Department of Treasury (Treasury Department) also maintains a listing of values for the purpose of assessing *ad valorem* (value-added) customs duties.

Expert assistance may be needed in cases where the currency in question is not readily transferable or has little or no market. Experts also may be helpful in the management of foreign currency assets between takeover and distribution, as well as the matching of assets to anticipated liabilities.

It is helpful to address currency issues at the outset of the receivership, particularly in the case of international insolvencies. Some statutes do not contemplate such issues. The receiver should have the supervising court approve the receiver's practices and procedures on this point when the court enters the order allowing claim payments.

VI. INTERIM AND FINAL DISTRIBUTIONS

With the approval of the receivership court, a receiver may declare and pay one or more partial distributions on claims (as those claims are allowed), as well as a final distribution. All claims allowed within a priority class are paid at substantially the same percentage. (See ISection 802(A) of Model #555.) Model #555 specifically permits the liquidator to pay benefits under workers' compensation policies after entry of the liquidation order if certain conditions are met and only until the appropriate guaranty association assumes responsibility for payment or determines that the claim is not a covered claim. (See Section 802 D of Model #555 and Chapter 6—Guaranty Associations.) Procedures for continuation of pharmacy benefits should also be addressed. In some cases, it will be preferable to continue the company plan for a period of time. In other cases, the guaranty funds have ongoing vendor relationships and can make a transition expeditiously. Model #555 and most state laws also require the liquidator to make early access payments to guaranty associations from distributable assets of the liquidation estate. (See Section 803 of Model #555 and Chapter 6—Guaranty Associations.) State law should be reviewed in all cases to determine specific requirements and authority regarding partial distributions, priority of claims, workers' compensation prepay procedures, pharmacy benefit continuation, and early access.

In determining the percentage to be paid on claims, the receiver may consider the estimated value of the insurer's assets (including estimated reinsurance recoverables) and the estimated value of the insurer's liabilities. (See Section 802(B) of Model #555.) But see, for example, the aforementioned *Integrity*, *Quackenbush,* and *Holland-*

America legal cases for additional information on how IBNR claim estimates and corresponding reinsurance recoveries were addressed in other receiverships.

An insurer's assets often consist of readily available (i.e., liquid) assets and those that may not be readily collected or liquidated. The latter category may include litigation recoveries, subrogation and salvage recoveries, reinsurance recoverables for claims that the receiver recently approved, the proceeds of difficult collection actions, or the sale of real estate. If liquid assets are substantial and the collectibility of other assets is uncertain, the receiver may be able to pay an interim distribution from available assets, with later payments coming from other assets, if and when liquidated.

Distribution of property in kind may be made at valuations set by agreement between the liquidator and the creditor and as approved by the receivership court. (See Section 802(C) of Model #555.)

A receiver may find that estate closure can be expedited by entering into a settlement with the guaranty funds on long tail liabilities, such as workers' compensation, that may remain open after the estate is otherwise resolved. The settlement should be negotiated with the involved guaranty funds and include a distribution for claim payments, as well as administrative expenses. The NCIGF can assist with coordination with the appropriate guaranty funds.

A. Unclaimed Funds

Often, small sums of money remain at the end of the distribution process, usually unpaid distributions (i.e., misdelivered or unclaimed checks). The receiver should not treat these assets as "found money." State law typically requires the receiver to retain unclaimed or unproved assets for a specified time, during which the assets should be deposited with an appropriate financial institution, and at the end of which the assets may escheat to the state. The receiver should consult the relevant receivership statute, escheat statutes, and legal counsel, particularly in regard to circumstances in which a state may be entitled to interest on funds held for escheat. The retention of escheated funds may also present challenges for closing the receivership. The receiver should consider the use of a trust for escheated funds on approved claims if the receiver is ready to close the receivership estate, but the required time period has not passed for the payment of escheated funds to states. Under the trust approach, the escheated funds are paid to the trust, the receivership is closed, and then the trustee (the commissioner or former receiver) of the trust pays the escheated funds to states permitted under applicable state law.

Model #555 provides that any funds that are unclaimed after the final distribution should be placed in a segregated unclaimed funds account to be held by the commissioner for two years, or in the alternative, that such funds should be handled in accordance with state unclaimed property laws. (See Section 804 of Model #555.)

Receivers should also check the applicable state agency for escheated funds to see if there are unclaimed funds that are owed to the entity in receivership.

B. Surplus Assets

In rare cases, assets may remain after the principal amount of all non-equity claims have been paid "in full." In some states, payment in full means principal plus interest on all timely filed claims. In a few states, where assets remain after such claims have been paid in full, a second claim filing deadline may be set, and the foregoing process may begin anew, albeit on an abbreviated basis. The receiver should review the applicable law to determine how to proceed in such cases. It has been held that a receiver may request court approval for payment of statutory interest on allowed claims where receivership assets exceed the amount necessary to pay all claims in full. (See *Wenzel v. Holland-America Insurance Company*, 13 S.W.3d 643 [Mo. 2000].)

C. Equity Distributions

Finally, in the rarest of cases, shareholders, mutual insurer members, and other owners of an insurer are paid. The receiver should take care to ensure that the administrative expenses of the estate are paid before the final distribution is made and should retain an amount sufficient for common post-receivership expenses (e.g., record storage, etc.)

VII. SPECIAL ISSUES REGARDING CLAIMS

This section discusses special issues regarding particular claims, namely: 1) claims of the Federal Home Loan Bank (FHLB); 2) life and health claims; and 3) claims under large-deductible programs. As large-deductible programs involve both policy claims and the collection of amounts due under those policies, both subjects are covered in that subchapter

A. FEDERAL HOME LOAN BANK CLAIMS

1. Overview

Insurance companies are increasingly likely to be members of, and have a borrowing relationship with, one of the 12 FHLBs (each, an "FHLBank"). The FHLBanks are federally chartered cooperatives under the Federal Home Loan Bank Act (FHLBank Act), regulated by the Federal Housing Finance Agency (FHFA), and their business practices are subject to the terms and limitations of the FHLBank Act and FHFA regulations. Although each FHLBank is a separate legal entity with its own geographical territory and its own specific policies, the FHLBanks share a common mission and have similar business models.[2]

2. An insurance company can only be a member of the FHLBank in the district where the insurer is domiciled or where it maintains its principal place of business as defined by FHFA regulations

3. If a newly appointed receiver finds that the delinquent insurer has a relationship with an FHLBank, they should promptly determine from the insurer's records:

i) The amount owed to the FHLBank.

ii) The interest charged on that debt.

iii) The payment due dates.

iv) The collateralization of this debt, and whether and how it is over-collateralized.

v) The amount of FHLBank stock held by the insurer.

Armed with this data, the receiver should establish goals for the program, including whether it is better to service the loan due to its low cost or to repay it, and whether reduction of overcollateralization or stock redemption would aid the receivership materially.

Once the goals are established, an initial friendly dialogue should be undertaken with the bank. In general, the bank's principal concern will be avoiding default. Overcollateralization will be important to the bank in service to this first goal. If the receiver can persuade the bank that some reduction in collateral will not unduly increase default risk for the bank, the bank may be more accommodating. While prepayment may create hedging issues for the bank, avoiding prepayment is generally a secondary goal, and the bank may

[2] For additional information regarding the mission and purpose of the FHLBanks, visit http://www.fhlbanks.com.

show greater flexibility in permitting it. Similarly, stock redemption may be permitted more freely if the bank is in sound financial condition. For the dialogue to be productive for the receiver, they should first become generally informed about the bank's condition and management structure. It will be helpful for the receiver to remind the bank that (at least as of this writing) no FHLBank has ever lost a penny due to an insurer insolvency. The receiver should strive to induce the bank to treat resolution of the insurer's financial problems as a common public policy goal in which the bank should be interested at least for the preservation of harmonious relations between the FHLB system and insurance regulators.

The Federal Home Loan Bank (FHLB) Claims Supplement that follows elaborate on these topics.
[Note: To Publishing create hyper-link in electronic version.]

B. LIFE/HEALTH CLAIMS

Overview

The processes for handling claims in life/health and P/C receiverships differ substantially due to the nature of the policies and the coverage provided by the guaranty associations. In a life/health receivership, coverage will continue for policies covered by the guaranty association to the extent provided by the state guaranty act, and a primary focus is dealing with these continuing obligations.

Role of Guaranty Associations and the National Organization of Life and Health Guaranty Associations

In a multistate life/health insolvency where guaranty associations across the country are triggered, the guaranty associations will—to the extent of their statutory limits—guarantee, assume, or reinsure policy obligations, and in turn will be subrogated to the policyholder claims against the estate. In these situations, the NOLHGA will play a key role in the coordination of policy and financial analysis, preparation of bid packages, analysis of bids, negotiation of assumption agreements, and policyholder notification. For a description of how the NOLHGA operates, see Chapter 6—Guaranty Associations.

Other possible issues relevant to life insurance company insolvencies include notice for and court approval of assumption agreements, opt outs (by policyholders and guaranty associations), closings for transfers of obligations, early access distributions, and guaranty association coverage limits.

Annuities

In the insolvency of an annuity insurer, special consideration should be given to any single premium immediate annuities that were issued to form the basis of funding of periodic or lump sum payments in personal injury settlements, commonly known as structured settlement annuities.

These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS tax codes (primarily 104(a)(2)) and various Revenue Rulings in order to preserve the tax benefit to the beneficiary or payee. However, some older annuities (prior to 1986), although not issued to a QA company, may nonetheless enjoy the same tax benefits. Generally, periodic payments are excludable from the recipient's gross income only if the payee is not the legal or constructive owner of the annuity and does not have the current economic benefit of the sum required to purchase the periodic payments.

When these blocks of business are resolved in the insolvency context (typically through assumption reinsurance), extreme care must be taken to ensure that the resolution does not compromise the tax benefits to the payees. It is strongly recommended that competent and experienced tax counsel be retained to guide the receiver through this potentially complicated process.

Structured settlement annuities are typically issued to fund the settlement of underlying tort actions, and the amounts of these annuities tend to be fairly large, reflective of the seriousness of the injuries sustained by the

beneficiaries. The nature of these policies should be taken into consideration when determining the appropriate notice to these beneficiaries.

Non-covered claims

State life and health guaranty acts provide for the continuations of certain policies covered by the guaranty association. The liquidator should determine how any portion of the policy that is not covered by the guaranty association and any non-covered claims should be handled under the state's receivership act and case law.

C. BEST PRACTICES FOR SUCCESSFUL BILLING AND COLLECTION OF LARGE-DEDUCTIBLE PROGRAMS IN LIQUIDATION

1. Overview of Large-Deductible Workers' Compensation

A large-deductible workers' compensation policy or program is a method of insuring workers' compensation risk with the employer assuming some of that risk in a deductible of $100,000, $250,000, or even higher per claim and an insurer taking on the remaining risk. Large-deductible programs for workers' compensation can be complex arrangements and depend on the employer's fulfillment of its obligation to reimburse all claims within the deductible. If the employer is unable to fulfill that obligation, the financial consequences to the employer could be catastrophic, and the employer's inability to pay could have a cascading impact on the financial health of the insurer. In order to manage this risk successfully, insurers and state insurance regulators must have a clear understanding of the nature and size of the insurer's exposure. Additionally, they must ensure that there are adequate measures in place to limit and mitigate the risk of the employer's failure to pay and ensure injured workers will receive benefits in compliance with state law.

Professional employer organizations (PEOs) often operate workers' compensation programs that are backed by large-deductible policies. A PEO is an outsourcing firm that provides services to small and medium-sized businesses under a contractual co-employment agreement with its clientele. Where permitted by state law, these services generally include workers' compensation coverage obtained by the PEO in its own name. If the PEO assumes most of the risk of that program by purchasing a large-deductible policy, it recovers the estimated cost through the fees it charges its clients. If those fees are inadequate to cover the actual costs of the claims, or the PEO fails for any other reason to reimburse its share of the claims, the insurer incurs an unexpected liability. The failure of the claim reimbursement mechanism has been a significant factor in a number of insurer insolvencies. For further information and guidance on high-deductible workers' compensation insurance and PEOs, refer to the NAIC's *2016 Workers' Compensation Large-Deductible Study*.

2. Administration of Large-Deductible Plans

The administration of large-deductible plans is affected by entry of an order of liquidation. In such cases, there are three versions of applicable model legislation for states to consider. The most recent is Guideline #1980. The three model alternatives are as follows:

(a) Section 712—Administration of Loss Reimbursement Policies of Model #555.

(b) Guideline #1980.

(c) The NCIGF Model.

Each of these three alternatives provide statutory guidance that articulates the respective rights and responsibilities of the various parties, greatly enhancing the ability to manage complex large-deductible programs post-liquidation. Generally, all approaches provide for the collection of large-deductible reimbursements from

policyholders, clarify entitlement to reimbursement, and ensure that the claimants are paid. The most significant difference is the approach taken to address the ultimate ownership of and entitlement to the deductible recoveries paid by the employer or drawn from collateral as between the estate and the guaranty fund, and collateral as between the estate and the guaranty fund. Section 712 of Model #555 generally treats these funds as general assets of the estate, while Guideline #1980 and the NCIGF Model apply them directly to the payment of claims. It should be noted that the NCIGF Model has evolved over time based on additional experiences from insolvencies, and the NCIGF continues to modify its model as warranted; as a result, states that have based their laws on the NCIGF Model have done so with varying language.

3. Communication and Reporting Between the Liquidator, Policyholders, and Guaranty Associations, Including Administration of Self-Funded Policyholder Programs

I.i.Claim Payment, Reserve, and Reimbursement Reporting

The administration of large-deductible programs requires strong communication and reporting programs between the liquidator, guaranty associations, and policyholders. Under all three model alternatives, the liquidator is required to administer large-deductible programs and related collateral securing large-deductible obligations, consistent with the policyholder's policy provisions and large-deductible agreement (LDA), except where those provisions conflict with the statute. All three model alternatives make provision for two types of LDAs: 1) those that permit direct payment by the policyholder; and 2) those that require initial payment by the insurer or guaranty association with reimbursement by the policyholder. Both arrangements necessitate the reporting of claim payments and outstanding claim reserves to the liquidator for billing, guaranty association reimbursement, and establishing collateral need requirements. The liquidator's Uniform Data Standard (UDS) should be deployed as the reporting protocol for guaranty association claim payments and outstanding claim reserves. Policyholders that continue self-payment under their LDA will need to continue or establish a claim information reporting protocol with the liquidator through the policyholder's third-party claim administrator or through a proprietary claim information aggregator. All three model alternatives require the liquidator to form an independent opinion on outstanding claim reserves reported by policyholders and guaranty associations, including an allowance for adverse development and IBNR liability to ensure that collateral remains adequate throughout the administration of the program.

Iiii. Agreements Between the Liquidator and Guaranty aAssociations

An agreement between the liquidator and the guaranty funds may be advisable, though it is less important in states that have enacted one of the three model alternatives or other comprehensive statutory framework for the liquidator's administration of large-deductible programs. The model alternatives can serve as an outline for the issues that should be addressed in such an agreement in states that have not enacted pertinent legislation. Among other things, an agreement should address: 1) whether large-deductible recoveries are estate assets subject to the liquidator's distribution regime or directly pass through to the guaranty association on account of its prior claim payments; 2) claim reporting protocols; 3) frequency of collateral review and reimbursement activity; and 4) administration of collateral for under collateralized non-performing policyholder accounts.

Iviv.Converting Policyholder Accounts From an Incurred to Paid Basis Under the Model Act.

Generally, LDAs are on a paid basis with collateral for the reserves. However, liquidators may encounter contractual arrangements where an LDA is constructed such that policyholders pay periodic large upfront payments that were accounted as premium based on losses incurred, as opposed to paid basis. After a certain number of years, the LDA provides policyholders with an opportunity to elect paid basis rather than incurred basis, which converts the incurred payments to collateral. The liquidator may wish to negotiate a conversion at the outset of liquidation. Conversion of a policyholder's LDA at liquidation from an incurred to a paid basis is beneficial to policyholders in several ways. Most importantly, conversion at liquidation treats pre-liquidation incurred loss payments made by the policyholder to the insurer as collateral and, thus, property of the policyholder pledged to the insurer and restricted to the satisfaction of that policyholder's claims, rather than as a general asset of the liquidation estate. Conversion also offers flexibility to a policyholder as to the

type of security provided to an insurer in satisfaction of the collateral requirement. Conversion affords policyholders the ability to use an LOC to secure an insurer for the outstanding portion of their loss, rather than payment of cash, since the outstanding bill after conversion is reflected in the liquidator's collateral need analysis, rather than an incurred loss billing.

The liquidator should consider notifying large-deductible policyholders of these important policyholder rights at the inception of a liquidation proceeding and offer policyholders the opportunity to elect to convert their large-deductible programs from an incurred to paid basis memorializing any elections with an endorsement that otherwise follows and requires the policyholder to adhere to the provisions of applicable law.

iii. Large-Deductible Billing by the Liquidator

The liquidator should establish a large-deductible billing and collection program that bills policyholders on a periodic basis (e.g., quarterly). The liquidator's invoice to policyholders should communicate a claim payment summary that includes detail such as the insurer or guaranty association's check number, date of payment, payee, account year, and remaining large-deductible limits. Large-deductible programs that are paid directly by policyholders should also report their claim payments to the liquidator on a similar periodic basis so that the liquidator can establish appropriate claim reserves, track the exhaustion of the policyholder's deductible limits, report to reinsurers, and collect reinsurance. Consideration should be given to using one of many proprietary billing and collection software programs to automate the large-deductible billing and collection process. Large-deductible recoveries that are subject to guaranty association reimbursements should be aggregated and distributed on a quarterly or other periodic basis that balances the liquidator's accounting requirements and the guaranty associations' reimbursement needs.

vi. Annual cCollateral Rreview by the Liquidator

Guideline #1980 and the NCIGF Model require the liquidator to perform a periodic collateral review for each policyholder account. Consistent with the typical LDA, this review should be performed annually to ensure that the liquidator holds adequate collateral to support a policyholder's large-deductible obligations and to release any excess collateral held back to the policyholder. This review should include: a report to the policyholder on total incurred claims; claims paid; outstanding reserves, including an appropriate allowance for adverse development and claims IBNR; any additional safety factor; and total collateral need. The liquidator's collateral review should result in a report to the policyholder and an invoice for additional collateral need or a release and distribution of excess collateral. The liquidator should consider whether any additional safety factor should be included for nonperforming policyholder accounts. Guideline #1980 provides flexibility on the timing of the annual review, enabling the liquidator to perform the annual review process throughout the calendar year so that all policyholder account reviews are not due at the same time.

2.Administration Fees

Section 712(G) of Model #555 provides:

> The receiver is entitled to recover through billings to the insured or from largedeductible policy collateral all reasonable expenses that the receiver or guaranty associations incur in fulfilling their responsibilities under this section. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants.

Further, Section 712(F) provides, in part:

> The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at any priority; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

Several states have adopted statutory provisions similar to the provisions regarding handling of large deductibles in an insolvency and provide for the receiver to retain reasonable actual expenses incurred from the reimbursement to the guaranty association(s). Similarly, statutes may provide for the guaranty association to net expenses incurred in collecting a reimbursement.

Subsection (F) of Guideline #1980 provides:

(a) The receiver is entitled to recover through billings to the insured or from collateral all reasonable expenses that the receiver incurred in fulfilling its collection obligations under this section. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants or guaranty associations.

(b) To the extent the receiver cannot collect such expenses pursuant to paragraph (1), the receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements.

(c) To the extent such amounts are not available from reimbursements or collateral, the receiver, or guaranty associations if provided under an agreement with the receiver under Subsection D(5), shall have a claim against the estate as provided pursuant to [insert state priority of claim statute].

When there is no statutory guidance, receivers should include a provision for reimbursement of reasonable actual expenses in an agreement with the guaranty associations regarding the collection and allocation of large deductibles.

3. 3.Policy and Collateral Definitions

It is important that state laws define large-deductible workers' compensation policies and large-deductible collateral. Defining the treatment of such policies and associated collateral is imperative for developing polices and processes for administering the collection of assets. The following definition is taken from Guideline #1980. The definitions in the other model acts are similar. However, the term used in Model #555 is "loss reimbursement policy."

"Large-deductible policy" means any combination of one or more workers' compensation policies and endorsements, and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:

(a) Pay directly the initial portion of any claim covered under the policy up to a specified dollar amount, which the insurer would otherwise be obligated to pay, or the expenses related to any claim.
(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term "large-deductible policy" also includes policies that contain an aggregate limit on the insured's liability for all deductible claims, a per claim deductible limit, or both. The primary purpose and distinguishing characteristic of a large-deductible policy is the shifting of a portion of the ultimate financial responsibility under the large-deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer, and the insurer remains liable to claimants in the event the insured fails to fulfill its payment or reimbursement obligations.

The dollar amount of "large" will vary by state law. While many states might associate a minimum financial threshold, it is more important to consider the administration of the policy compared to a traditional policy. Deductible amounts can include: claim-related payments by the insurer for medical and indemnity benefits; allocated LAEs, such as medical case management expenses; legal defense fees; and independent medical exam

expenses. It is critical that the policy specify the claim-related payments that are the responsibility of the policyholder and not be inside agreements or other agreements outside of the policy.

Collateral held by the insurer should be defined as amounts held as security for the insured's obligations under the large-deductible policy. The policy should specify acceptable financial instruments that can be held for the large-deductible policy. Typical collateral requirements include: cash, LOCs, surety bonds, or other liquid financial means held for the benefit of the insurer.

Guideline #1980 defines "large-deductible collateral" to mean "any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay to the insurer as may be required for other secured obligations."

4. Responsible Party for Collection of Large Deductible Reimbursements

It is critical to immediately establish the party responsible for billing and collecting large-deductible payments or reimbursements. While some states might have specific statutory language that specifies the entity responsible, some statutes might be silent. In the case where the statutes do not specify responsibility, it is recommended that the receivers and guaranty associations enter into an agreement that allows for the most efficient administration of the large-deductible collections.

Specific consideration should be given to large-deductible policies that provide coverage in multiple states and have claimants subject to the jurisdiction of multiple guaranty funds. If feasible, the most efficient approach for such policies would likely be for the receiver to administer the deductible billing and collection process. Throughout the life of the estate, claimants continue to incur benefit payments and expenses, and deductible collection efforts may last beyond the life of the estate. The party responsible for collections needs the ability to compromise and settle the future obligations.

The receiver should make provisions in its discharge motion and court order, to the extent possible, regarding the transition of ongoing deductible collections to the guaranty association, as well as the disposition of any collateral being held by the receiver.

5. Treatment of Collateral in Receivership

When collateral has been posted by or on behalf of a large-deductible policyholder, what does the receivership estate actually own? The answer is generally found in the documents pledging the collateral to the insurer.

Model #555 defines "property of the estate" to include "all right, title and interest in property ... includ[ing] choses in action, contract rights, and any other interest recognized under the laws of this state."[4] In states without an explicit statutory definition, the common-law definition is substantially similar.

This means that the insurer's right to draw on the collateral automatically becomes an asset of the receivership estate, but the collateral itself is not an estate asset unless and until it is drawn. In the first instance, the conditions and procedures for drawing the collateral should be spelled out in the relevant contract documents (which could include third-party instruments, such as LOCs or surety bonds), but state law could provide additional rights[5] and will specify what the receiver may do when the documents are silent, incomplete, or missing.

[4] Section 104(V)(1) of Model #555.

[5] For example, Section 712(D) of Model #555 specifically provides that the relevant provisions of the policy are not controlling "where the loss reimbursement policy conflicts with this section."

Possession and control over the collateral are distinct from ownership. The insurer could already be in possession of the collateral before the receivership, or the receiver might act to take possession by enforcing applicable contract rights or by negotiating an agreement. Nevertheless, this does not immediately give the receiver the right to use the collateral to pay claims. The defining characteristic of collateral is that it is intended to serve as a backstop in case the policyholder does not meet its obligations to pay all reimbursements promptly and in full. Commonly, the right to draw on collateral only attaches after the policyholder has defaulted or has consented to a draw, or, if the collateral is an LOC, after the issuer has given notice of nonrenewal (in which case, the receiver must act promptly to call the LOC or obtain replacement collateral). There could also be the opportunity to negotiate an agreement under which the policyholder turns over the collateral and makes a lump-sum payment to commute any further reimbursement obligations, or the collateral might have been structured from the outset as a "working" loss fund from which the insurer was expected to pay claims in the ordinary course of business.

In any case, while it is essential for the receiver to preserve and exercise the right to access the collateral as needed, it is also essential to ensure that collateral is not dissipated to pay claims that the policyholder should be funding. Special consideration needs to be given in situations where the policyholder is at risk of being or becoming judgment-proof, or where rights to the collateral are shared with other creditors of the policyholder and prompt action is necessary to preserve the receiver's priority.

When the guaranty association is paying the claims, it is generally entitled to receive the proceeds of any policyholder reimbursements, including draws on the collateral. Under laws substantially similar to Model #555, these payments are considered early access distributions (but without the necessity for court approval), which may be subject to subsequent clawback, while Guideline #1980 and the NCIGF Model treat them as the ultimate source of funding for the underlying claims, so that they belong unconditionally to the guaranty association.[6] Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral,[7] unless there is a formal written agreement assigning that right to the guaranty association.

Finally, there is always the hope that the policyholder's reimbursement obligations will be oversecured or will become oversecured as claims are run off. In that case, any excess collateral will revert to the policyholder or the policyholder's guarantor. State law might expressly provide a process for determining when excess collateral is being held by or on behalf of the receiver,[8] or the ability to return collateral before the estate is closed might be part of the general powers of the receiver. However, because workers' compensation is a long-tail exposure with significant risk of adverse reserve development, receivers must take great care not to make premature or excessive return distributions.

6. Issues Raised by Net Worth Exclusions and Deductible Exclusions

Unlike other lines of insurance, workers' compensation insurance is generally exempt from the statutory caps on guaranty association coverage so that the guaranty fund is usually obligated to pay workers' compensation claims in full. However, individual states may have adopted caps on guaranty association coverage.[9] States have created this exception to honor their state's promise that injured workers will be paid the full benefits to which they are entitled. The general purpose of these exclusions is to avoid any obligation for the guaranty association to pay losses that can and should be borne by the policyholder. Net worth exclusions make guaranty association protection unavailable to policyholders with net worth above a specified threshold, while deductible exclusions expressly prohibit guaranty association coverage for amounts within a policy deductible.

Unless these exclusions are drafted and implemented carefully, there is a risk that they could result in delays in claims payments or even a complete loss of coverage. In some states, claimants might be protected by an

[6] Compare Section 712(C)(3) of Model #555 with Section C of Guideline #1980 and Section 712(C) of the NCIGF Model.
[7] See Section (E)(3) of Guideline #1980 and Section 712(E)(3) of the NCIGF Model.
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[8] See, e.g., Section (E)(4) of Guideline #1980 and Section 712(E)(5) of the NCIGF Model.
[9] See Section 8(A)(1)(a)(i) of the *Property and Casualty Insurance Guaranty Association Model Act*. Almost all states have some provision requiring payment in full of workers' compensation claims, but some states might have caps or other limitations on coverage.

uninsured employer fund, but that is not the purpose of those funds, so even if such a fund exists in your state, it should be a priority to ensure that however it is done, the estate, employer, or guaranty association will provide for payment in full of all benefits due under the state's workers' compensation laws. If this is not possible under current law, regulators should advocate for a change in the law. A variety of successful approaches are available; there is not a single one-size-fits-all solution that is best for every state.

Iii. Net Worth Exclusions

The *Property and Casualty Insurance Guaranty Association Model Act* (#540) contains an optional section with a variety of alternative provisions states can select, excluding coverage for high-net-worth insureds, whether they are individuals or business entities.[10] The base version sets the threshold at $50 million, while one of the alternatives sets the threshold at $25 million. Many states have enacted some version of this clause or some comparable net worth exclusion.

The impact on workers' compensation coverage depends on how the exclusion is structured. In states with provisions substantially similar to any of the three alternatives under the Model #540, coverage is excluded completely for first-party claims by high-net-worth insureds, but workers' compensation claims against high-net-worth policyholders are administered by the guaranty association on a "pay-and-recover" basis; that is, the guaranty association has the obligation to pay the claim in the first instance and the right to be reimbursed by the policyholder.[11] Thus, claimants are fully protected, and for large-deductible policies, this mirrors the structure of the policy for claims within the deductible. In states with guaranty association laws similar to Guideline #1980 or the NCIGF Model, this is the same reimbursement right the guaranty association would have as the insurer's successor in the absence of the exclusion.

If the policyholder is cooperative, the guaranty association has the option of negotiating an agreement where the policyholder advances funding for claims within the deductible. However, if the policyholder is not cooperative, guaranty associations have expressed concern that the pay-and-recover framework is burdensome and gives the policyholder too much leverage to avoid or delay paying its obligations in full. If Model #540's Alternative 2 is modified to treat workers' compensation claims the same as other third-party claims, then the guaranty association has no obligation unless the formerly high-net-worth policyholder has become insolvent.[12] Otherwise, the claimant's only recourse is against the policyholder or the insured's estate. As stated above, the injured worker should be protected by some means in these cases.

When a guaranty association net worth exclusion and a large deductible both come in to play on the same claim, it is imperative that the receiver and guaranty association stay in close communication in order to avoid any confusion regarding which entity is responsible for the collection. In Section 712 of Model #555, Guideline #1980, and the NCIGF Model, the guaranty fund is entitled to collect net worth reimbursements. Coordination of these collections with receiver efforts to collect on high deductible will do much to avoid duplication of billings and potential resulting collection delays.

Iiii.Deductible Exclusions

Model #540 does not contain any explicit deductible exclusion. Instead, it simply provides that: "In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under

[10] Section 13 of Model #540.
[11] Alternative 1 applies the pay-and-recover obligation to all third-party claims. Alternative 2 excludes most third-party claims as well as all first-party claims, but requires the guaranty association to pay workers' compensation claims, statutory automobile insurance claims, and other claims for ongoing medical payments. Alternative 3 excludes only first-party claims and claims by out-of-state claimants that are subject to a net worth exclusion in the claimant's home state. This alternative does not create any statutory right of recovery when the guaranty association is obligated to pay a third-party claim.
[12] Section 13(B)(2) Alternative 2 of Model #540.

the policy or coverage from which the claim arises."[13] However, some states have enacted explicit language further clarifying that there is no guaranty association coverage for amounts within a policy's deductible or self-insured retention.[14] For example, Minnesota law excludes "any claims under a policy written by an insolvent insurer with a deductible or self-insured retention of $300,000 or more, nor that portion of a claim that is within an insured's deductible or self-insured retention" from coverage by the P/C guaranty association.[15]

A Minnesota employer entered into an employee leasing arrangement with a PEO, which obtained a workers' compensation policy with a $1 million deductible. Both the PEO and the insurer became insolvent, and the Minnesota Court of Appeals held that there was no guaranty association coverage for workers' compensation claims against the client employer because of the statutory deductible exclusion.[16] The court observed that the legislature deliberately chose to protect the guaranty association from unlimited exposure, without mentioning that the legislature also deliberately created an exception making the cap on coverage inapplicable to workers' compensation claims (which strongly suggests that the statute in question, which is tied to the statutory $300,000 cap on coverage, was not written with workers' compensation in mind).[17] Likewise, the court took for granted that the statute's undefined term "deductible" included the contract provision at issue in the case, even though the insurer had assumed the unconditional liability to pay all claims in full. The opinion did not consider the possibility that the legislature's intent was simply to clarify that the guaranty association has no obligation to drop down and pay claims from the first dollar if the insurer would have had no obligation to pay those claims.

Therefore, if states determine that there is a need to include express provisions addressing deductibles and self-insured retentions in their guaranty association laws, it is essential to avoid unintended consequences. In particular, the key terms should not be left undefined. For this reason, Model #555 coined the term "loss reimbursement policy" in its section addressing these types of policies to distinguish them from true deductibles, where the insurer has no obligation to pay anything except the portion of the loss that exceeds the deductible.[18]

This is the crucial difference between a large-deductible workers' compensation policy and an excess policy. Although large-deductible policies transfer a significant amount of risk back to the policyholder, they do not extinguish the insurer's liability. That is why large-deductible policies, in states that allow them, are accepted as a mechanism for satisfying the policyholder's compulsory coverage obligations, while excess policies generally are not. Usually, excess workers' compensation policies may only be issued to self-insurers that have been approved by the state. It is the approved self-insurance program, not the excess policy, that satisfies the employer's compulsory coverage obligation, and the insurer has no liability for any portion of a claim that falls within the employer's self-insured retention.[19] Thus, despite the terminology that is commonly used, it is the excess policy, not the large-deductible policy, that functions as a "deductible" in the traditional sense of the term.

It is worth noting, however, that commercial self-insured retention and large-deductible policies can vary widely in policy terms and sometimes "side agreements" supplement the policies. Arrangements can contain aggregate

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[13] Section 8(A)(1)(b) of Model #540. Compare Section 3(B)(2)(a) of the *Life and Health Insurance Guaranty Association Model Act* (#520), expressly excluding from life and health guaranty association coverage: "A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner."

[14] Currently, the only states with language specifically excluding claims within policy "deductibles" are Iowa, Louisiana, Minnesota, Missouri, and Nevada. Louisiana's exclusion applies only to policies issued to group self-insurance funds, and Missouri's does not apply to workers' compensation claims.

[15] Minn. Stat. § 60C.09(2)(4).

[16] *Terminal Transport v. Minnesota Ins. Guar. Ass'n,* 862 N.W.2d 487 (Minn. App. 2015), *review denied* June 30, 2015.

[17] Minn. Stat. § 60C.09(3).

[18] For example, if a consumer has an auto policy with a collision deductible of $1,000, and the repair costs $5,000, the insurer's liability is limited to $4,000. "Self-insured retentions" (SIRs) in commercial excess policies are designed to function the same way on a larger scale. If a business is found liable (or a third-party claim is settled) for $500,000, and its liability policy has an SIR of $300,000, the insurer is never responsible for more than the remaining $200,000, even if the policyholder is bankrupt.

[19] In many states, a separate self-insurance guaranty fund protects claimants if a self-insured employer becomes insolvent. Those funds typically operate entirely under the state's workers' compensation laws, not the state's insurance receivership or insurance guaranty fund laws.

limits, can vary on the obligation for defense cost and expenses, and, in some cases, permit the insured to "self-fund" its claims with an account in the possession of the TPA that is handling the claims. Because of these complexities, policy terms and any related endorsements and side agreements should be carefully reviewed. Whether such side agreements are legally enforceable requires a thorough case-by-case analysis in light of applicable state laws.

Federal Home Loan Bank Claims Supplement

This supplement will provide additional details for receivers involved in Federal Home Loan Bank (FHLB) transactions.

Definitions Specific to FHLBank Transactions

The following are common terms that a receiver is likely to encounter when dealing with an FHLBank and may be more specifically defined in FHLBank documents:

a. "Advance" means a secured loan from the FHLBank to its member in accordance with such terms and conditions as are applicable to such loan under an advances agreement, and it includes without limitation a funding agreement executed under an advances agreement.

b. "Advances agreement" means one or more written agreements, including any written, document, policy, or procedure of the FHLBank and incorporated by reference into such written agreements between the FHLBank and its members pursuant to which the FHLBank makes or agrees to make advances and provide other extensions of credit or other benefits to the member and the member, among other things, grants to the FHLBank a security interest in certain collateral.

c. "AHP" means the Affordable Housing Program of the FHLBank.

d. "Assuming insurer" means an insurer that has entered into a purchase and assumption agreement with the insurance department by which the assuming insurer has agreed to assume some or all obligations of a member.

e. "Member" means an insurer that is a member of an FHLBank. Such members will own FHLBank capital stock and may from time to time have outstanding advances or other obligations to the FHLBank, which have not been satisfied in full, or have not expired or been terminated.

f. "Capital stock" means all capital stock of the FHLBank owned by a member. Each FHLBank has its own capital plan (which is published on the FHLBank's website), with its own specific capital stock requirements and policies, but generally, each FHLBank requires a member to purchase membership stock (calculated annually) and activity-based stock. (The required amount fluctuates with the amount of a member's advances or other obligations outstanding.) By statute, capital stock is collateral for a member's obligations to the FHLBank.

g. "Collateral" means all property—real, personal, and mixed—in which either a member or an affiliate of the member has granted a security interest to the FHLBank, or the FHLBank has otherwise acquired a security interest. Each FHLBank has its own policies regarding collateral that the FHLBank will accept to secure advances and other obligations, the minimum amount of collateral required, and how the value of such collateral is calculated for purposes of pledging to the FHLBank.

h. "Obligations" are any and all indebtedness, obligations, and liabilities of the member to the FHLBank pursuant to the terms and conditions of the advance agreement or any other agreement between the member and the FHLBank, subject to applicable law.

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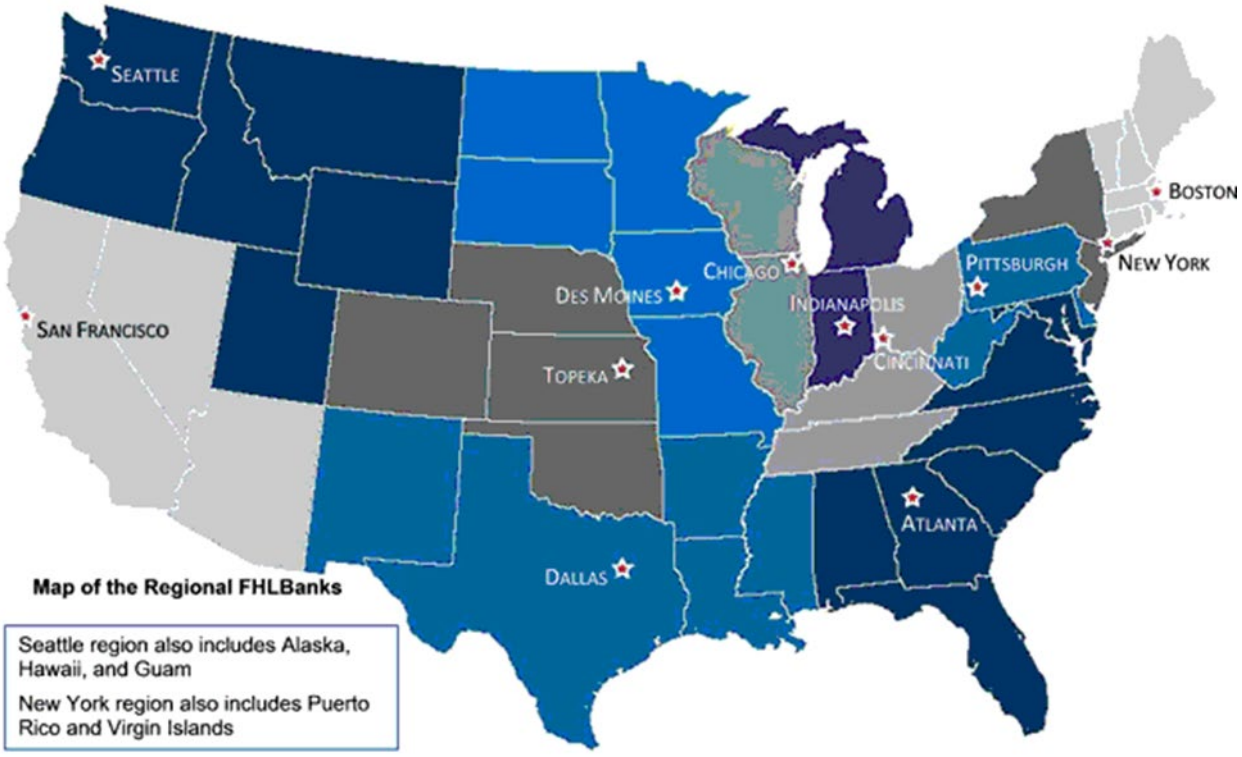

FHLBank	Title/Department	Phone
FHLBank Atlanta	Member Support Operations	mergers@fhlbatl.com
FHLBank Boston	Director of Credit	617-292-9705
FHLBank Chicago	General Counsel	312-565-5805
FHLBank Cincinnati	Vice President, Credit Risk Management	513-852-7525
FHLBank Dallas	Chief Banking Operations Officer	214-441-8546
FHLBank Des Moines	VP/Credit Risk Officer	515-281-1054
FHLBank Indianapolis	Chief Credit and Marketing Officer	317-465-0459
FHLBank New York	General Counsel	212-441-6822
FHLBank Pittsburgh	Chief Credit Officer	412-288-3425
FHLBank San Francisco	Chief Credit Officer	415-616-1000
FHLBank Seattle	Chief Counsel	206-340-2300
FHLBank Topeka	Chief Credit Officer	785-438-6055

3. Coordination of Efforts With an FHLBank

When an insurer that is a member of the FHLBank system is placed in receivership, the receiver must address a number of issues. There is no prescribed order of steps for managing the insurer's obligations to an FHLBank. The following may facilitate the process:

1. Gain an Understanding of the History and the Current Status of the FHLBank Program[20]

[20] The guidance in Sections B.1, B.8, B.9, and B.10 are intended only to offer practical suggestions for managing the relationship between the receiver and the FHLBank based on the experience of the Shenandoah Life Insurance Company in receivership, related discussions, and circumstances as existed generally at the time of this writing. It is important to note that

It is imperative that the receiver understand fully the history and components of the program. Important aspects of this basic information include:

a. Contacts

Who are the individuals at the bank (including outside counsel and advisors) who manage the bank's role with the insurer, and how can they be reached, especially if contact on short notice becomes necessary. Similarly, who will be "point" for the receiver in managing the ongoing relationship? Providing the bank with a contact person upon inception of delinquency proceedings will temper the possibility that the bank will take summary protective action for lack of information.

b. Complete Documentation

The receiver should strive to obtain and review carefully all of the documents governing the relationship, including the initial documents establishing the relationship and those related to subsequent advances and repayments.

c. Inception Date and Terms

The terms on which the relationship was established are likely to govern all subsequent advances and repayments. Not only is the formal agreement important, but so are emails and other communications that may provide a more complete understanding of the parties' actual expectations and concerns. Whether or not legally sufficient to alter the formal agreement, course of conduct may be critical guidance on how transactions actually were to be conducted.

d. History of Advances and Repayments

The relationship may have been in place for years and involved a number of advances and repayments. It is important that the receiver gain a thorough understanding of this history to determine whether certain remedial steps (such as stock redemption or release of excess collateral) are indicated immediately.

e. History of Collateral

For similar and other reasons, the collateral requirements upon which the parties agreed when the relationship was established and with each subsequent advance, and how the posting and release of that collateral has evolved over time, are important factors in understanding what company assets are properly hypothecated or pledged to the FHLBank (and, therefore, unavailable to pay other claims or expenses), and which assets may be so identified on the company's records but may in fact be eligible for release from such FHLBank claims. Note that the agreement(s) with the FHLBank may require that the insurer post collateral of a stated value in excess of outstanding advances and may also prescribe a reduction in the value assigned to that collateral (the "haircut"), with the combined effect of leaving the bank over-collateralized. It may be possible to negotiate some relief from the over-collateralization of outstanding advances. Note also that the use of proceeds from advances and posting of collateral from other invested assets of the insurer may create or exacerbate asset-liability mismatches. For example, using previously acquired longer duration, high-grade assets as collateral but using the advance proceeds to acquire shorter duration and/or lower-grade (higher potential yield) investments may result in an

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every situation has its own characteristics and circumstances and that the relationship between one insurer and one FHLBank is likely to differ materially from any other such relationship. Further, no effort is made in this guidance to explore the legal or policy bases for the parties' rights and liabilities, nor to evaluate suggested legislative or regulatory improvements.

imbalance between the duration of existing liabilities and newly acquired investments intended to fund them.

f. History of Acquisition and Redemption or Disposition of Bank Stock

As a condition of becoming a member of the FHLBank system, and therefore eligible for advances, the insurer will likely have been required to purchase a certain amount of "membership" stock in the FHLBank. There is typically no independent market on which that stock can be sold, and the only way in which the insurer can dispose of it is to sell it back to the FHLBank on redemption terms established by the parties' agreement. Normally, the agreement requires that the insurer retain the membership stock so long as the agreement remains in place and advances remain outstanding. But redemption by the bank of membership stock may be subject to its discretion informed by the bank's own liquidity and financial condition. As a result, an insurer may be required to retain membership stock for which there is no market and which has no liquidity long after repaying all advances in full.

Further, with each advance, the insurer may have been required to purchase additional bank stock as "activity stock," typically in quantities constituting a small percentage of each advance. As with "membership" stock, there is no independent market on which activity stock can be sold, and the only way in which the insurer can dispose of it is to sell it back to the FHLBank on redemption terms established by the FHLBank's capital plan and the parties' agreement. The agreements or explicit terms and conditions of the stock may give the FHLBank discretion to postpone the redemption of membership and activity stock.

Because the stock is illiquid and, therefore, of little value to the receiver in managing the rehabilitation or liquidation, exploring prompt redemption of outstanding stock may be prudent.

g. Investment of Advances

It is important to determine whether the collateral obligations created by advances have resulted in the hypothecation of other assets of the insurer in a way that may have resulted in asset-liability mismatches and potential liquidity problems. It is not unusual to find a disproportionate share of the insurer's high-grade, liquid assets pledged as collateral for advances, the proceeds of which were instead invested to potentially create beneficial leverage or interest rate arbitrage. Over time, and with deteriorating conditions in the capital market, this can create serious challenges for the receiver. The potential substitution of collateral should be explored with the FHLBank to ameliorate these challenges. However, an FHLBank is limited by regulation on the types of collateral it may accept.

h. Performance in Relation to Repayment Obligations

By design, the FHLBank program is structured so that the FHLBank does not take on much risk in connection with advances to members, including insurers. The pricing (interest rates charged) for the advances do not typically contemplate material risk of default, and collateral requirements are intended to all but eliminate such risk. The receiver should familiarize themself with the history of the relationship to determine whether there are outstanding concerns for the bank that should be addressed promptly so that the bank does not feel compelled to exercise its rights to the collateral in a manner that might prove disruptive to the receivership. Outstanding defaults or near-defaults should be identified and remedied to preserve the collateral.

i. Current Balance of Advances

Obviously, the amount of outstanding advances and resulting repayment obligations must be understood well by the receiver, particularly in relation to collateral pledges. The records of troubled insurers may not be sufficiently complete or accurate to allow for proper monitoring of these outstanding balances, and efforts should be made to reconcile the insurer's records to those of the bank.

j. Repayment Due Dates and Segregated Cash Account Balance

Advances are made with specific repayment obligations. These obligations will address both interest and principal payment obligations, with specific dates established for both. It is common for segregated-cash-account requirements to be imposed from which the bank can draw some or all of these payments. The receiver needs to identify how much cash the insurer is required to maintain in specified accounts by the agreement(s) and the dates and amounts of required interest and principal payments. Plans should be made to assure liquidity and the ability to comply with these requirements or to make other payment arrangements. If forbearance or accommodations become necessary or desirable, those should be negotiated promptly, if the bank has the ability to provide them.

k. Excess Cash

If the insurer finds itself with more cash than required in the specified account(s), discussions should be undertaken with the FHLBank. Ideally, the receiver and the bank will agree that excess cash will automatically be redirected to the insurer's general account. However, if the bank is unwilling to permit the receiver to withdraw cash from the account to which the bank has no contractual claim, it may be necessary to resort to the receiver's right to seek a court order mandating the release of excess cash collateral.

l. Prepayment Fees

Typically, the agreements discourage early repayment of advances because such repayments may be inconsistent with hedges and other arrangements made by the bank in connection with the advances to the insurer. Prepayment may, therefore, trigger prepayment charges or fees owed by the insurer. However, the bank's need to charge those prepayment fees may be reduced or eliminated by changing circumstances affecting the hedges or other arrangements made by the bank. The receiver should, therefore, consider whether prepayment may be advantageous (e.g., because of associated collateral release or stock redemption). If prepayment would be helpful to the receiver's strategy, discussions with the bank should ensue to determine the most optimal prepayment timing that will result in the lowest applicable prepayment fees.

m. Cash Required

As noted, the agreements typically require the insurer to maintain specified liquidity, likely in segregated accounts at the bank, for the protection of the bank. The receiver will need to address these requirements.

2. Notice of Receivership to the FHLBank

a. Notify FHLBank of Receivership

Immediately following the establishment of the receivership, the receiver should contact the FHLBank (see initial FHLBank contact information above) to inform the FHLBank that the insurer has been placed into receivership.

b. Identify Authorized Individuals

The receiver should forward electronically to the FHLBank all legal agreements, court orders, and/or notices that evidence the appointment of the receiver and a delegation of authority designating individuals authorized to transact business on behalf of the receiver in a mutually satisfactory form. To protect the receiver, the FHLBank may place the account of the member "on hold," prohibiting any additional member/receiver-initiated activity until the required agreements and authority delegations are received.

c. Schedule Initial Conference Call or Meeting

The receiver and the FHLBank should schedule a mutually convenient time to meet via conference call following the establishment of receivership.

3. Considerations for the Initial conference Call or Meeting with the FHLBank

a. Identify Contact Person(s)

The FHLBank, the receiver, and the assuming insurer, if applicable, should each identify their primary contact person(s) and business activity coordinator(s). The receiver should also provide to the FHLBank a key point person(s) who will remain involved with the disposition of all residual issues pertaining to the receivership through completion.

b. Identify Outstanding Obligations, Pledged Collateral, and Capital Stock

During the initial conference call meeting, the receiver should request that the FHLBank identify all outstanding advances and any other outstanding obligations of the member, including AHP subsidy exposures, LOCs, and correspondent services exposures. Furthermore, the receiver should request that the FHLBank provide information regarding the amount and nature of collateral pledged, the balance of any member cash accounts or safekeeping accounts, and the member's capital stock.

c. Establish Receivership Timeline

During or prior to the initial conference call meeting, the receiver should inform the FHLBank of the planned receivership timeline and the identity of any other parties involved in the receivership process.

d. Discuss Payment of Obligations and Collateral Releases

The FHLBank will need to know what the receiver's intentions are with respect to the obligations and if it desires to retain continued correspondent services activities during the receivership. Depending on the facts and circumstances, and subject to renegotiation with the receiver, the FHLBank may allow the receiver to:

- Level the obligations outstanding in accordance with their existing terms and conditions, including scheduled interest and principal payment dates and collateral requirements.

- Prepay the obligations, subject to FHLBank policies and procedures regarding prepayments.

- Transfer the obligations to an assuming insurer acceptable to all parties.

The receiver should request that the FHLBank discuss the process and timing for release of any collateral once all or any part of the outstanding obligations have been satisfied, assumed, or secured with other collateral. If a court-ordered or statutory stay is in effect, the receiver and the

FHLBank may need to execute an agreement detailing the agreed-upon payment of obligations and treatment of collateral.

e. Prepayments

If the receiver wants to pay down advances prior to the scheduled maturity date, the receiver should contact the FHLBank and request that the FHLBank calculate an estimation of the final payment due as of that agreed-upon prepayment date. The requested estimation should include outstanding principal, accrued interest up to the date of prepayment, and applicable prepayment/settlement fees.

f. Assuming Insurer

If the obligations of the member are expected to be transferred to an assuming insurer, such transfer is subject to the approval of the receiver, the FHLBank, and the receivership court. If approved, the FHLBank likely will require that the assuming insurer execute [21]an assumption agreement, and such agreement will stipulate that the assuming insurer is responsible for the timely payment of assumed obligations, direct or contingent, in accordance with the terms and conditions of the advances agreement and any other agreements in effect between the member and the FHLBank.

g. Summary of Call

Following the initial conference call, the receiver should request that the FHLBank provide a detailed closing statement for the receiver along with a summary of other matters discussed and agreed upon during the call. The summary of the call could provide the framework for the development of a memorandum of understanding between the parties.

4. Disposition of Obligations

The FHLBank will expect payment from the receiver in the event obligations are outstanding unless the obligations have been purchased by or assigned to an acceptable assuming insurer.

With the approval of the receiver, FHLBank, and the receivership court, the obligations may be transferred to an assuming insurer through the execution of an assumption agreement that will be provided by the FHLBank. Such obligations will be required to be collateralized in a manner acceptable to the FHLBank prior to any release of collateral pledged by the failed member. Such collateral requirements may differ from the requirements the assuming insurer may be accustomed to if it is a member of another FHLB.

Obligations that the receiver has decided not to resolve immediately will need to remain collateralized in accordance with the advances agreement.

5. Release of Collateral

(Assuming all member obligations have either been satisfied or assumed and fully collateralized by the assignee)

[21] If the assumption is consummated during a receivership proceeding, then the receivership court would have to approve the transaction, and if the assuming insurer is a U.S. insurer, then the domiciliary insurance department would also have to approve the transaction.

If mortgages have been listed and/or delivered to the FHLBank or to a third-party custodian, the FHLBank will initiate the delivery of those mortgages to the receiver or the receiver's designee in a timely manner, and the FHLBank will file a UCC-3 termination statement[22] upon request.

If cash or securities have been pledged by the member, the FHLBank's interest in those assets will be promptly released, and the assets will be delivered to the receiver or receiver's designee based on instructions provided.

Partial payment of obligations may allow for partial release of collateral in accordance with the FHLBank's collateral release practices.

6. Capital Stock

Typically, capital stock holdings of the member may be retained by the receiver or transferred to an assuming insurer, if such assuming insurer is a current member of the FHLBank. If the assuming insurer is not a member of the FHLBank, then the capital stock may be repurchased if permissible under applicable laws, regulations, regulatory obligations, and the FHLBank's capital plan and the proceeds of the capital stock transferred to the assuming insurer or receiver as long as the proceeds of the capital stock are not required to be retained by the FHLBank as collateral or as capital required against remaining outstanding business activity, in accordance with the FHLBank's policies, procedures, or practices.

Treatment of capital stock and any payment of dividends are subject to the provisions and restrictions set forth under applicable laws, regulations, regulatory obligations, and the FHLBank's capital plan.

7. Other Matters

If the member was a participant in other FHLBank programs such as AHP or LOCs, collateral will be required to support all obligations that continue to exist past the life of the member. The receiver should request that the FHLBank provide a detailed account of all other programs in which the member participated and the term of exposure and the amount and type of collateral required.

The receiver and the FHLBank should determine an appropriate frequency of follow-up correspondence throughout the receivership process.

8. Areas of Possible Agreement

The receiver seeks to maximize the value of the estate and to protect policyholders, claimants, and beneficiaries of the insurer. To this end, the receiver takes all appropriate steps to marshal and preserve assets for distribution in a liquidation or to facilitate rehabilitation or other resolution of the impaired or insolvent insurer. Apart from maximizing the value of the estate, liquidity is important to both the ongoing operation of the estate and more timely distributions. While more formal means to accomplish the purposes of the receivership are always available and should be pursued if necessary, money and other resources ought not to be devoted to that pursuit unless good faith attempts to reach consensual resolution with the FHLBank have failed. In particular, receivers may seek agreement with the FHLBank in the following areas:

a. Release of Excess Cash

[22] When a secured lender obtains a lien on collateral pledged to it, the lender files a UCC-1 so that there is a public record putting other creditors on notice of the lien. A UCC-3 is a termination statement filed by a secured lender to update the UCC record to reflect the lien has been released.

As noted, the history of the relationship may have resulted in the insurer porting more cash than required by the agreement in accounts accessible solely by the bank and unavailable to the receiver for other purposes. Release of this excess cash to the general assets of the receivership should be pursued promptly.

b. Release of Excess Collateral

Over time, the insurer may have caused more collateral to be pledged to the bank than is required by the agreements (e.g., because repayments may not have resulted in full release of the associated collateral or because of the appreciation of the collateral). In addition, because of the deteriorating condition of the insurer, the bank may have had the right to require that the insurer post additional collateral (sometimes as much 25% over the amount of outstanding advances). It may be possible to convince the bank to release some of this excess collateral so that it can be used for other receivership purposes. This is particularly true if the bank can be assured that reducing collateral will not unduly endanger the probability for full repayment when due.

c. Reduction of Haircut and Excess Collateral Requirements

If the formula for determining excess collateral and haircuts applied to collateral values no longer reflect economic reality, the receiver should work with the FHLBank to recalculate these in the light of current conditions, again resulting in the release of some collateral.

d. Repurchase of Excess Stock

Over time, the insurer may have accumulated more bank stock, especially activity stock, than is required by outstanding advances (i.e., excess stock) because, for example, the bank may have been slow in repurchasing stock following repayment of advances. Although the bank cannot be required to redeem excess stock upon demand by the receiver, except after expiration of a redemption period (typically five years), if the bank's financial condition is not an issue, and barring any statutory or regulatory prohibition, the receiver might seek waiver of the redemption period in order to negotiate the repurchase of excess stock, converting it into liquid assets available for receivership purposes.

9. Managing the Relationship[23]

Apart from seeking accommodations, the receiver should manage the ongoing relationship.

a. Evaluate Prepayment

The receivership should consider when it would be optimal to repay outstanding advances and plan accordingly in cooperation with the bank.

b. Evaluate Need for Extensions

It may be necessary or appropriate to renegotiate the repayment schedule with the bank and to evaluate the cost of doing so.

c. Evaluate Substitution of Collateral

Due to asset liability matching considerations or for other reasons, it may be helpful to explore the possibility of substituting collateral posted against outstanding advances.

d. Determine Desirability of Maintaining the FHLBank Program

[23] See Footnote 3.

The FHLBank program typically provides the insurer a facility for financing or access to liquidity on desirable terms. The receiver should consider whether continuation of the program may play a useful role in rehabilitation or liquidation plans. If sale of the company is being considered, preservation of the program may add value to potential buyers, making the insurer that much more attractive.

e. Develop an Exit Strategy if Desirable

Conversely, the receiver may conclude that terminating the FHLBank program is the best option. In that case, a thoughtful program for concluding the relationship in cooperation with the bank should be developed and implemented.

10. Share Experience with the NAIC[24]

In any case, because this is a relatively new development in the world of insurance receiverships, sharing the receiver's experience with the NAIC and other receivers is indicated provided that appropriate confidentiality can be maintained under applicable law. Developing a body of knowledge will facilitate the management of these programs by banks and receivers involved in subsequent cases.

[24] See Footnote 3.

CHAPTER 6 – GUARANTY FUNDS / ASSOCIATIONS

NOTE: ALL PAGE NUMBERS WILL BE UPDATED IN THE FINAL

I. INTRODUCTION

This chapter provides an overview of the operation of state Property and Casualty Insurance Guaranty Funds and the Life and Health Insurance Guaranty Associations and their relationship to a receivership. All 50 states, Puerto Rico, the United States Virgin Islands (property/casualty only) and the District of Columbia have a guaranty mechanism[1] in place for the payment of covered claims arising from the insolvency of insurers licensed in their state. In the case of life/health insurance, the guaranty mechanism also provides for the continuation of eligible contracts that would otherwise terminate because of the insolvency. Before the creation of guaranty association systems, a typical claimant might wait years for payment of a claim and then receive only a small percentage of what was due under the policy or contract. Guaranty associations, subject to statutory limitations, alleviate these problems. Section II of this chapter will discuss in greater detail the operation of property/casualty guaranty funds. Section III is devoted entirely to life/health guaranty associations.

Insurance guaranty mechanisms obtain the funds necessary to pay claims from remaining estate assets, in some cases from statutory deposits collected by states and by assessing member insurers. Assessments are limited by state law to a certain percentage of the members' written premium. In the case of property casualty guaranty funds, the members may be permitted by statute to recoup the assessments through premium increases, premium tax offsets or policy surcharges. As for the life/health guaranty associations, recoupment of assessments through premium increases or policy surcharges is typically not feasible because many life/health contracts are issued on a level premium basis.[2] The burden of the assessments on solvent insurers is mitigated in the majority of states, by statutes that allow insurers to offset a portion of the insurer's assessments, over a period of years, against the insurer's premium tax liability. Section 13 of the NAIC's Life and Health Insurance Guaranty Association Model Act (the "Life Model Act"), some version of which has been adopted in most states, permits offsets against premium, franchise or income taxes over a five year period for amounts paid by life/health insurers to meet their assessment obligations. In addition, Section 9G of the Life Model Act allows life/health insurers to consider the amount reasonably necessary to meet their assessment obligations in the determination of the premiums they charge.

Guaranty associations (both life and health and property and casualty)in most states are overseen by a board of directors, largely composed of representatives of member insurers. Some guaranty association boards also include public members. A minority of guaranty associations also have representatives of state departments of insurance or legislative representatives sitting on the guaranty association's board. The guaranty associations typically employ a Manager, Administrator or Executive Director to oversee daily operations.

Before a claim against an insolvent insurer can be considered a "covered claim" and eligible for guaranty association coverage, the guaranty association must be "triggered" with respect to the particular insolvency. Guaranty associations generally are triggered by the issuance of a court order of liquidation with a finding of insolvency. Some guaranty associations may be triggered under other circumstances. In the event of a multi-state insolvency, it is important that the receiver communicate and coordinate with NOLHGA or NCIGF as appropriate. before preparing an order of rehabilitation or liquidation. This will ensure that guaranty associations are triggered as intended, and are not triggered prematurely or inadvertently. NOLHGA and NCIGF have the ability to help with coordination and communication to affected GAs.

The guaranty associations and the receiver both have statutory duties to protect policyholders of the insolvent insurer. The duties of the guaranty associations to protect policyholders are limited to covered policies or claims, as set forth in state guaranty association statutes. The guaranty associations can be very helpful, if not critical, to

[1] The term "guaranty fund" typically refers to a property and casualty insurance guaranty fund. The term "guaranty association" typically refers to a life and health insurance guaranty association. However, in various places throughout this handbook, the terms "guaranty fund" and "guaranty association" are often used synonymously, particularly when referring to both types of guaranty mechanisms. Efforts have been made in this chapter to specify property and casualty or life and health when referring specifically to one or the other type of guaranty mechanism or insurer insolvency proceeding.

[2] A few states do permit policy surcharges to recoup assessments for health insurance insolvencies.

the receivership process. In a life/health insolvency, for example, the guaranty associations may, in some cases, be able to arrange for and facilitate transfer of covered obligations to a solvent insurer upon entry of an order for liquidation with a finding of insolvency, provided there has been sufficient pre-liquidation planning and coordination.[3] Maintaining open communication and cooperation between the guaranty associations and the receiver (subject to appropriate confidentiality agreements) during pre-receivership planning and throughout the course of the proceedings will enable both the guaranty associations and the receiver to function more efficiently for the benefit of those whose interests they are obligated to serve.

II. PROPERTY AND CASUALTY GUARANTY FUNDS

A. Introduction

Most property/casualty guaranty fund enabling acts are based on the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act (Model Act). Although the Model Act is useful for a better understanding of how guaranty funds operate, the law in each state should be consulted, as most states have modified provisions of the Model Act.

The property and casualty guaranty funds have formed an organization known as the National Conference of Insurance Guaranty Funds (NCIGF). Its address is:

National Conference of Insurance Guaranty Funds
300 North Meridian Street
Suite 1020
Indianapolis, IN 46204
Phone: (317) 464-8199
Facsimile: (317) 464-8180
Web site: http://www.ncigf.org

NCIGF can be a useful source of information to receivers when a new property/casualty insolvency occurs. It can help disseminate information to triggered guaranty funds, schedule initial meetings between the receiver and guaranty funds, and establish a coordinating committee to work with the receiver to resolve issues that may arise during the receivership. This organization can also provide names and addresses of guaranty fund contacts and assistance in establishing data reporting to and from the guaranty funds. The Secure Uniform Data Standards (SUDS) is managed by the NCIGF and has become the standard mechanism to transfer data in a secure manner. (See supra for more information on UDS and SUDS.)

The NCIGF Web site (See at http://www.ncigf.org) has tables that summarize the key provisions contained in each state's property/casualty guaranty fund enabling act, including lines of insurance covered, whether coverage is provided for unearned premium, whether the guaranty fund has net worth limitations or a claims bar date and the per claim limit and deductible that applies to each claim. The tables are intended to provide a general summary of the guaranty fund laws. The applicable state statute should be reviewed to determine coverage for a specific claim.

B. Triggering Fund Liability See Chapter 1(II) (G) (4)

1. General Statutory Activation Requirements

Previously, the Model Act defined insolvent insurer as "(a) an insurer authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and (b) determined to be insolvent by a court of competent jurisdiction." Due to a variety of triggering related

[3] In some instances, it is possible to arrange for the transfer to close as of the effective date of the liquidation order.

issues that could not be readily resolved by such a general, simplistic definition, amendments to the Model Act expanded the definition of "insolvent insurer" to read as follows:

> "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

This amended language makes it clear that guaranty fund resources are only to be used in situations where any doubt pertaining to the insurer's insolvent status has been fully considered and resolved by a judicial proceeding. It must be noted, however, that there are a number of variations found within enacted guaranty fund statutes around the country. While many jurisdictions have either adopted or moved toward the current Model Act triggering test, there are numerous others that fall at various points along the spectrum between the current version and the original 1969 version. It is imperative that the statutes be carefully reviewed in each jurisdiction where activation is anticipated.

2. Regulatory Status of Company

In addition to being declared insolvent, an insurer must have been "licensed," either at the time the policy was issued or when the loss occurred, to be eligible for guaranty fund coverage.[4]

New Jersey has a separate statutory mechanism for the payment of covered claims arising in connection with coverages issued by eligible surplus lines insurers. This mechanism exists in addition to the guaranty fund for insolvent licensed property and casualty insurers. Even in New Jersey, however, there is no statutory protection for ineligible surplus lines insurers.

The initial triggering inquiry must not be limited to whether the insurer in question was licensed at the time of the finding of insolvency.[5] Many, probably most, guaranty fund acts contain language that is sufficiently broad to include claims against an insurer whose license has been surrendered or revoked prior to the declaration of insolvency, so long as the insurer was licensed at the time the policy was issued or when the insured event occurred. When this situation arises, the receiver should contact the relevant guaranty fund as it will be most familiar with its enabling statute and local court decisions interpreting the statute.

3. Court of Competent Jurisdiction

The requirement of a finding of insolvency can only be satisfied by a judicial declaration. The rationale for this requirement is that activation triggers numerous consequences, many of which are irreversible once put in motion. Judicial review is perceived to be an effective safeguard against arbitrariness and ambiguity.

The current version of the Model Act gives exclusive competent status to the court that is within the insurer's state of domicile. Although it is theoretically possible for a court in another jurisdiction to be viewed as competent for the purpose of triggering guaranty fund obligations, the Model Act's current version does not confer jurisdiction on these courts.

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[4] In this context, "Licensed" means holding a Certificate of Authority, which authorizes an insurer to do business in a state. Such insurers are also referred to as "admitted insurers." Insurers doing business on a surplus lines or other non-admitted basis are not authorized.

[5] At the time of publication of this Handbook, the NAIC is considering "restructuring mechanisms" permitted under the laws of some states (i.e., insurance business transfers and corporate divisions). Whether claims of an assuming or resulting insurer in one of these transactions would be considered "covered claims" eligible for guaranty fund coverage in the event of its liquidation is a question of state law. NCIGF is working with the NAIC to address this issue and provide clarity going forward.

4. Liquidation Order

Were a court of competent jurisdiction to issue a declaration of insolvency that is later modified or reversed on appeal, after guaranty funds have been triggered and claim payments have been initiated, problems can arise. To remedy such consequent dilemmas, both the Model Act and many state legislatures have modified the triggering test, requiring that the judicial declaration of insolvency be final. In other words, activation of guaranty funds in such jurisdictions can be deferred, and perhaps avoided, depending upon the pursuit or exhaustion of stays or appellate remedies.

Nonetheless, although the Model Act drafters clearly contemplated that activation of the guaranty funds would occur only where liquidation had been ordered, the wording of the initial triggering clause left open the possibility that companies placed in rehabilitation could trigger guaranty fund benefits. The more current view, which has also been incorporated in the Model Act, is to require not only a final determination of insolvency, but rather an actual order of liquidation with a finding of insolvency. This limiting language precludes the use of guaranty fund resources as bail-out funds to be used in an attempt to rehabilitate—rather than liquidate—the company. There are a few guaranty funds, however, which still trigger with a finding of insolvency without an order of liquidation. Because of the complexity and variation from state to state of the trigger, it is important to seek legal assistance and to work with the NCIGF when drafting the orders of liquidation or rehabilitation to ensure the appropriate activation of the guaranty funds. (See the Laws and Laws Summaries under Resources on the NCIGF Web site at http://www.ncigf.org).

C. Scope of Coverage

Guaranty funds that have been properly triggered by a liquidation order are obligated to pay "covered claims," that is, claims that are defined as covered under the applicable guaranty fund act(s). Generally speaking, unpaid loss and unearned premium claims under specified property/casualty lines of business written by an insolvent insurer are covered claims, but only to the extent of the lesser of either (1) the applicable policy limits; or (2) the statutory guaranty fund limits on covered claim payments. Residency is usually determined at the time of the insured event. In addition, in order for claims to be covered, the various acts typically require that: the claim be incurred either prior to the entry of the liquidation order or within 30 days of the entry of the order, or before the policy expires or the insured replaces the policy if either of the latter occurs within 30 days of the entry of the liquidation order. Claims of an affiliate of the insolvent insurer typically are not covered, even if such claims otherwise meet the definition of covered claims.

Property/casualty lines of business usually not covered by a guaranty fund include: mortgage guaranty; financial guaranty; fidelity and surety; credit insurance; insurance of warranties or service contracts; title insurance; ocean marine insurance; and any insurance provided by or guaranteed by government. Only direct insurance (not reinsurance) is covered. The receiver should consult with the affected guaranty fund(s) to determine which lines are covered and which lines are excluded.

Usually the guaranty fund of the state of the insured's residence has primary responsibility for a claim, and the guaranty fund of the state of the claimant's residence has secondary responsibility. One exception to this rule involves workers' compensation claims. The guaranty fund of the state of residence of the claimant has primary responsibility for these claims. With respect to claims involving property with a permanent location, the guaranty fund of the state where the property is located has primary responsibility. Guaranty funds are usually entitled to take credit for amounts paid by other guaranty funds on the same claim.

Some guaranty fund statutes provide for a per claim deductible. A majority of guaranty association statutes provide that coverage is limited to $300,000 per covered claim, except for workers' compensation claims, which are covered to the extent of benefits provided by state law.[6]

[6] .

Most guaranty fund statutes require a claimant to first exhaust all other sources of recovery, including other insurance. The guaranty association's obligation is reduced by any amounts recovered from other sources.

The majority of the property casualty guaranty funds' enabling acts contain "net worth" limitations. These net worth limitationseither exclude high net worth insureds (and in a few cases, third party claimants) from coverage in the first instance or permit the guaranty fund to recover from the high net worth insured amounts paid on their behalf.

Most of the guaranty funds' enabling acts also require the claim to be timely filed either with the liquidator or the guaranty association. Bar date restrictions vary from state to state and specific state law should be reviewed on this matter. See Section D (3) for more information regarding bar dates.

D. Notice and Proof of Claims

1. Notice

a. Notice to Claimants

Most state receivership statutes give the receiver the primary responsibility for issuing notice to all persons known or reasonably expected to have claims against the insolvent insurer. The guaranty funds have a secondary responsibility in this regard under the Model Act. Because of the extensive interrelationship between the receiver and the guaranty funds regarding claims resolution, the receiver should coordinate the drafting of the receivership claims notice with the guaranty funds so that accurate information concerning the following is included:

- Brief general explanation of the guaranty fund system: the policyholder protection it offers, its anticipated role in the receivership and any delay that will be necessary while the receiver assembles and forwards the files to the guaranty funds.

- Receivership bar date and its legal significance: the fact that many guaranty funds will have no obligation regarding claims filed after the receivership bar date, recommendation to check with the appropriate guaranty fund immediately in order to ascertain whether the guaranty fund has a separate bar date in addition to the receivership bar date.

- Receivership proof of claim form: information, if available, about whether a separate guaranty fund proof of claim form may be required by certain participating guaranty funds; information concerning the address to which proof of claim forms must be sent.

- Clarification that questions regarding the claims determination process should be directed to the appropriate guaranty fund; include here any comments deemed necessary regarding the determination process for claims which are in excess of the statutory maximum coverage of the guaranty funds.

Insolvencies involving long-tail business present notice challenges to liquidators. Company records may not exist to provide addresses for occurrence based policyholders that were in force from 5 to 25 years ago. Public policy considerations confront the receiver.

A supplemental notice may also be used in situations where additional relevant information becomes available after the first notice has been sent.

b. Notice to the Guaranty Funds

The receiver must notify the guaranty funds that may become obligated as a result of the receivership as soon as possible. Even if such notice is not a statutory requirement, the receiver should notify all interested guaranty funds as a matter of courtesy. That notice should include a

copy of the claimants' notice issued by the receiver, along with copies of the receivership order and any domiciliary injunction which has been entered. The regulator, receiver, and guaranty funds should coordinate and share information well before the liquidation order is rendered. See Section E for more information in this regard.

2. Proof of Claim

a. Claims Determination Framework

Nowhere is the interrelationship between the receiver and the guaranty associations more prominent than in the area of claims determination. This relationship is defined by Section 11(3) of the Model Act that provides that the receiver shall be bound by settlements of covered claims by the guaranty funds. However, Section 703 A of the Insurer Receivership Model Act (IRMA) and many state receivership statutes contain provisions that prohibit the receiver from accepting any claim for an amount in excess of or contrary to the terms of the policy.

There has been uncertainty between guaranty associations and receivers as to who determines whether a claim is covered under the policy terms. The receiver and the guaranty funds should discuss questionable coverage issues as they arise in order to prevent subsequent problems.

b. Forms of Proof

The information to be contained in the proof of claim form is usually established under the receivership statutes in the insolvent insurer's state of domicile. However, some guaranty associations require that each claimant submits a separate proof of claim form, the contents of which will be dictated by the law and practice of the guaranty association's state. This is because statutes creating the guaranty funds contain a series of specific eligibility requirements and limitations on allowability, each of which may require additional information in order to establish the fund's obligation. For this reason, the receiver should coordinate with the guaranty fund prior to any notification to potential claimants regarding the proof of claim form.

c. Protective Filings via Proof of Claim Forms

Many guaranty funds are not permitted to recognize general proofs of claim (intended as a protective filing for claims that are unknown to the insured at the time of filing) as sufficient notice. These guaranty funds require that specific claim information about known claims must be provided in the proof, including the date and other particulars relating to the insured event.

3. Late-Filed Claims

a. Rationale

Most receivership statutes contain a provision that requires claims to be filed by the claims filing date established by the liquidation court. See IRMA § 701. If a claim is filed after that date, it is usually not allowed or is subordinated to a lower distribution priority. In addition, many guaranty funds are not permitted to pay claims filed after the earlier of the claims filing date or a bar date established pursuant to the guaranty fund's enabling act.

The receiver may have the ability to allow policyholders to file "omnibus" or "policyholder protection" claims to meet the bar date requirements, but guaranty fund statutes may not allow coverage of such claims.

b. Extensions

Once a receivership's bar date has been established, guaranty funds generally take the position that the receiver should not extend the bar date, as such an extension may result in guaranty fund coverage issues.

c. Excused Lateness

Some receivership statutes provide a procedure for allowance of late-filed claims which authorizes the receiver to allow such claims under certain circumstances. See IRMA § 701. The receiver should consider claimant requests on a case-by-case basis, through the specific mechanism established in the receivership statutes. The receiver should also consider giving notice to those guaranty funds that may be affected prior to allowing a late-filed claim in order to provide those guaranty funds the opportunity to address how allowance of the claim would impact them.

E. Claim Files Information

1. Information Needed by Guaranty Funds

The key to the successful handling of filed claims is cooperation between the receiver and the guaranty funds throughout the claim process. Receivers should keep in mind that the guaranty funds require reasonable access to those insurer's records which are necessary for them to carry out their statutory obligations.

Recent experience has shown that pre-liquidation coordination and information exchange are essential for the smooth transition of claims servicing responsibilities to the guaranty funds without disrupting ongoing benefit payments. Regulators, receivers and guaranty associations should coordinate and communicate, even if liquidation of the company is not a certainty. A "two-track" approach is recommended. While efforts continue to revitalize the company, the receiver and the guaranty funds should also be taking steps to ensure a smooth transition to liquidation if liquidation becomes necessary.

The receiver's cooperation in providing information and making files available to the guaranty funds is essential to minimize claim interruption. More specifically, the receiver should locate and forward to the involved guaranty funds the following information (See § 405 of IRMA):

- A general description of the business written or assumed by the insurer;
- Information concerning licensure of the insurer;
- Claim counts and policy counts by state and line of business;
- Claim and policy reserves;
- Unpaid claims and amounts;
- Sample policies and endorsements;
- Listing of locations of claim files;
- Listing of third party administrators, description of contractual arrangements and copies of pertinent executed contracts;
- Listing of claims in litigation or dispute and assigned defense counsel; and
- Such other information as may be needed by the guaranty funds.

Please note, loss adjustment expenses incurred prior to the liquidation order are not covered by guaranty funds, and therefore, should not be sent to the guaranty funds for payment.

2. Claim Files

To facilitate the protection of policyholders and claimants; regulators, receivers and guaranty funds should coordinate transition of claim files well before the company is liquidated. The receiver should forward claim files as soon as possible to the appropriate guaranty funds. Some guaranty funds may require access to or copies of the filed proof of claims forms. Receivers and guaranty funds should consider entering into agreements as to ownership, return of files, auditing rights, inventory controls and reporting.

Most company claim records are held in electronic format. It is essential to address data conversion to Uniform Data Standards (UDS) well before the guaranty funds are triggered. (See chapter 2 of this handbook.) If there are non-electronic claims records, UDS records will need to be prepared.

Priority should be given to identifying and forwarding all active workers' compensation files and all active files where major litigation or settlement is imminent.

Determination of which guaranty fund should be the recipient of a particular file will depend on a series of factors. Generally, the receiver should deliver the file to the guaranty fund of the insured's place of residence. However, if it is a first-party claim for damage to property with a permanent location, the receiver should deliver the file to the guaranty fund where the property is located. In most instances, if it is a worker's compensation claim, the receiver should deliver the file to the guaranty fund of the state with jurisdiction over the claim.

Claim files sometimes are delivered to the wrong guaranty fund. In this situation, the preferable course of action is for the guaranty fund that received the file to secure from the appropriate guaranty fund their concurrence. After that, either fund will ask the receiver to resend the UDS record to the appropriate guaranty fund or will notify the receiver if the receiver does not mae the actual UDS records transfer. The receive will elt the parties know if itprefers the original fund to close the file or to report the transfer with UDS "C" record with transaction code "080". See the UDS Manual[1] for additional information. NCIGF can assist in cases where a high volume of files need to be transferred.

In multi-state insolvencies receivers and guaranty funds should work together on protocols for transmitting files to the appropriate guaranty fund.

F. Unearned Premium Claims

Although most guaranty funds cover unearned premium claims, some do not (see the NCIGF Web site at http://www.ncigf.org at the Guaranty Fund Laws tab for unearned premium coverage by state). For those states where unearned premium is covered, the receiver should prepare and disseminate the necessary calculations as soon as possible. This will allow guaranty funds to make timely refunds to enable the insureds to make arrangements for replacement coverage.

To make payments possible, guaranty funds will need the following information for each potential claimant: policy identification, insured name and address, policy periods and expiration dates, cancellation date, current payment status, and the amount of the unearned premium. If possible, this information should be provided by the receiver by Uniform Data Standards (UDS) B Record. (The initial B Record may not have the calculation, but will advise of the "potential" claimants. A subsequent B Record would provide the calculation/audit.) In addition, the receiver should forward to the guaranty funds a general explanation clearly showing how the unearned premium was calculated. The calculations should be on a pro rata basis rather than short-rated. The information should be as accurate as possible, given the state of the insurer's records, and should be accompanied by the receiver's initial evaluation of the information's reliability.

The receiver should be prepared to provide a sampling of the insurer's records and the receiver's calculations to demonstrate the reliability of the unearned premium figures to guaranty funds. Where agents have advanced unearned premium to the insureds in exchange for valid legal assignments, the receiver and guaranty fund should coordinate their positions on acceptability.

It should be kept in mind that where the insured's return premium claim is based on a premium audit or retrospective rating plan, it may not be covered by some guaranty funds. Additionally, net worth limitations embodied in a number of guaranty fund acts may preclude payment of unearned premium claims to certain high net worth insureds.

Premium financing arrangements often create special problems for the affected guaranty funds in processing return premium claims. If the receiver has information concerning premium financing arrangements, the receiver should provide that information to the guaranty funds to facilitate payment of returned premium to the appropriate person or entity.

G. Claim Reporting

How guaranty funds report claims and expense payments, outstanding reserves and administrative expenses to a receiver is an item of concern in every insolvency. This reporting is not only important for the guaranty funds as a creditor, but it also assists the receiver in gathering what is usually the major asset in most receiverships—reinsurance recoverables.

The NAIC in December 1993, adopted the UDS to be used for the reporting of policy and claim information between guaranty funds and receivers. UDS was the result of a joint effort of a number of receivers and guaranty funds to facilitate (1) reporting between receivers and guaranty funds, and (2) reporting to reinsurers by the receiver. The use of UDS file formats to transmit information at the policy or claim level will provide both receivers and guaranty funds with needed information in a uniform, easily usable format. Currently, most guaranty funds and receiverships are able to send and receive information in the UDS format. (The NAIC endorsed the use of UDS by receivers and guaranty funds effective March 31, 1995. Most insolvencies instituted prior to that date did not use UDS, nor did they later convert to UDS.) It is very important to note that an Operations Manual exists, and should be reviewed and used by receivers and guaranty funds for understanding UDS. Version 2 of the UDS was adopted by the NAIC for implementation on Jan. 1, 2005. Version 2 includes many improvements and revisions based upon the collective experience of receivers and guaranty funds with the original version over several years and insurer insolvencies. In 2006, the NAIC adopted the Standardized Financial Report (D Record) for addition to the Uniform Data Standards. A copy of the updated UDS Manual and file formats are at the National Conference of Insurance Guaranty Funds (NCIGF) Web site at https://www.ncigf.org/resources/uds/.

It is important to remember that the earlier the receiver determines what information is needed, and communicates those needs to the guaranty funds, the better and more efficient the reporting process will be. UDS, through the implementation of several lettered record formats, has simplified the aforementioned receivers' requirements. The formats were designed by the UDSTSD (UDS Technical Support Group),a group comprised of members of the receiver and guaranty fund communities, and approved by the NAIC.

As stated above, almost all claims data for the insolvent insurer will be in electronic format. Security concerns are paramount. The NCIGF addresses the security concerns with a system called the UDS Data Mapper. Using the Mapper, the receivers can map raw data to, or fully created UDS files to UDS record fields in a database. The Mapper will then create new UDS files to be placed in the guaranty associations' SUDS directories. This process has the dual benefit of ensuring UDS compliance and scrubbing the data of any unknown malicious code. This service is available at no charge to the receiver.

Recent estates with significant reinsurance recoveries have found it useful to also develop claims protocols setting out additional information that is needed for reinsurance recovery purposes and dealing with other matters such as new and reopened claims and closed files. Needed information often extends beyond that which can currently be provided by UDS data feeds. Some guaranty funds have agreed to give receivers

limited, read-only access to their claims database. Assistance from the UDSTSG can also be found by submitting a help request to help@udstsg.org.

H. Claims Exceeding Guaranty Fund Limits and Aggregate Claims

1. Claims Exceeding Guaranty Fund Limits or Claims Excluded from Guaranty Fund Coverage

Under the Model Act and state enabling acts, guaranty funds have per claim limits, or "caps," that can limit the guaranty fund's obligation to an amount less than the insolvent insurer's policy limits. For example, the amount paid in satisfaction of a covered claim (either non-workers' compensation or unearned premium) under the NAIC Model Act may not exceed $500,000 per claimant, even if the actual policy limits are greater. The caps vary among the states and the receiver must review applicable state guaranty fund acts. Here, the interrelationship between the guaranty fund and the receiver becomes critical (i.e., both act to pay or determine claims made against the insolvent insurer arising under the same policy and are eventually allowed against the insolvent insurer's estate).

The guaranty fund has a claim against the insolvent insurer's assets for the amounts paid as indemnity and the expenses and costs of handling the claims it pays. Furthermore, anyone with a claim over the guaranty fund's cap, subject to a guaranty fund deductible or subject to a statutory net worth exclusion has a claim against the estate for that portion of the claim not covered by the guaranty fund. From this perspective, the role of the guaranty fund and the receiver are not easily distinguishable. The guaranty fund is concerned with determining and paying its covered claims obligations under its statute while the receiver is determining how much of the claim should be allowed as a claim in the receivership. As a result, whenever a covered claim is filed in excess of the cap, it gives rise to a situation where extra effort and cooperation between the guaranty fund and the receiver will be necessary.

It should be noted here that, in some states, the guaranty fund will not settle a claim without a complete release, which may require participation by the receiver prior to any settlement. In some cases, however, the guaranty fund may pay the claim up to its statutory limit, leaving the excess to be paid by the insured, who will then retain a claim against the estate for the excess amount. Where the insured is unwilling or unable to pay the excess, the claimant may have a direct claim against the estate for the unpaid amount. In either instance, there is a portion of the claim above the cap that is left unsatisfied by the guaranty fund's payment. After approval by the receiver, the "over-cap" claim, as other allowed claims, will be paid as part of a distribution, pursuant to the applicable priority statute.

There may be other situations where the guaranty fund and the receiver will both have an interest in handling a claim. For example, where a claim includes allegations of bad faith or seeks punitive damages, the claim would not be covered by the guaranty fund but may be a claim in the estate.

The successful handling of over-cap claims is dependent upon early communication between the guaranty fund and the receiver. To prevent, or at least minimize, potential conflicts between the guaranty fund and the receiver regarding the payment of over-cap claims, full disclosure, communication and cooperation between the guaranty fund, the insured and the receiver's claims department must begin as soon as it is determined that an over-cap claim may exist. Prior agreement with the receiver should be obtained, where possible, on the amount of the over-cap claim. The guaranty fund has no authority to settle the claim in excess of its limit, and without the consent of the receiver, the claimant or insured (if paid by the insured) is taking a risk that all or a portion of the over-cap claim may be denied by the receiver. In fact, arranging to have the over-cap claims allowed as a claim in the estate may provide the needed leverage to settle the claim.

Receivers and guaranty funds have found it useful to develop specific procedures for dealing with claims where the cap will be exceeded and including such procedures in the claim protocols described above.

2. Aggregate Claims

Certain types of policies are often written on an aggregate basis. Aggregate policies may be in terms of a policy aggregate, a coverage aggregate, or both. In a policy aggregate, all claims are accumulated until the maximum limit of liability is reached. A coverage aggregate is one where claims against a specific coverage, such as products liability, are accumulated until the maximum coverage limit is reached. When an insurer is solvent, it monitors the erosion of all of its outstanding policies—in other words, the insurer keeps track of how much of a policy's aggregate limit is left as various claims under it are satisfied.

When an insurer is declared insolvent, and one or more guaranty funds begin to satisfy claims against such aggregate policies, problems can arise. The most obvious problem occurs when a guaranty fund paying claims under a policy is not aware that the policy has an aggregate limit. The receiver should take special care to advise the guaranty funds which policies are subject to an aggregate limit. The receiver should not assume the guaranty funds will discover this information on their own.

It is equally important that the receiver and the affected guaranty funds work together to monitor the erosion of aggregate limits. The receiver should advise the affected guaranty funds of claims that have been paid under the policy by the insurer before insolvency and track payments made by the guaranty funds after insolvency. Similarly, guaranty associations should not pay a claim under an aggregate policy prior to coordinating with the receiver. When the aggregate limits are close to being exhausted, the receiver should alert the guaranty funds and require that they obtain prior approval on any payment against such policy. See IRMA § 706 D.

The following example should help illustrate the problem. Assume that there is a products liability policy with an aggregate limit of $2,000,000. Assume further that there are 10 claimants filing claims under the policy with 10 separate guaranty funds. If each guaranty fund has a cap of $300,000, but is unaware of the other claims, then potentially, payments totaling $3 million could be made, thereby exceeding the aggregate limit. In this situation, regardless of the original extent of an individual guaranty fund's knowledge of a policy's aggregate nature, it cannot independently keep track of the policy's erosion. In situations like this, it is critical that the receiver monitor each guaranty fund's activity closely and keep all affected guaranty funds apprised of the situation as it develops.

When adequate safeguards are not in place, payments may be made in excess of a policy's aggregate limit and conflicts will arise between the receiver and the guaranty fund. Although the guaranty fund may have made the payment in good faith and within its statutory guidelines, the receiver may feel compelled to deny reimbursing the guaranty fund for that portion of the claim in excess of the aggregate limit. These problems are sometimes not discovered until long after the guaranty fund has settled all of its claims. To avoid such problems, the guaranty funds should not pay a claim covered by an aggregate policy without first consulting the receiver. State liquidation acts vary on the handling of estate distributions for amounts paid in excess of aggregate caps. These laws should be carefully reviewed in dealing with these matters. Section 706 D of IRMA addresses policies with aggregate limits and provides that the liquidator may apportion the policy limits ratably among timely filed allowed claims or notify the insured, third party claimants and affected guaranty associations of the erosion of the aggregate limit.

In summary, upon taking control of the estate, it is recommended that the receiver institute the following procedures:

- Determine which policies have aggregate limits;
- Determine policy erosion and continue to monitor aggregate accumulations resulting from payments made by guaranty funds;

- Advise guaranty funds of these policies and keep them apprised of any pre- and post-insolvency erosion;

- Require guaranty funds to determine how much of the aggregate limit remains available before making any settlements under these policies;

- As soon as it appears that the aggregate limit is about to be reached, notify the guaranty funds immediately that all future settlements should be cleared with the receiver;

- Require guaranty funds to immediately report to the receiver any paid or settled claims that affect aggregate limits; and

- Initiate a system that can earmark pending settlements. One of the benefits of the UDS is that it facilitates the tracking of policies subject to aggregate limits (See the Publications tab of the NCIGF Web site at http://www.ncigf.org).

I. Early Access

Most state receivership statutes contain a provision that requires the receiver to submit to the court a proposal to disburse general assets to guaranty funds. Such proposals are commonly referred to as "early access plans," and apply equally to life and health and to property and casualty insolvencies. The statutes typically contain provisions specific to both.

The purpose of an early access plan is to distribute funds from the estate to the guaranty funds as soon as possible and in the maximum amount possible in order to reduce the assessment burdens on member companies. Early access distributions are essential to the guaranty funds' continued ability to fulfill their statutory duties. See IRMA § 803.

1. Timing

   The standard early access provision requires that the receiver submit an early access plan within 120 days of entry of the liquidation order. IRMA requires that the receiver apply to the receivership court for approval to make early access distributions, or report that the receiver has determined that there are not sufficient distributable assets to make any distribution to the guaranty funds at that time, within 120 days of entry of the liquidation order, and at least annually thereafter. See IRMA §803 B. In practice, in order for the receiver to make the calculations necessary to demonstrate to the court that there are insufficient assets at that time to make any distribution, receivers should formulate an early access plan and file the form of the plan within the 120-day period for approval by the court. This procedure will fulfill the receiver's statutory obligation for filing a plan and will ensure that a plan is in place to make distributions when assets become available.

2. Reserves

   Most early access provisions in state receivership statutes require an early access plan to include, at a minimum, reserve amounts for the expenses of administration and the payment of the higher priority claims. See also IRMA §803 A(2). The reserve for expenses should take into account all administrative expenses anticipated to be incurred during the duration of the receivership proceeding. (See specific state statutes to determine if guaranty fund administrative expenses are Class I or Class II; see also IRMA §801 A & B.) The reserve for receivership expenses and for other claims that are at a higher priority than the guaranty funds' claim payments need not, however, be reserved 100% out of current liquid assets of the estate, as long as there are sufficient non-liquid assets that will be liquidated during the course of the receivership proceedings to cover those claims. The receiver should reserve a portion of the liquid assets to cover receivership expenses that will become due in the near term and prior to the liquidation of other non-liquid assets.

It may be difficult for the receiver of some estates to accurately determine the amount of policyholder claims not covered by the guaranty funds. An absolute determination of the amount is not necessary for purposes of the plan, however, as an estimate for calculation purposes is all that is needed. This estimate will be updated from time to time, and any overpayment to guaranty funds must be returned to the receiver. This "claw back" requirement is mandated by Section 803 F of IRMA and should be included in any written agreement between the receiver and the guaranty funds.

3. Liquid or Distributable Assets

Most early access agreements provide for payments from distributable assets, which generally means cash and cash equivalents, less reserves for Classes I and II. In developing early access plans, it is anticipated that the receiver will liquidate non-liquid assets as soon as economically prudent.

The receiver, however, is not required to increase liquid assets for purposes of the plan by making forced or quick sales of non-liquid assets that result in obtaining less than market value. In other words, receivers are not expected to hold "fire sales" in order to generate liquid assets for distribution as early access. It is in the interest of all creditors, including the guaranty funds, for the receiver to attempt to obtain full value for the estate's assets. On the other hand, where an asset can be sold at a fair market price, the receiver should consider liquidating the asset in order to generate early access funds and thereby reduce the assessment burden on solvent insurers and their policyholders. The public policy behind maximizing the value of estate assets and reducing assessment burdens on guaranty funds through early access distributions sometimes conflict and special understanding and cooperation between the receiver and the guaranty funds is necessary to resolve this conflict amicably.

Liquid assets do not include real estate, the book value of a subsidiary, assets pledged as security, special or general deposits held by other states that are unavailable to the receiver, or any assets over which the receiver does not have complete control.

4. Early Access Agreements

Any payment to be made under the provisions of an early access plan typically is conditioned upon the guaranty fund executing and returning an early access agreement to the receiver., IRMA obviates the need for an agreement by incorporating the key provisions of a typical agreement in the statute; however, currently, only a small minority of states have adopted this IRMA provision Such agreements include provisions requiring the guaranty funds to:

- Submit to the exclusive jurisdiction of the receivership court, but only for the purpose of the early access plan;

- Return to the receiver any previously disbursed assets, plus interest if applicable, that are required to pay claims that are of an equal or higher priority; no bond shall be required of any guaranty fund. See §803 F of IRMA;

- Periodically report to the receiver: all amounts paid by the guaranty fund on claims to date; the amount of expenses entitled to priority that have been paid by the guaranty fund; the reserves established by the guaranty fund on open claims; the amounts collected by the guaranty fund as salvage or subrogation recoveries; the amounts collected by the guaranty fund from any state deposit; and other information needed by the receiver. See §803 B of IRMA; UDS is the platform commonly utilized for the transfer of this data. See Chapter 2 for a broader discussion of UDS.

Calculations and distributions by the receiver should be done at least annually; however, in instances where the guaranty funds are reporting on a quarterly or more frequent basis and sufficient assets are available to make distributions, the receiver may consider making distributions on a more frequent basis.

5. Expenses

   Early access plans typically contemplate that the guaranty funds should receive prompt reimbursement of their administrative expenses. The calculation of liquid assets available for distribution as early access should be made after payment of all incurred receivership and guaranty fund administrative expenses.

   Certain categories of guaranty fund expenses may or may not be included in the administrative expense priority class. Therefore, it is necessary to consult the applicable statute to determine appropriate treatment.

   In a case where there is disagreement between the receiver and guaranty associations concerning the priority of particular guaranty association expenses, it may make sense to make administrative expense distributions under a reservation of rights, clearly specifying that the priority of certain expenses was a matter of dispute and that such payment does not preclude the receiver from later challenging the priority of particular expenses. Dealing with the issue in this manner ensures that the guaranty associations receive maximum distributions early in the proceeding—when the need for cash can often be critical. Resolution of expense classification issues, which may involve protracted discussions or even litigation, can be conducted while the funds have the necessary cash to pay claims.

6. Basis of Distribution

   Most early access statutes provide that distributions to guaranty funds will be based on claims paid and to be paid by the guaranty funds. Some states, however, have based distributions solely on paid claims. In states that follow the reserve language, early access should be based on both paid claims and reserves. This permits a more equitable distribution of assets among the guaranty funds instead of benefiting guaranty funds that make claim payments at an early stage of the receivership proceeding (e.g., a state that has mostly workers' compensation claims). See §803 A(2)(c) of IRMA.

7. Special Deposits

   Early access plans typically take into account state deposits by excluding such assets from the calculation of liquid assets available. Similarly, the plans typically take into account payment to guaranty funds from general or special state deposits by essentially treating such payments as prior early access distributions, thereby reducing the early access distribution to those guaranty funds receiving state deposits. If after receiving early access distributions, a guaranty fund receives payment from a special state deposit, then the guaranty fund may be required to return all or part of the early access distribution. Most early access plans do not allow the receiver to take credit for a special or statutory deposit that has not been paid to or is unavailable to the guaranty fund. See § 803 G of IRMA.

8. Salvage/Subrogation

   Historically, the majority of receivers have taken the position that salvage or subrogation recoveries collected by a guaranty fund, based on payments made by the guaranty fund, are the property of the guaranty fund. The recoveries are applied to reduce the net guaranty fund payment total that is the ultimate claim of the guaranty fund against the insolvent estate. These receivers accept reimbursement on a pro rata basis in instances where a guaranty fund has made a recovery that includes consideration of both pre-liquidation payment by the insurer and subsequent payment by the guaranty fund. Early access agreements will not be affected when receivers take this position.

   A minority point of view is that salvage or subrogation recoveries by a guaranty fund become general assets of the liquidation estate, regardless of whether the payment on which the recovery is based was made by the insurer or the guaranty fund. Specific language to address concerns may be needed in early access agreements when a receiver adopts this view.

J. Large Deductible Policies

In 2016, the NAIC adopted a white paper titled *Workers' Compensation Large Deductible* Study. The paper revisits and reconsiders issues raised in an earlier 2006 *Workers' Compensation Large Deductible Study.* The 2016 study provides valuable information about how large deductible policies work and special issues that can arise with their use.

As used in workers' compensation coverages, large deductible policies allow employers to retain a certain amount of claims risk, thereby reducing the cost of their workers' compensation coverage. Typically, these policies are administered by the insurer or a third-party administrator paying claims within the deductible and obtaining reimbursement from the insured employer. In the receivership context, where guaranty funds pay claims within the deductible, there is an issue as to the handling of the insured employer's reimbursement of payments within the deductible. That is, should the reimbursement be paid to the guaranty fund outside the receivership distribution scheme, or should the reimbursement be treated as an asset of the receivership estate subject to the claims of all creditors? Several states have provisions in place in their respective receivership statutes which provided that large deductible reimbursements should be paid directly to the guaranty fund outside the receivership distribution scheme.

Where the insolvent insurer wrote large deductible policies, the receiver should be mindful of this issue and should consult with the affected guaranty funds as soon as possible. The receiver should also review those states' guaranty fund statutes where the claims will be processed to determine whether claims within large deductibles are "covered claims" as defined in the appropriate guaranty fund act. Typically, claims under workers compensation policies will be covered. However, claims under policies for other lines of business may not be covered. The availability of guaranty fund coverage is to some extent dependent upon the specific language of the policy involved.

IRMA provides for a different treatment of large deductible collections. Under IRMA § 712, payments of such monies to the guaranty funds are treated as early access.

Under the *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) deductible recoveries are paid to the guaranty fund to the extent of their claim payments and are not considered early access distributions. Subsection B of this Guideline states, "Unless otherwise agreed by the responsible guaranty association, all large deductible claims that are also "covered claims" as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling." Refer to the Guideline subsection B for further discussion of deductible claims paid.

K. Coordination among Regulators, Receivers and Guaranty Funds

In 2005, the NAIC adopted a white paper titled Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System. The white paper addresses the various issues relating to communication and coordination among regulators, receivers and guaranty associations, and how the parties might better work together to protect consumers.[7]

[7] A copy of this White Paper may be obtained from the NAIC at: http://www.naic.org/store_home.htm
Phone: 816.783.8300; Fax: 816.460.7593; E-mail: prodserv@naic.org

III. LIFE AND HEALTH GUARANTY ASSOCIATIONS

A. Introduction

In 1970, the NAIC adopted the Life and Health Insurance Guaranty Association Model Act (the Life Model Act). Since 1970, the Life Model Act has undergone several major revisions. The most recent revisions to the Life Model Act were made in 2017.[8] All 50 states, the District of Columbia and Puerto Rico have enacted guaranty association laws based on some version of the Life Model Act. (For summaries of the provisions in each state's guaranty association laws see the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) Web site at https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

The Life and Health Insurance Guaranty Associations were created to protect certain policy, contract and certificate holders (and their beneficiaries, assignees and payees) from loss due to the insolvency or impairment of a member insurer.. Life/health insurance guaranty associations pay benefits and continue coverage, subject to statutory limitations, either directly or through a third-party administrator. With early communication, information sharing and coordination between guaranty associations and receivers, the guaranty associations can work with receivers to help develop and put in place the infrastructure and solutions that may be able to provide for a seamless transition into liquidation, thereby avoiding unnecessary delays and disruptions, and maximizing protections for policyholders. Early coordination between the receiver and the guaranty associations will also help minimize confusion, avoid duplication of effort and lead to greater administrative efficiency and lower costs for both the receiver and the guaranty associations.

NOLHGA is a vital resource for receivers in multistate life/health insolvencies. NOLHGA, whose members are the life/health guaranty associations of all the states and the District of Columbia and Puerto Rico, collects and distributes information for its members and receivers. It performs analyses of various alternatives by which guaranty associations can fulfill their statutory obligation to protect policyholders and serves as the guaranty associations' national coordinating mechanism for resolving issues. Through its Members Participation Council, NOLHGA works with its affected member guaranty associations and the receiver to develop and implement plans for the disposition of covered claims and contractual obligations through, for example, assumption reinsurance or claims administration.

Ideally, the receiver and NOLHGA, on behalf of the guaranty associations, should commence planning and coordination efforts at the earliest practicable opportunity. As discussed in the NAIC's 2004 whitepaper on Communication and Coordination Among Regulators, Receivers and Guaranty Associations, cited in Chapter 1 of this handbook, coordination and communication with guaranty associations should begin "no later than when a company is placed into rehabilitation, and in many cases, involvement even earlier will enhance consumers' protection and decrease costs of the insolvency to all stakeholders" subject to entering into a confidentiality agreement as appropriate. NOLHGA can be reached at:

National Organization of Life and Health
Insurance Guaranty Associations
13873 Park Center Rd., Suite 505
Herndon, VA 20171
Phone: (703) 481-5206
Web Site: https://www.nolhga.com

[8] All references in this chapter to the "Life Model Act" are to the 2017 version, unless otherwise specified. As of this writing, a majority of states had adopted or substantially adopted the 2017 amendments, and further legislation is expected in additional states. It is always important, however, to check individual state statutes for variations from the Life Model Act in actual cases.

B. Triggering Guaranty Associations

1. "Insolvent" Insurers

Under the Life Model Act, guaranty associations are triggered when a member insurer is determined to be an "insolvent insurer," as defined therein, i.e., it has been placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency. A member insurer is defined in the Life Model Act as "an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn…."[9] Certain types of insurers are excluded from the Life Model Act definition, such as fraternal and mutual assessment companies. Moreover, while a majority of states now include Health Maintenance Organizations ("HMOs") as member insurers, not all states do. State guaranty association laws will govern whether HMOs are member insurers for purposes of guaranty association coverage in a given state.

2. "Impaired" Insurers

Under the Life Model Act, a guaranty association may act in its discretion if a member insurer is "impaired," subject to certain conditions and limitations. An insurer is an "impaired insurer" as defined in the Life Model Act, if it has not been declared insolvent but is under a court order of rehabilitation or conservation. In such situations, the Life Model Act provides that the guaranty association may, in its discretion and subject to any conditions imposed by the guaranty association that do not impair the contractual obligations of the impaired insurer, and that are approved by the Commissioner, take certain actions to provide protections to policyholders of the impaired insurer. The primary purpose of the guaranty associations is to protect policyholders, however, not to bail out impaired or insolvent insurers so that they can continue as going concerns. Guaranty associations, therefore, have traditionally been extremely reluctant to provide coverage before liquidation.

There are subtle variations among some state guaranty association triggering provisions which could potentially impact uniform triggering of guaranty associations in affected states. Coordination with guaranty association representatives and NOLHGA (if a multistate insolvency), as early as possible subject to appropriately executed confidentiality agreements before a petition for receivership is filed will help to reduce the risk of complications in regard to guaranty association triggering. or individual state provisions, see the NOLHGA Web site (https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

C. Scope of Coverage

1. Covered Policies and Limits of Coverage

Guaranty associations were created to provide a limited, but substantial safety net to protect policyholders from loss as a result of the impairment or insolvency of a member insurer. e Under the Life Model Act, the following coverages are provided:[10]

[9] HMOs were added to the definition of "Member Insurer" as part of the 2017 package of amendments to the Life Model Act. As of this writing, those amendments had been largely adopted in 36 states. However, at least one of those states has continued to exclude HMOs from the definition of Member Insurer.

[10] While there are a few exceptions, these coverage limits have been fairly uniformly adopted in most states. For individual state limits, see the NOLHGA website (https://www.NOLHGA.com/factsandfigures/main.cfm/location/statinfo) or consult the applicable state guaranty association.

- Life insurance: $300,000 in death benefits, but not more than $100,000 in net cash surrender and withdrawal values, per life. In the case of corporate-owned or bank-owned life insurance, however, overall benefit coverage is capped at $5,000,000 per owner.

- Health insurance: i) $500,000 in benefits for health benefit plans, which are defined to include "any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract", subject to certain enumerated exclusions. The term "health benefit plan" which was introduced in the 2017 amendments to the Life Model Act, replaces the prior reference to basic hospital, medical and surgical insurance and major medical insurance, and includes coverage under health maintenance organization subscriber agreements; ii) $300,000 in benefits for disability income insurance and long-term care insurance; and iii) $100,000 for other health policies not defined as disability income insurance, long-term care insurance or health benefit plans. All limits are applied per life.

- Individual (allocated) annuities: $250,000 in present value of annuity benefits, including net cash surrender and withdrawal values, per life.

- Structured settlement annuities: $250,000 in present value of annuity benefits, per payee or beneficiary. See Chapter 3 for a discussion of structured settlements.

- Unallocated annuities: Coverage for unallocated annuity contracts[11] is typically limited. As of this writing, 28 states provide coverage for limited types of unallocated annuity contracts. The remaining 22 states, plus the District of Columbia and Puerto Rico, do not provide coverage for unallocated annuity contracts. For those states that do provide coverage for unallocated annuity contracts, coverage is typically limited to unallocated annuity contracts issued to or in connection with specific employee benefit plans or government lotteries. Life Model Act §3(A)(3). Coverage limits are stated as (i) $5,000,000 per contract owner/plan sponsor for unallocated annuity contracts issued in connection with either governmental lotteries or private employer employee benefit plans that are not protected by the Pension Benefit Guaranty Corporation, and (ii) $250,000 per plan participant for unallocated annuity contracts issued to governmental retirement plans. Life Mode Act §3(C)(2)(b) and (e). Unallocated annuity contracts are not covered in every state, and the Appendix to the Life Model Act includes alternate Section 3 text adopted by several states that do not provide coverage for unallocated annuities.

- Aggregate limits across policy types: Aggregate benefits covered with respect to any one life for life insurance, individual annuities, and health insurance (other than health benefit plans) are capped at $300,000. Aggregate coverage for health benefit plans and other policy types is limited to $500,000 with respect to any one life.

2. Exclusions

Products excluded from coverage, in whole or in part, are described in Life Model Act Section 3(B)(2). Under the Life Model Act, coverage is expressly excluded for policies or portions of policies under which the risk is borne by the policyholder or that are not guaranteed by the insurer, as well as certain interest crediting rates that exceed the limits described therein. Self-funded employer-provided welfare benefit plans are also among the products excluded, as are unallocated annuity contracts issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation. Reinsurance is

[11] For purposes of guaranty association coverage, an unallocated annuity contract is "an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate." Life Model Act §5(Y).

also specifically excluded unless assumption certificates have been issued. For a more complete listing of products or portions thereof generally excluded from guaranty association coverage, refer to Section 3(B)(2) of the Life Model Act. For specifics concerning coverage exclusions in any particular state, consult with the guaranty association in that state..

In addition to the product exclusions referenced above, the Life Model Act excludes coverage for policies or products issued by entities that are not regulated under the standards applicable to legal reserve carriers, and are therefore excluded from the definition of Member Insurer under the model, such as insurance exchanges, assessment companies, fraternals, and hospital or medical service corporations. HMOs were added as member insurers under the Model as part of the 2017 amendments. However, these amendments have not yet been adopted in all states. Moreover, a few states may have separate HMO guaranty associations established under state law. Accordingly, it will be important to review state law to determine whether and to what extent a state provides guaranty association coverage for HMO products. Hospital or medical service corporations that are members of the Blue Cross/Blue Shield Association may be required by their franchise to participate in their state's guaranty association if permitted by statute, or to establish some other form of insolvency protection for their participants. Whether these entities are included as member insurers for purposes of guaranty association protection may vary by state and must be considered based on the circumstances in each case.

3. Residency Requirements

. Residency is determined on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer, whichever occurs first. Typically, this results in the state of residence being determined on the date an order of liquidation with a finding of insolvency is issued. If there is a gap between the start of the receivership and the date an order of liquidation is issued, policy and contract holders may relocate, which could affect the situs of coverage.

The Life Model Act generally provides for coverage of policyholders and certificate holders under group policies who are residents of the state, as well as their beneficiaries, regardless of where the beneficiaries reside. It also provides coverage for contract owners of unallocated annuities if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in the state. Nonresident policyholders and contract holders may be covered under certain limited circumstances. If the insolvent insurer's domiciliary state follows the Life Model Act, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty association law and the policyholders in that state are not eligible for coverage there because the insurer was not licensed in that state at the time specified in that state's guaranty association law. An example of such a situation might be a a resident of State A, who owns a policy of the XYZ Life Insurance Company, domiciled in State B, and placed in liquidation in state B. If the State A resident policyholder is not eligible for coverage by the State A guaranty association because the company was not licensed in State A (and therefore was not a member insurer of the State A guaranty association), coverage would be provided by the State B life and health insurance guaranty association.

D. Guaranty Association Claims Administration

In the case of a multi-state insolvency, life/health guaranty associations work through NOLHGA's Members' Participation Council (MPC) to develop and implement a plan for providing guaranty association coverage, whether through transfer of the covered policies to a solvent insurer, making arrangements for providing ongoing policy and claims administration, or some combination thereof. I

For multi-state insolvencies, NOLHGA appoints a guaranty association task force that includes representatives from the domestic guaranty association and other state guaranty associations affected by the insolvency. The size of the task force depends in large part on the number of affected state guaranty associations and the size of the insolvency.

1. Information Needs of the Guaranty Associations

For guaranty associations to evaluate and discharge their functions with the least possible duplication and delay, they must have detailed information about the insurer and its business. While information needs may vary from case to case, NOLHGA typically requests this information from the receiver on behalf of its members and, if necessary, will offer to assist the receiver in obtaining and assembling the information. Types of information routinely requested include:

- All administrative and judicial petitions and orders with attachments or exhibits;
- The insurer's most recent annual statement;
- The insurer's most recent financial statement, audited or unaudited, and department or independent financial audits or reviews, including identification of assets that are hypothecated or not publicly traded and unbooked contingent liabilities;
- A list of states that have terminated or suspended the insurer's license;
- A breakdown, by state, of the insurers' estimated liabilities/reserves by line of business;
- A list of third-party administrators and administrative offices, identifying the policies, claims and group policyholders they served, and copies of all provider/vendor agreements;
- Actuarial evaluations of the insurer's business;
- Copies of policy and contract forms;
- Copies of reinsurance contracts, assuming or ceding;
- Drafts of the receiver's notices to policyholders, including any cancellation notices;
- A breakdown of assets, by category, at the most recent market value available and other valuations of assets that would be helpful in cash flow analysis;
- The names and addresses of policyholders and certificate holders with in-force coverage during the preceding year, broken down by state, indicating the type of coverage each had, the date to which premiums have been paid, cancellation or non-renewal dates for business that was canceled or non-renewed according to policy terms, copies of cancellation notices, and the date to which claims have been paid; [12]
- Policy values (face amounts, cash surrender values, policy loans, interest crediting rates, rate crediting history, etc.);
- Premium files (and status indicators, such as Reduced Paid Up, Extended Term, or Waiver of Premium status);
- Claims data/claims history (including plan of care and related information for LTC lines);

[12] Specific policy data needs will depend on the facts and circumstances of each case as well as the types of business involved. Initial, critical data needs will typically include all relevant summary policy and reserve information. If the policy master/eligibility records can be provided, that file may contain sufficient information for preliminary coverage determinations and to consider the potential feasibility of an assumption transfer. Additional information will be needed to coordinate coverage and begin planning for implementation of any administration, transfer or other disposition strategies.

- Rate files/history; and
- Information concerning the receiver's marketing contacts and expressions of interest received about the insurer's business.

2. Notice to Claimants

Shortly after a receiver is appointed, the receiver should collaborate with NOLHGA to provide notices to policyholders. Several notices may be necessary over the course of the receivership. Because of the special nature of life and health insurance guaranty association obligations, the receiver and the guaranty associations should collaborate closely on the contents of all notices to policyholders that involve guaranty association obligations, and may, in some instances, send joint communications to policyholders. Normally, the notices should:

- Provide notice of proceedings against the company;
- Explain the existence of the g guaranty associations and their role in the receivership
- Provide basic information concerning guaranty association continuation of coverage, including general reference to the statutory limitations;
- Where applicable, advise regarding the possibility that a portion of the policies or contracts may be assumed or reinsured by another insurer;
- Provide instructions on filing claims under their insurance policies and remitting future premiums (during rehabilitation);
- Indicate how the guaranty associations intend to treat cancelable policies;
- Provide information about conversion policies in the event of policy terminations;
- Provide notice of liens or moratoriums;
- Identify any applicable claims bar date ;
- Describe the receiver's handling of claims in excess of guaranty association statutory maximums; and
- Describe the receiver's handling of claims that are ineligible for guaranty association coverage.

When a company goes into liquidation, the guaranty associations will typically send their own notice to policyholders, sometimes as part of a joint mailing with the receiver. The guaranty association notices will provide information about guaranty association coverage and limits, contact information for the state guaranty association providing coverage for insureds in each state, instructions for continuing to pay premiums and submitting claims, customer service contact numbers, and other relevant details depending on the unique facts and circumstances of the case.

3. Notice to Guaranty Associations

In many states, the receiver is required to provide notice of the receivership to all guaranty associations that may be triggered as a result of the receivership. Even if the notice is not a statutory requirement, the receiver should provide NOLHGA (in the case multi-state receiverships) and all affected guaranty associations as much advance notice of receivership as is reasonably possible under the circumstances subject to appropriate confidentiality agreements in order to facilitate the coordination that will be necessary for a successful receivership, and achieve the best outcomes for policyholders. NOLHGA and the affected guaranty associations should also be provided with an advance copy of all notices

being issued by the receiver to policyholders, as well as copies of the receivership order and any domiciliary injunctions that may have been entered.

4. Proof of Claim

   A proof of claim form is less frequently required in life/health receiverships, due in part to the fact that in many instances the guaranty associations will be continuing coverage. Generally, policyholders are not required to file formal proofs of claim for policy benefits. However, policyholders may assert claims for extra-contractual liability against the insurer, such as claims for bad faith. The receiver should consider requiring a proof of claim where extra-contractual liability is involved. Neither the guaranty associations nor assuming reinsurers accept liability for extra-contractual claims.

   Receivers and guaranty associations must have data on the policy deductibles and benefit caps under health insurance policies. If the business is transferred to a new carrier, incurred claims will have to be allocated between pre- and post-assumption date periods. In addition, special provisions in the assumption agreement may require additional information in the proof of claim form.

5. Claim Files

   The information needs of the guaranty associations generally are addressed earlier in this section of the Handbook. To ensure secure data transfer, receivers or insurance department personnel typically establish a secure website portal or FTP site to provide NOLHGA and its member associations with secure access to the data needed. Otherwise, NOLHGA (or a designated Third-Party Administrator or consultant) can establish a secure file portal where designated users can upload records. Files and records should be made available at the earliest practical opportunity to allow for the planning and coordination needed for a smooth transition and to to avoid any disruption to benefits and claim payments .

6. Premiums

   The continued and timely payment of premiums is necessary in order for a policyholder to receive continued coverage from a life/health guaranty association. Under the Life Model Act, "premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association." Receivers should work with NOLHGA and the guaranty associations to ensure smooth transition of premium collection. For premiums collected before the liquidation order but providing coverage for periods after the liquidation order, the Receiver should coordinate with the guaranty association to facilitate appropriate allocation of those funds.

E. Early Access

The guaranty associations' administrative costs, like the receiver's, typically have the highest priority in distribution of funds from the insolvent insurer's estate. In addition, guaranty associations have a statutory claim and right of subrogation, allowing them to recover from the estate to the extent they pay covered benefits. Guaranty association claims for the payment of covered benefits are accorded the same priority as policyholder claims (Class 3 under §801 of IRMA), and are taken into account in the calculation of association benefits as part of a rehabilitation or liquidation plan. The guaranty associations' claims in the aggregate often make the guaranty associations the largest claimants against the estate.[13] In recognition of this fact, most state laws provide for the guaranty associations' "early access" to payments from the estate. See §803 of IRMA. Early access is typically accomplished by specific agreement, which should include a provision that the guaranty associations will return excess funds.

[13] In some cases, the guaranty associations may also present claims against the estate for the insolvent insurer's unpaid guaranty association assessments. These claims have general creditor status ranking below other guaranty association claims and all policyholder claims.

F. Claim Reporting

Guaranty associations should make timely reports to receivers of their costs for policy transfers, policy administration (including TPA costs), claim payments and administrative expenses. In multi-state insolvencies, NOLHGA will typically collect the necessary data from the affected guaranty associations and report to the receiver on their behalf in the form of an Omnibus Proof of Claim, which may be updated from time to time.

G. Guaranty Association Obligations During the Formulation of a Rehabilitation or Liquidation Plan

The successful creation and implementation of a plan to protect policyholders requires good communication and cooperation between receivers and guaranty associations. To the extent consideration may be given to restructuring of covered policies or contracts, the receiver should coordinate with the guaranty associations early in the development of the plan to consider whether the proposed restructuring is consistent with the guaranty association statutory obligations with respect to those policies or contracts. Any restructuring needs to be carefully considered in light of all applicable statutory requirements.

H. Reinsurance

The guaranty associations may find it advantageous to keep in-force ceded reinsurance treaties that the insolvent insurer had in place on covered blocks of business. Accordingly, the receiver should not cancel ceded reinsurance contracts with reinsurers or stop paying premium to reinsurers without consulting NOLHGA or the affected state guaranty associations. The existence of a ceded reinsurance treaty covering a block of business may make the business more attractive to prospective purchasers. In the case of health insurance, reinsurance recoveries may lessen the impact of catastrophic claims upon the affected guaranty associations. See Section 8 N of the Life Model Act and Section 612 of IRMA, both of which provide that the guaranty association(s) may elect to succeed to the rights and obligations of the insolvent insurer under ceded indemnity reinsurance agreements.

J. Special Issues

Under the Life Model Act, guaranty associations have the power and discretion to "guarantee, assume or reinsure . . . the policies or contracts of the insolvent [or impaired] insurer." Relying on this authority, guaranty associations have, on more than one occasion, acted collectively to establish an insurance company for purposes of collectively managing assets and assuming or administering guaranty association covered obligations. Whether similar arrangements may be appropriate in future insolvencies depends entirely on the circumstances.

J. Guaranty Association Procedures for Collective Action

MANY INDIVIDUAL STATE GUARANTY ASSOCIATIONS MAY BE TRIGGERED IN CONNECTION WITH A MULTISTATE INSOLVENCY. SIMPLY COMMUNICATING WITH EACH GUARANTY ASSOCIATION INDIVIDUALLY WOULD BE A DIFFICULT TASK FOR A RECEIVER'S STAFF. THE RECEIVER SHOULD WORK CLOSELY WITH NOLHGA, THROUGH THE MPC'S APPOINTED TASK FORCE, TO COMMUNICATE AND COORDINATE WITH THE AFFECTED GUARANTY ASSOCIATIONS. RECOGNIZING THE NEED FOR CONCERTED ACTION WHEN MULTIPLE GUARANTY ASSOCIATIONS MUST COVER THE INSURANCE OBLIGATIONS OF AN INSOLVENT COMPANY, THE GUARANTY ASSOCIATIONS HAVE DEVELOPED AND INSTITUTIONALIZED PROCEDURES THAT, THROUGH NOLHGA, ENABLE THEM COLLECTIVELY TO ADMINISTER CONTINUING POLICY OBLIGATIONS, PAY COVERED CLAIMS AND,

ULTIMATELY, DISCHARGE THE COVERED OBLIGATIONS. THESE PROCEDURES PROVIDE A VALUABLE MECHANISM FOR ENTERING INTO BINDING CONTRACTS

V.

[1] UDS Manual link to be included when published from .ncigf wesite

CHAPTER 7—REINSURANCE (THIS WILL CHANGE WITH FINAL)

I. INTRODUCTION

Reinsurance is often referred to as "insurance for insurance companies," but it is separate and distinct from the insurance relationship existing between a policyholder and its insurer. The direct (primary, umbrella, or excess) insurer (reinsured or ceding company) cedes to a reinsurer (assuming company) a portion of its risk under policies issued to its policyholder (the original insured) pursuant to a reinsurance agreement. Reinsurance is an agreement of indemnity, whereby the assuming insurer in consideration of premium paid agrees to indemnify the ceding company against all or part of the loss that the ceding company may sustain under the policy or policies it has issued. Generally, absent a cut-through (discussed below at _), the reinsurer has no privity with or obligation to the original insured.

Just as reinsurance is important to the operations of an insurer, it is equally important to a receiver. Reinsurance receivables often represent a significant portion of an insurer's assets. Understanding reinsurance is critical to the efficient collection of this important asset. Generally, ceded reinsurance agreements should be continued. In the context of a life/health company insolvency, IRMA §612 provides for ceded reinsurance to be continued or terminated pursuant to the terms of each contract if the ceding insurer is in conservation or rehabilitation proceedings, but further provides that such contracts *shall be continued in liquidation* unless they were terminated in accordance with their terms prior to liquidation or were terminated pursuant to the liquidation order. In addition, both IRMA §612 and §8(N) of the NAIC's Life GA Model Act, as adopted in state laws, provide the life and health insurance guaranty associations the right to elect to continue and assume the rights and obligations of the ceding insurer with respect to reinsurance contracts that relate to guaranty association covered obligations, subject to the requirements set forth therein. To the extent those guaranty association covered obligations are subsequently transferred to an assuming insurer, the reinsurance continued on those contracts may also be transferred to the assuming insurer.

Reinsurance is a sophisticated international industry involving various types of unique contractual relationships. Reinsurance is utilized by insurers to achieve a variety of purposes and effects. It can increase an insurer's capacity to accept larger risks, provide financial support for an insurer, add stability to an insurer's results, protect against accumulations of losses, and provide the expertise of reinsurers who specialize in a particular area of insurance. Reinsurers may in turn be reinsured by other reinsurers referred to as "retrocessionnaires," who may also be reinsured, and so on. In this fashion, a broad spreading of risk is achieved.

It is important to note the terms used in reinsurance do not necessarily have the same meaning when used in the insurance context. A classic example is date of loss. In insurance it often means the date of the damage, while in reinsurance it can be the date the contract was accepted, terminates or any other meaning agreed by the parties. Some common definitions are:

Acceptance	Agreement by which a reinsurer consents to underwrite risk from a ceding company under specified circumstances.
Bordereau	A list compiled by a ceding insurer that provides the loss and premium histories of risks ceded or proposed to be ceded to a reinsurer.
Cede	To transfer part or all of a risk to a reinsurer.
Cedent	Company that is transferring the risk to a reinsurer. Generally the term is used when referring to the direct insurance company that is ceding business to the reinsurer.
Ceding Commission	The amount the reinsurer pays (or ceding company retains) when the cedent buys reinsurance. Generally, the amount of the commission is attributable to the cedent's acquisition costs.

Cession	The portion of the risk that has been ceded to the reinsurer.
Commutation	The manner in which the cedent and the reinsurer will agree to a termination of past and future liabilities under a reinsurance contract.
Cover Note	A document issued by the reinsurance intermediary or the broker, indicating the reinsurance coverage that has been bound.
Cut-through Clause or Endorsement	A guarantee by the reinsurer to a party that is otherwise not in privity with the reinsurance contract (often the insured) that payment will be made by the reinsurer under certain specified conditions, e.g., insolvency of the cedent.
Excess of Loss Reinsurance	Reinsurance that attaches once a loss has exceeded a specific amount.
Facultative Reinsurance	Reinsurance in which the reinsurer retains the "faculty" to underwrite each risk individually.
Inuring Reinsurance	When for the benefit of the reinsurer, it will refer to other reinsurance contracts that will reduce the amount otherwise recoverable under a particular reinsurance cover. When for the benefit of the cedent, it refers to other reinsurance contracts that will not reduce the amount recoverable under a particular reinsurance cover. Sometimes referred to as "common account."
Quota Share Reinsurance	Generally, a reinsurance agreement by a reinsurer to reimburse a cedent in the same percentage in which the reinsurer receives premium from the cedent.
Reinsurer	A person or entity that assumes risk from the cedent.
Retention	The amount of risk retained by the ceding company.
Retrocedent	A reinsurer that transfers risk it has assumed to another reinsurer; e.g., cedent cedes to a reinsurer that in turn retrocedes to a retrocessionnaire.
Retrocession	A transaction whereby a reinsurer transfers risk that it has assumed from the cedent to another reinsurer.
Retrocessionnaire	A reinsurer that assumed risk from the retrocedent.
Surplus Share Reinsurance	A type of reinsurance treaty, similar to quota share reinsurance, which spells out specific amounts to be retained by the cedent.
Treaty	A type of reinsurance contract that differs from a facultative contract because it does not retain the faculty of underwriting the individual risk.
[New row] Unauthorized	A reinsurer that is unlicensed to conduct the business of insurance. The reinsurer is said to be "unauthorized" and not to provide security to the cedent which the cedent may reflect in its statutory financial statements either as an asset or a reduction in liabilities.

Additional definitions may be found in the NAIC's *Credit for Reinsurance Model Law* (#785), *Credit for Reinsurance Model Regulation* (#786), *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787) *Special Purpose Reinsurance Vehicle Model Act* (#789), *Life and Health Reinsurance Agreement Model Regulation* (#797), and *Assumption Reinsurance Model Act* (#803). Glossaries can be found at various Web sites.

Guaranty Association Coverage

When an insolvent insurer is a reinsurer, guaranty associations do not provide coverage for reinsured policies unless there has been an assumption and novation and the insolvent insurer has become directly obligated to the original policyholders. See NAIC Life GA Model Act § 3(B)(2)(b) and NAIC P&C GF Model Act § 5(D) (which has been adopted in a minority of states and sometimes with modification to supporting definitions).

II. REINSURANCE BASICS

There are several reinsurance arrangements that one might expect to find in an insurer's reinsurance program. Whether undertaken in property and casualty, or life, accident and health insurance lines, there are numerous provisions that are required to be included in reinsurance agreements pursuant to state law (e.g., an insolvency clause – see _ below). In addition, all of the terms and conditions of a reinsurance relationship are required to be written as part of the principal agreement; "side" agreements and letters are not permitted.A. Property and Casualty Reinsurance Arrangements

A reinsurance program can be extremely complex and may consist of multiple interacting arrangements, all responsive to the same loss. Furthermore, an insurer's net retention, after applyingtreaty reinsurance and facultative reinsurance, may be further protected by catastrophe or stop loss reinsurance. Also, overlap between different treaties may cover aspects of the same loss.

Two particular types of reinsurance arrangements bear specific mention – fronting and cut-through arrangements. Both fronting and cut-through arrangements affect the parties to the transaction, but do not change the ultimate economics involved.

Fronting is an arrangement by which an authorized insurer issues policies to cover risks underwritten by unauthorized or inexperienced insurers (or for the benefit of insureds who cannot transact the business of insurance) and then transfers its own liability to such unauthorized insurer by means of reinsurance. Fronting involves two actions: (1) a substantial cession of business; and (2) a delegation of claims and underwriting authority from a licensed to an unlicensed insurer. The fronting insurer remains financially liable to the policyholder for the entire insured amount even though, in reality, the fronting insurer may only bear a small financial liability, if any. While fronting can serve useful purposes, abuses can occur if the fronting company fails to exercise control with respect to underwriting, claims, or the risk to which it exposes its assets. A certain amount of disclosure, however, is required on Schedule F of the Annual Statement. Ceding companies are required to disclose whether they have contracts ceding 75 percent of direct written premiums in Schedule F.

A cut-through is either a clause in or an endorsement to an insurance policy or reinsurance contract which provides that, in the event of the insolvency of the insurance company, the amount of any loss that would have been recovered from the reinsurer by the insurance company (or its statutory receiver) will, instead, be paid by the reinsurer directly to the policyholder, claimant or other payee, as specified by the clause or endorsement. Cut-throughs may provide a competitive advantage among commercial insurers. Some clients require insurers to obtain a cut-through or face the possibility of losing business to another insurance company. Reinsurers usually provide cut-throughs only when requested by the insured and reinsured. If a reinsurer issues a cut-through, it has a contractual obligation to pay the beneficiary of the cut-through rather than the receiver. The cut-through does not change the amount of the reinsurance recoverable, only to whom

it is paid. Cut-throughs are common in captive arrangements, particularly where the insured owns, rents, or otherwise participates in the captive.

In general, reinsurance agreements are written as proportional or non-proportional and on either a treaty or facultative basis. Proportional reinsurance is reinsurance that involves the cession by the cedent of a specified share of risk, so that premiums and losses are shared proportionately between the ceding insurer and the reinsurer. Non-proportional reinsurance is a form of reinsurance that, subject to a specified limit, indemnifies the ceding company against the amount of loss in excess of a specified retention. It includes various types of reinsurance, such as catastrophe reinsurance, per risk reinsurance, per occurrence reinsurance and aggregate excess of loss reinsurance. Treaty reinsurance (or obligatory reinsurance) refers to an arrangement under which a reinsurer automatically reinsures all the risks of a specific portfolio of the reinsured, without an option to decline specific risks within the portfolio. Facultative reinsurance, on the other hand, refers to the type of risk where the reinsurer has retained the "faculty" to underwrite the individual risk. A facultative contract is generally referred to as a facultative certificate.

1. Treaty Reinsurance

Under a treaty, the reinsurer is obligated to accept the cession of a class or certain classes of business written by the ceding insurer in accordance with the definitions, exclusions, terms and conditions of the reinsurance agreement. There are common treaty clauses, but each treaty must be read in its entirety to determine how subject premiums and losses are to be treated and how the treaty is affected by other treaties, i.e., inuring treaties. (See definitions in I. Introduction, above.)

A treaty can cover different types of risks. Some treaties cover one line of business, such as fire, casualty, marine, aviation, directors and officers, or boiler and machinery. Others cover an entire program or all business written by a managing general agent, program administrator or specific underwriting department. There are two principal categories of treaty reinsurance: (i) pro rata or proportional reinsurance, and (ii) non-proportional or excess of loss reinsurance.

Treaties tend to be long documents with many clauses and provisions. There are no "standard" contracts, and no two are alike.

2. Facultative Reinsurance

Facultative reinsurance is reinsurance of individual risks by offer and acceptance wherein the reinsurer either retains the "faculty" or ability to accept or reject each risk offered by the ceding company, or limits its acceptance to certain risks or lines of business of the cedent.

There are two principal categories of facultative reinsurance: facultative obligatory and semi-automatic facultative.

- Facultative obligatory reinsurance: These contracts are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

- Semi-automatic facultative reinsurance: Semi-automatic facultative reinsurance requires the reinsurer to accept certain defined risks of the reinsured, subject to the right of the reinsurer to reject liability for any of such risks within a stated period after submission. Like facultative obligatory reinsurance, semi-automatic facultative reinsurance is also a hybrid of both treaty and facultative reinsurance.

Unlike treaties, many facultative contracts take the form of "certificates" comprising a Declarations page and a page of "standardized" General Terms and Conditions in order to ensure concurrency of terms within the reinsurance market.

3. Pro Rata and Excess of Loss Reinsurance

Pro rata and excess of loss reinsurance are forms of either treaty or facultative reinsurance.

a. Property/Casualty Pro Rata Reinsurance

Pro rata reinsurance, also known as proportional reinsurance, consists of quota share reinsurance and surplus reinsurance. Quota share reinsurance is a cession of a specified portion of the risk up to a certain limit of liability, such as 50 percent of the risk per occurrence up to $1 million.

Surplus treaties are pro rata reinsurance that are usually designated by such names as first surplus, second surplus, special surplus, etc., reflecting layers of surplus reinsurance over specified retentions. Several reinsurers may each have a percentage of liability on a surplus treaty in each of these layers. Each reinsurer's liability may be referred to as their "participation." It is called surplus reinsurance because it is reinsuring over a net retention by the cedent or over other layers of reinsurance. A reinsurer's respective participation is designated in a document known as an Interests and Liabilities Statement or agreement (I&L) and is designated as being on either a joint (each insurer is liable for the entire amount reinsured) or several (each reinsurer is liable only for a specified amount or percentage) basis.

b. Excess of Loss Reinsurance

Excess of loss reinsurance applies to losses that exceed an agreed dollar amount or percentage of premium. The reinsurance may apply to a single risk, to a number of losses arising out of one event, or to an aggregation of losses. Excess of loss reinsurance written on a per risk basis is most common, sometimes supplemented by aggregate loss limits applied on an annual basis. Because excess of loss reinsurance does not participate in the entire loss, premium and losses are not shared on a proportional basis with the cedent.

There are many types of excess of loss reinsurance, such as working excess, layered excess, per-risk reinsurance, aggregate excess of loss, and catastrophe or clash cover. The following are examples of excess of loss reinsurance:

- Working excess: This form of excess of loss reinsurance focuses on loss frequency, as opposed to loss severity, and is usually written with relatively low indemnity in excess of low retention, e.g., $400,000 indemnity in excess of $100,000 retention. (In reinsurance parlance, this is expressed as $400,000 xs. $100,000.)

- Layered cover: First excess is usually written over a retention where frequency diminishes and severity of loss is more of a factor. To protect against increased severity, second, third, fourth and higher excess layers may have also been purchased. A single loss may potentially expose any number of these excess covers.

- Per risk: Reinsurance in which the reinsurance limit and the reinsured's loss retention apply "per risk" rather than per accident, per event, or in the aggregate. With per risk reinsurance, the cedent's insurance policy limits are greater than the reinsurance retention. For example, an insurance company might insure commercial property risks with policy limits up to $10 million and then buy per risk reinsurance of $5 million in excess of $5 million. In this case, a loss of $6 million on that policy will result in the recovery of $1 million from the reinsurer.

- Catastrophe reinsurance: This cover requires more than one loss resulting from a catastrophe or series of events. For example, if only one insured building was damaged due to an earthquake, catastrophe reinsurance would not cover the claim. If multiple losses

resulted, the catastrophe reinsurance might respond, but only after application of other available reinsurance. It is generally very high level, such as xs. $100 million. It is a form of excess of loss reinsurance that, subject to a specific limit, indemnifies the ceding company in excess of a specified retention with respect to an accumulation of losses resulting from an occurrence or series of occurrences arising from one or more disasters. It generally covers multiple books of business. Catastrophe contracts can also be written on an aggregate basis, under which protection is afforded for losses over a certain amount for each loss in excess of a second amount in the aggregate for all losses in all catastrophes occurring during a period of time, usually one year. There will be two limits that the receiver will have to track: the catastrophe limits and the individual loss limits.

- Clash cover: Clash cover is a form of casualty excess of loss reinsurance under which a cedent may combine and cede the losses of multiple direct insureds, subject to a single reinsurance retention, when the losses arise from the same event or occurrence.

- Aggregate or stop loss reinsurance: This coverage applies when total losses on a group of risks accumulate to a specified retention, which may be defined as a specific amount or a percentage of premium. Generally, once the retention is reached and the aggregate or stop loss reinsurance kicks in, the reinsurance covers all risks above the designated retention.

B. Life Reinsurance Arrangements

1. Types of Reinsurance

There are three distinct types of life reinsurance: yearly renewable term, coinsurance and modified coinsurance.

- Yearly renewable term (YRT): Under yearly renewable term reinsurance, the reinsurer indemnifies only the mortality risk. The mortality risk, but not the permanent plan reserves, is transferred to the reinsurer for a premium that varies each year with the amount at risk and ages of the insureds. While YRT reinsurance allows a ceding company to transfer mortality risk, it leaves the company responsible for establishing reserves. The reinsurer becomes liable for the reinsured portion of the net amount at risk but has no cash surrender value liability. While the precise formula for determining the reinsured portion of the net amount at risk varies from treaty to treaty, in general it equals the death benefit less cash surrender value on the portion reinsured. Thus, as the cash surrender value grows from year to year, the amount of reinsurance decreases.

- Coinsurance: Coinsurance is a broader form of reinsurance, under which the reinsurer indemnifies a proportionate share of all risks under the policy. In return, the reinsurer receives a proportionate share of the cedent's gross premium, less an expense allowance or ceding commission, and is responsible for establishing reserves. Under a coinsurance funds withheld treaty, the cedent retains all or some of the reinsurance premiums as security for the reinsurer's obligations. With a reinsurer that is not authorized for credit for reinsurance purposes ("unauthorized reinsurer"), additional security is often provided by trust accounts and letters of credit for any difference between the liability of the reinsurer and the funds withheld by the cedent.

- Modified coinsurance: Modified coinsurance differs from coinsurance in that the reserves on the reinsured portion of the policy are not held by the reinsurer; instead, the reserves are held by, and are the responsibility of, the cedent. The reinsurer receives its proportionate share of the cedent's gross premium, less expense allowances. Periodically, a reserve adjustment payment is made, which is equal to the reserves at the end of the reporting period less the sum of (i) the reserves at the beginning of the period and (ii) the earnings on the reserves at the

beginning of the period. The interest element in this calculation is stated in the treaty. If the result of this calculation is positive, the payment is made to the ceding insurer, and if it is negative, the payment is made to the reinsurer. Generally, as long as new business flowing into the account exceeds lapses, the reserve adjustment will be positive.

Each of these forms of life reinsurance are documented in agreements having clauses and provisions unique to the business reinsured. Some contracts empower reinsurers to compel cedents to raise premium rates on the underlying business, which present many unique issues for receivers. Obtaining advice of competent legal counsel in such situations is important.

2. Types of Acceptance

- Automatic reinsurance: This is the most common form of life reinsurance. Automatic reinsurance enables the cedent to issue policies in excess of its retention promptly and economically. The maximum amount of reinsurance that may be ceded automatically on a particular life policy is usually a multiple of the ceding insurer's retention. In the past, the most common multiple was four, but in recent years, there has been a tendency toward higher multiples, such as six, eight or ten. Automatic treaty limits may also be expressed as a dollar amount. Reinsurers seek a reasonable relationship between a cedent's exposure and the exposure it can cede automatically to a reinsurer. It is assumed that the proper balance will provide more assurance that the ceding insurer will act prudently in underwriting a risk if it is retaining a meaningful or "material" portion of that risk.

- Facultative reinsurance: Virtually all automatic treaties also provide facultative facilities for risks that cannot be ceded automatically and for situations where the ceding insurer seeks the underwriting assistance of the reinsurer. A "facility" is an agreement setting out, among other things, the rules under which a reinsurer will reinsure risks ceded by the other party. Unlike automatic reinsurance where the underwriting assessment is made by the cedent, under facultative reinsurance, the reinsurer determines whether it will accept the risk and, if so, at what underwriting classification.

- Facultative obligatory reinsurance: These treaties are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

- Second excess reinsurance: These are automatic reinsurance treaties that are excess of an initial layer of automatic reinsurance provided by another reinsurer. For instance, a cedent might have first excess automatic cover of four times its $150,000 retention from one reinsurer plus a second excess automatic facility of two times retention from another reinsurer, permitting the cedent to issue up to $1,050,000 of insurance ($150,000 + 4 x $150,000 + 2 x $150,000) on its own underwriting authority. Second excess facilities are sometimes provided on a "criss-cross" basis by two reinsurers sharing an automatic account. One reinsurer might provide first excess cover on lives of persons whose surnames begin with any letter from A to K and second excess cover for surnames starting with L to Z. The other reinsurer would then provide first excess for L to Z and second for A to K. It is a convenient way of providing higher automatic cover when appropriate, without either reinsurer having too large a risk on any one life.

C. Financial Reinsurance

A reinsurance contract that fully participates in the insurance risk of the underlying policies and literally follows the fortunes of the ceding company, such as a simple quota share reinsurance treaty, is referred to

as traditional reinsurance. A reinsurance transaction that does not transfer sufficient insurance risk, sometimes referred to as financial reinsurance or finite reinsurance, should be accounted for separately and not commingled with traditional reinsurance transactions. (See SSAP No. 62R, Property and Casualty Reinsurance and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, for further discussion on deposit accounting for reinsurance that does not transfer sufficient risk.) Thus, reinsurance transactions that do not transfer sufficient insurance risk are still a viable tool to achieve economic goals, but must be accounted for and reported separately from traditional insurance or reinsurance transactions. See Chapter 9—Legal Considerations.

Although the authoritative language on transfer of risk is in the Statement of Statutory Accounting Principles—SSAP No. 61R for Life, Deposit-type, Accident and Health and SSAP 62R for P&C—of the NAIC's *Accounting Practices and Procedure Manual*, some jurisdictions have enacted legislation, promulgated insurance regulations, or issued insurance bulletins that address transfer of risk issues. The receiver should consult applicable or governing state laws and regulations on this subject.

D. Loss Portfolio Transfer

Loss portfolio transfers are arrangements under which an existing block of loss reserves from events that have already occurred is transferred to a reinsurer acting as retrocessionnaire, and so without privity to the insured. The loss reserves may include known case reserves, reserves for incurred but not reported (IBNR) losses, and loss adjustment expense reserves. Since the losses on casualty business are not payable until future years, the consideration for the loss portfolio transaction is calculated based on present value concepts, i.e., the time value of money. Thus, the ceding company is transferring ultimate loss reserves at a discounted value, and the transaction will create immediate income and surplus relief to such company. The essential elements in this transaction are the payout stream of the loss reserves and the time value of money. The financial responsibility of the reinsurer may be capped.

E. Pooling Arrangements

Pooling arrangements are utilized among two or more insurers or reinsurers to underwrite a particular risk or type of business. An allocation of a share of premium, loss and expense is made to each member of the pool based on the pooling agreement. Pooling can be used among either affiliated or unaffiliated companies. Pooling is common within insurance holding company systems or groups of affiliated insurers, and must be reported as such.[1]

III. INTERMEDIARIES AND THEIR ROLES

A. Reinsurance Intermediaries and Brokers

If the ceding insurer chooses direct placement, it will handle all negotiations directly with the reinsurer. However, a ceding insurer may have received the assistance of a reinsurance intermediary (also known as a broker) to place reinsurance coverage. The terms "reinsurance intermediary" and "broker" are sometimes used interchangeably. In a number of jurisdictions, the reinsurance intermediary/broker is legally considered to be the agent of the cedent; this can be reversed by the reinsurance contract.

The reinsurance intermediary facilitates the relationship by acting as the liaison between the ceding insurer and the reinsurer. The reinsurance intermediary may be responsible for documenting the activity between the parties and passing through accounts and payments between the ceding insurer and reinsurer. Should the reinsurance intermediary agree that it is to have any of these obligations, the reinsurance contract should contain a reinsurance intermediary clause. The following is a sample:

> Intermediary is hereby recognized as the intermediary negotiating this Agreement for all business hereunder. All communications (including but not limited to notices, statements, premiums, return

[1] NAIC SSAP No. 63; *see also* Statutory Issue Paper No. 97 (Finalized March 16, 1998)

> premiums, commissions, taxes, losses, loss adjustment expense, salvages and loss settlements) relating thereto shall be transmitted to Insurer or Reinsurer through Intermediary. Payments by Insurer to Intermediary shall be deemed to constitute payment to Reinsurer. Payments by Reinsurer to Intermediary shall be deemed to constitute payment to Insurer only to the extent that such payments are actually received by Insurer.[2]

For the cedent, the reinsurance intermediary finds reinsurers willing to accept the risk and helps to negotiate reinsurance agreement terms and produce documentation. For the reinsurer, the reinsurance intermediary brings proposals from cedents and administers the transaction details. The reinsurance intermediary receives a fee (called brokerage or commission), which may be deducted from the premium amounts paid to the reinsurer.

Typically, the reinsurance intermediary will place a cedent's business with one or more reinsurers. When accounts are rendered by the cedent, the reinsurance intermediary will prepare an account for each reinsurer and distribute payments to them or seek reimbursement of amounts due the cedent, as appropriate.

The insolvent cedent, possibly subject to certain limitations, may elect to change the reinsurance intermediary at any time during the treaty and need only notify, in writing, the reinsurance intermediary of its decision and its intended handling of its reinsurance in the future. The receiver should be aware; however, that such change may result in the insolvent cedent incurring an obligation to pay an additional commission. Whether such commission is subject to set-off is an issue to consider with competent legal counsel.

The ceding insurer provides the reinsurance intermediary with a broker of record letter pursuant to which the reinsurance intermediary is granted the authority to solicit reinsurers to subscribe to a program. The reinsurance intermediary then presents a package of information to potential reinsurers, compiled in coordination with the insurer, which documents the program to be written and the insurer it represents. Traditionally the reinsurance contract was rarely signed by all parties prior to the inception date of the coverage. Instead, the reinsurers signed placement slips indicating their percentage participation and containing a summary of the reinsurance coverage—limits, retention, exclusions, standard clauses to be used in the contract, etc. The ceding insurer signed a similar document but referred to it as a cover note. When the reinsurance contract was ultimately circulated for execution, each reinsurer would execute a separate signature page or I&L , binding them to the formal contract. More recently, pursuant to US and international regulations, documentation of the transaction must be executed within nine months. many brokers and direct reinsurers have been moving toward contract at placement or contract certainty, the idea being that the full contract wording is agreed upon prior to the inception date of the coverage. In such a case, there would be no need for a placement slip; rather, the reinsurer would sign the I&L page to the contract.

The reinsurance intermediary then gathers all executed slips and I&Ls and provides them to the ceding insurer, indicating that the placement has been completed and summarizing its terms and conditions. Thereafter, the reinsurance intermediary often has the responsibility to draft a reinsurance treaty based on the agreed terms.

The ceding insurer reports premiums to the reinsurance intermediary, who then prepares the necessary accounts to the reinsurer or correspondent broker, together with appropriate remittances less the reinsurance intermediary fee, which may be netted against such premiums.

The ceding insurer reports losses through the reinsurance intermediary to the reinsurer. The reinsurer pays losses through the reinsurance intermediary to the ceding insurer. In some instances, a reinsurer will make its check payable to the cedent and forward it to the reinsurance intermediary, who will simply mark his records as paid and forward the check to the cedent. In other instances, the check will be drawn in favor of

[2] Note that the last sentence of the intermediary clause reverses the general accepted rule that payment to a disclosed agent is payment to the principal.

the reinsurance intermediary, who will then be obligated to pay the cedent. Funds so paid are held in a fiduciary capacity. Most current reinsurance intermediary clauses deem payment as having been made only upon actual receipt by the cedent. For an example, see the NAIC *Reinsurance Intermediary Model Act* (#790) and New York Regulation 98.

State law following the NAIC Model requires reinsurance intermediaries to be licensed and to have written agreements with their cedents.

B. Role Upon Insolvency

The reinsurance intermediary should be immediately notified of the receivership of either the cedent or reinsurer. The reinsurance intermediary should be provided with a copy of any legal documents (insurance department letter or court orders). It is then the responsibility of the reinsurance intermediary to notify and advise all reinsurers or cedents of the status of the insolvent insurer. It may also be necessary to obtain underwriting and premium records of the reinsurance intermediary, since they are generally more complete than those of the company in receivership.

The responsibility of the reinsurance intermediary does not terminate when the insurer is placed in receivership. The reinsurance intermediary must continue to act in the best interest of the insolvent insurer, including rendering accounts and assisting in the collection of funds from reinsurers. In turn, the estate should continue to provide the reinsurance intermediary with timely claims and accounting reports that need to be rendered to reinsurers. Nonetheless, given the change in the relationship due to the receivership, the receiver may have to contemplate making a new arrangement if he/she has difficulty receiving service from the reinsurance intermediary. If not, there may be an issue whether the intermediary is entitled to assert set-off in respect of pre-receivership financial obligations that include commission(s). In that event, the receiver will want to seek advice from competent legal counsel.

IV. REINSURANCE ACCOUNTING AND COLLECTION PROCEDURES

The purpose of this section is to describe the accounting and collection responsibilities of the receiver for assumed and ceded reinsurance.

A. Introduction

For accounting purposes, reinsurance treaties are classified as either prospective or retroactive. A prospective treaty is one that covers future insurable events arising on or after the effective date of the contract. A retroactive reinsurance treaty (e.g., loss portfolio, as described above in _) is a treaty that covers past insurable events. A reinsurance treaty, whether prospective or retroactive, must transfer insurance risk. Unless insurance risk is transferred, the treaty must be accounted for as a deposit and not as reinsurance. Deposit accounting postpones recognition of revenues and income until the end of the treaty. Under the "nine-month rule," unless the full treaty wording is signed by the parties within nine months of its effective date, the accounting treatment for the reinsurance treaty must be converted from prospective to retroactive. For statutory accounting, a retroactive treaty must be excluded from the underwriting results of an insurance company and cannot be commingled with a prospective treaty.

SSAP No. 62R requires that, for a transaction to be classified as reinsurance, and to be included in the underwriting accounts of the company, the reinsurance treaty must be prospective, and the transaction must contain both underwriting and timing risk.

1. Underwriting risk is the ultimate amount of net cash flows from premiums, commissions, claims, and claims settlement expenses.
2. Timing risk is the timing of the receipt and payment of such cash flows.

SSAP No. 62R further requires that indemnification of the ceding company against loss or liability relating to insurance risk in reinsurance requires both of the following:

1. The reinsurer assumes significant insurance risk under the reinsured portions of the underlying insurance contracts.
2. It is reasonably possible that the reinsurer may realize a significant loss from the transaction.

For complex or non-traditional reinsurance contracts, present value cash flow analysis of a transaction is often prudent to determine whether significant risk has been transferred or a loss may be realized. If a transaction does not meet these requirements, then the transaction must be reported in the financial statements as non-reinsurance or as a deposit. The authoritative statutory guidance for deposit accounting is contained in SSAP No. 61R.

The receiver's primary objective should be to examine the reinsurance agreements with a view to what is best for the estate. It is possible that reinsurance agreements may be amended, terminated, rescinded, commuted or continued to meet this objective.

B. Unearned Premium Reserves

There may be unearned premium reserves related to a reinsurance treaty for some time after the termination date of the treaty, as the underlying policies have not yet reached their expiration and premiums have not been fully earned. This situation may be altered by the termination method utilized. Typically, the parties may elect to terminate a treaty on either a "cut -off" or "run-off" basis. In run-off, a reinsurer will remain liable for losses for policies in force at termination, even if the occurrences take place after the termination date. Since cut-off terminates the reinsurer's liability as of a certain date, usually with a return to the cedent of any unearned premium reserves held by the reinsurer, the period for which the reinsurer may be liable for losses may be substantially reduced as compared to a run-off provision.

C. Contractual Adjustments

Reinsurance treaties may be subject to future premium or commission adjustments based upon experience. Common adjustments are retrospective premium rating, deposit premium adjustment and reinstatement premium adjustments. The most common commission adjustments are for contingent (profit) and sliding scale commissions.

A retrospective rated premium adjustment is a calculation of the final reinsurance premium for the treaty based upon the loss experience developed during the term of the treaty. An estimated reinsurance premium, sometimes referred to as a deposit premium, is paid by the cedent until the retrospective premium is determined. The final reinsurance premium is the deposit premium plus or minus the adjustment, often subject to a minimum and maximum dollar limit.

Ceding commission adjustments represent a sharing of profits between the reinsurer and cedent and are usually associated with pro rata reinsurance. A contingent commission, or profit commission, is a sharing of a predetermined amount of the profits, if any, realized by the reinsurer from the reinsurance treaty. A formula is specified in the treaty describing how premium, losses, IBNR, expenses and commissions are calculated for determining profitability. At specified dates, this calculation is made and settlement of accounts is undertaken. No additional premium results from a contingent commission agreement. These arrangements in life reinsurance may be referred to as experience refunds.

A sliding scale commission arrangement is one in which the final ceding commission is determined by calculating the loss ratio and relating this to a predetermined range of commission rates. As the loss ratio increases, the amount of commission decreases, or vice versa, usually subject to stated limitations.

D. Ceded Reinsurance Recoverables

The initial step in establishing control over ceded reinsurance receivables is to gather and update all ceded reinsurance treaties and facultative certificates in order to create working abstracts of these arrangements. Once individual arrangements have been analyzed, a matrix of reinsurance coverages in place, by book of business, should be established so that the relationship of various ceded treaties is known. See Exhibits 7-1 and 7-2.

The most current account rendered for each treaty should be reviewed, and any open balances due to or payable from the estate should be reconciled. If the reinsurance was purchased through a reinsurance intermediary, there are likely to be multiple reinsurers. Each reinsurer and its percentage of participation should be identified and accounts verified.

Each treaty should be reviewed to determine:

- Lines of business covered
- Limits of coverage
- Dates of coverage
- Workflow and procedures needed to generate premium, losses, etc.
- Outstanding balances
- The appropriateness and method of cancellation of the coverage
- The method of termination (run-off or cut-off)
- The location and security of records underlying the placement of the treaty

Once all participants have been identified in the treaty review phase, an analysis of each reinsurer should be made to determine its financial strength. Procedures should be established to periodically monitor the solvency of reinsurers. If the financial stability of a reinsurer becomes a concern, possible commutation of the reinsurer's liability should be considered.

Treaties may contain security provisions requiring or permitting the insurer to obtain collateral for the reinsurers' obligations. If a treaty provides for letters of credit to secure the obligations of the reinsurers, the obligations of reinsurers should be reviewed and letters of credit either obtained or updated to reflect appropriate liability.

The initial step in the ceded reinsurance accounting process is to develop procedures that allow the assembly of data to produce reporting in conformity with requirements under the treaty.

Allowed claims in liquidation proceedings constitute the basis for submitting claims to reinsurers. Generally, rehabilitation follows the rules of the contract. Thus, it is important to maintain record-keeping systems that fully support the calculation of total claims reinsured.

1. Premium Processing

   In most property/casualty liquidations, the court order cancels coverage on the insurer's direct in force insurance business within 30 days of the date of the receivership. The cancellation of the underlying business terminates the need for ceded reinsurance for losses occurring after the termination date, but does not terminate the reinsurance under the treaty when the receivership is a liquidation based upon a finding of insolvency. In this event, the first consideration in premium accounting is to calculate any

unearned premium reserves that the reinsurers may be holding at the termination date and request that they be returned to the estate. There may, however, be additional premiums or adjustments to be forwarded to the estate for direct business issued and in-force prior to receivership.

Appropriate calculation of this premium should take into consideration the earned portion due reinsurers. Proportional ceded reinsurance involves a calculation of the gross earned premium that is subject to the agreement and a credit to the reinsurer's account for the appropriate proportion. The gross earned premium is subject to ceding commissions due to the estate and, in most events, may be subject to an offset for paid losses.

2. Reinstatement Premiums

Premium adjustments may become due from the insurer to one or more reinsurers as subject premium is received or loss experience develops on business that was reinsured.

Certain types of excess of loss reinsurance agreements, primarily aggregate excess of loss agreements, may provide for an additional premium to be paid to the reinsurers if the total liability limit under the agreement is exhausted by loss payments. This additional premium is known as a reinstatement premium because its payment reinstates the limit of liability of the reinsurance agreement. Reinstatement may be optional, in which case the liquidator may wish to consider whether it should be paid, or if ultimate liabilities will be reduced due to the termination of the underlying policies.

Losses from direct business may be known sooner by the receiver, and reinstatement calculations, as defined by the treaty, may be prepared more rapidly. Losses from assumed reinsurance, however, usually develop over a period of years. For this reason, appropriate controls in accounting and claims are needed to identify any aggregate losses that may be subject to recovery from reinsurers.

The relative priority of such obligations should be considered in a liquidation, and the potential for preferential transfers should be considered in a rehabilitation. Notwithstanding this, it is important for the receiver to maintain current billing practices.

3. Losses Recoverable

Losses to be recovered from reinsurers may arise from both direct and assumed reinsurance operations. It is desirable for the receiver to coordinate reporting with guaranty funds to ensure complete, accurate and detailed information. Controls over this information are required to meet the data requirements of the reinsurance agreements.

In establishing its reinsurance processing procedures, the insurer should have provided for the capture of loss balances due or owing under each treaty or facultative certificate and for each participating reinsurer. If this information does not exist, it is important for the receiver to analyze each treaty by participation to identify each reinsurer. As a result of closer monitoring, a better control over slow-paying or non-paying reinsurers should be achieved.

In addition to paid losses for which the insurer seeks indemnification, outstanding reserves for losses and expenses (and possibly IBNR calculations) are to be reported to reinsurers. Controls should exist to identify certified and unauthorized reinsurers and to monitor the collateral they should provide, as well as the potential recovery against such collateral.

E. Assumed Reinsurance

Accounts for assumed business usually represent liabilities of the estate, as most premiums, except for premium adjustments, are typically received prior to receivership. Because assumed reinsurance is not covered by guaranty funds, and assumed reinsurance generally falls within the general creditor class of the estate's distribution priorities, its accounting is often not of primary importance in liquidations unless

collateral is involved. The existence of collateral account heightens the importance for ongoing accounting and reporting in the underlying business. Whether collateral is supporting an assumed reinsurance transaction might not be clear on the insurer's financial statement, but that collateral could go back to the ceding company if the reinsurance agreement terminates. That transfer of assets could have an adverse effect on the assuming insurer. Typically, ceding companies have low priority claims in liquidation and GAs don't cover assumed (but not novated) reinsurance, therefore unwinding assumed reinsurance agreements could have an effect on the assuming insurer's financials. The insurer, however, may have purchased reinsurance protection on this business and is required to properly record and report these transactions to its reinsurers or retrocessionnaires in order to realize recoveries from them, which may be significant. Also, it is common for insurers both to assume and cede reinsurance to the same insurers/reinsurers, so that mutual accounts may need to be completed to collect balances.

The general accounting approach to assumed reinsurance is the same as that for ceded reinsurance. The receiver should obtain and safeguard all original documentation, abstract arrangements for working purposes, establish balances as of the receivership date, review each treaty and facultative certificate, develop experience histories by treaty, and assign maintenance responsibilities.

Controls similar to those used for ceded insurance should exist over assumed reinsurance reporting. If business has been solicited directly from cedents, those cedents should be informed of any reporting requirements. If, however, a reinsurance intermediary is involved, then the receiver should communicate the requirements to the intermediary, who has the continuing obligation to report to the ceding insurers.

Intermediaries often remit a net payment for the balance due, which may cause problems in the identification and allocation of payments to various cedents' balances. This becomes more of a problem in liquidations, due to possible statutory limitations on setoff. The receiver should consult with competent legal counsel and determine whether to notify intermediaries not to use net accounting or multiple treaty or reinsurer setoffs. Unless rigorous control is maintained by the receiver, the cash allocation process may become difficult.

The action plan for assumed reinsurance is:

1. Documentation
    - Obtain all treaties and update all documentation
    - Establish how treaties were assumed (direct/broker)
    - Abstract treaties into usable format
    - Update any electronic data processing systems used for assumed reinsurance
    - Prepare a matrix of the reinsurance program
2. Accounts
    - Establish latest account position by treaty and cedent
    - Verify balances with broker or cedent, if direct assumption
    - Review experience on each treaty
    - Develop plan to deal with problem accounts
    - Request any missing accounts

- Establish diary for any adjustments due on accounts
- Review documentation to ensure proper reporting of catastrophic losses and aggregate accumulations
- Establish diary control for collection of balances
    - separate responsibility for pro rata reinsurance and excess of loss reinsurance
    - set up procedures for evaluating and recording excess of loss claims

F. Reinsurance Accounting Systems

Reinsurance accounting systems can vary however most systems are web-based. In a few cases, there may be a limited accounting systems.. The type of system used may depend upon the extent and the diversification of the cedent's reinsurance program.

1. Minimum Accounting System Requirements

The reinsurance accounting system must provide information to record the subject business for reinsurance in a manner readily identifiable for each reinsurance contract. The subject reinsurance premium is computed by application of the treaty rate to the subject premium and is adjusted for premiums paid on other reinsurance treaties that inure to the benefit of the treaty.

Losses that emanate from the subject business should be identified. Once the covered losses are identified, reinsurance recoverable under each treaty is computed. If the cedent reports to a reinsurance intermediary, who in turn reports to individual reinsurers, then one summary report should be prepared and mailed to the reinsurance intermediary. If the cedent insurer reports directly to the reinsurers, then individual reports should be prepared. The ceding insurer often retains a percentage of the risk for its account. This can be accounted for on a net basis or as if the ceding insurer is also a reinsurer.

2. Inventory of Reinsurance Accounting Records

The inventory of reinsurance accounting records should be coordinated with the inventory of records for the primary accounting function. The reinsurance accounting records should include:

- Chart and summary of the reinsurance program
- Correspondence files with intermediaries
- Correspondence files with reinsurers
- Formal reinsurance contract wording
- Reinsurance slips (if a formal treaty has not been finalized)
- Signed I&L forms from each reinsurer
- Letters of credit or other forms of security from reinsurers
- Reinsurance accounting folders

The insurer may have a reinsurance accounting procedure manual available that describes the reinsurance accounting cycle and how the data necessary for the reinsurance accounting is obtained and processed to comply with the reinsurance treaties.

The chart and summary of the reinsurance program should describe the various reinsurance treaties, the business covered, and the relationship between the treaties. An individual chart and summary may be available for each reinsurance accounting year. The chart and summary change from year to year as the reinsurance program changes to meet the insurer's needs, objectives and business reinsured.

Correspondence files with intermediaries may include confirmations of reinsurers' participation, accounting reports sent to the intermediaries, or letters requesting payments or cash advances, disputing amounts recoverable, requesting collateral, etc. The reinsurance intermediary is required under the NAIC *Reinsurance Intermediary Model Act* (#790) to retain documents for 10 years. The receiver should instruct the reinsurance intermediary to retain all documents until notified that the documents are no longer needed by the receiver. If the relationship with the reinsurance intermediary is to be terminated, arrangements should be made for the intermediary to deliver all documents in its possession, or copies of the documents, to the receiver.

3. Review of Reinsurance Intermediary Records

The receiver may benefit by reviewing the systems and procedures currently being used by the reinsurance intermediary and evaluating its performance. Where applicable, various reports generated by the insurer should be compared to the reinsurance intermediary's records. When reviewing the records of the reinsurer or of the reinsurance intermediary, consider the following:

- What is the status of the treaty documentation?
- Do the balances developed by underwriting year and by reinsurer conform to the balances generated from the insurer's system?
- Has there been a delay between submission of a request for payment and receipt of the payment? This information may become part of the reinsurer evaluation process. If a reinsurer is habitually late in making payments, the receiver should determine what actions are required. The receiver may wish to have the reinsurance intermediary copy the receiver on all billing transmittals.
- While not customary, the receiver should consider a periodic review of the reinsurance intermediary (every quarter to six months). The purpose of the audit is to verify that the receiver has received complete documentation concerning its reinsurance contracts (e.g., wordings and I&Ls), the reinsurance intermediary has collected all money due from the reinsurer, and all payments received by the reinsurance intermediary have been paid to the appropriate parties.

G. Reinsurance Audits

By custom as well as by contract, reinsurers may have access to the cedents' books and records that pertain to the business reinsured. This section will briefly explain the various types of audits, the purpose of each and the information that one can expect to obtain.

Virtually every reinsurance treaty has an access-to-records clause or an inspection clause, such as, "The reinsurers or their authorized representative shall at all times have access to the books and records of the company, which pertain in any way to the business transacted under this agreement." Most facultative certificates have a similar provision. The same often holds true for agreements with pool managers, managing general agents and reinsurance managers.

Audits typically cover accounting, claims and underwriting. Many reinsurance counterparties conduct separate audits, although it may be more effective to examine all three areas simultaneously. This is especially true in those instances where the audit is being conducted as a result of a dispute or in anticipation of arbitration or litigation. (Note that a "dispute" has statutory accounting consequences, so the prudent receiver will beware declaring a dispute too soon.) The receiver needs to coordinate with the reinsurer and

any affected guaranty funds as to how the audit should be conducted and who should be involved in the audit. The prudent receiver also will negotiate a memorandum of understanding or non-disclosure agreement that summarizes the intent, scope and logistics (onsite vs. remote access, hours and location(s)) for any audit, which may include, e.g., provisions governing confidentiality, admissibility in a dispute resolution foruam, etc.

Except in unusual circumstances, the auditors may be limited to review of records directly related to the business their clients assumed. They are generally allowed to review original records together with the cedent's and receiver's summaries of experience, to the extent those are prepared in the normal course of business. However, auditors should be denied material prepared in anticipation of litigation or preparation for trial, and in particular they should be denied access to communications to and from counsel retained in connection with reinsurance collections. These materials should be kept in files separate from the underlying claims and underwriting files. Auditors generally do, however, receive access, under appropriate safeguards to preserve confidentiality, to communications to and from claims counsel.

An important consideration is who needs to be present during an audit, from both the audting and audited sides.

1. Accounting Audit

The primary scope of this review focuses on verification of the periodic reporting (monthly, quarterly accountings) of the cedent. Although the bulk of the audit will be conducted at the cedent's offices, a significant amount of work, such as the following, may be conducted prior to that time.

- Review terms and conditions of reinsurance contracts, such as:
  - coverage (type of reinsurance contract, limits, underwriting restrictions, classes of risk and territory)
  - reinsurance period (including cancellation and termination provisions)
  - reporting and settlement
  - definitions
  - procurement of common account protection
- Review cedent's recent financial information, including:
  - financial statements
  - independent auditor's reports
  - financial reports filed with the Securities and Exchange Commission or similar authorities
  - financial statements filed with insurance regulatory authorities
  - other insurance department regulatory reports

A schedule of accounts and settlements between the assuming company and the cedent, according to the reinsurer's documentation, should be prepared to verify the balance outstanding on the account. This analysis should then be compared to a similar schedule from the cedent's records. The results can be used as a source of further investigation, if necessary.

Copies of the cedent's procedural manuals for accounting, claims, reinsurance, and audit should be obtained, reviewed and stored.

Documentation on hand should include the most recent experience reports on the program. Investigation should be made into significant deviations from normal business custom and practice. If desired, a comparison to similar programs with other cedents may also be made.

Comparison of such data to actual historical information, especially in the areas of premium volume and loss experience, may be performed to help determine the scope of the audit required.

Prior to inception of the audit, which maybe in person or remote, a list of information and documentation required for the audit should be submitted to the cedent to facilitate its availability. The documentation that may be requested would include digital/electronic, read-only access to document sharing systems, and/or printed copies of:

- Premium and claim registers for originating business (primary or assumed)
- Individual policy and claim files to support registers for originating business
- Premium and claim registers for ceded business
- Individual policy and claim files to support ceded registers
- Accounts and bordereau from the cedent
- Cash receipt and disbursement records (including checks, cash journals, ledgers) applicable to settlement of premiums and losses for originating and ceded business
- All contracts relating to managing general agents, brokers, intermediaries and common account protection for originating and ceded business
- All documentation and support relating to letters of credit, trust accounts and funds withheld

Although generally not specified in the inspection clause, the auditors should have reasonable access to personnel involved in the preparation of any of the cedent's documentation pertinent to the audit procedures.

Having completed review of the pre-audit documentation and assuming the availability of all required information at the cedent's office, the audit may:

- Trace information on originating premium and claim registers through the reports to assuming reinsurers.
- Determine relationship of premium and claim registers for originating business (primary or assumed) to ceded premium and claim registers.
- Verify accuracy of reinsurance accounts and the existing control procedures for preparation of accounts to assuming reinsurers based on review of originating and ceded premium and claim registers.
- Analyze cash records in conjunction with accounts to assuming reinsurers to determine balance due from or to cedents;
- Verify timeliness of reporting and settlement of accounts.

- Sample policy files (reinsurance contract files for assumed business) and claim files from premium and claim registers to verify that:
    - policies are in agreement with treaty terms relative to class of risk, period, limits and other provisions.
    - premium allocations for policies are proper, as are all commissions and other deductions.
    - claims are adequately documented and fall within the policy conditions.

Irregularities encountered in any of the above may be referred to the appropriate staff member of the cedent for resolution of the problem.

This is a simplified outline designed to establish a pattern for the audit. These general steps may not apply to the same degree in all instances. Individual audit programs should be geared to address the needs of the situation, contingent on the nature and volume of the business, as well as the auditor's evaluation of control systems in place.

2. Claim Audit

The ceding insurer should have adequate control procedures in place to allow the assuming insurer to make a determination on the accuracy and validity of the claim information it receives, as well as to assess the competence of the cedent's claims personnel.

- Claims procedure. Preliminary examinations of claim procedures, as outlined in the cedent's current and any prior claims manual(s), should be performed prior to the on-site review. Prior to the examination, a list of documentation required, including the following, should be requested:
    - Claim staffing, including description of positions
    - List of outside vendors, including adjusters, defense/claim attorneys and others
    - Claim control log
    - Claim registers, including aged listing of outstanding claims and salvage and subrogation registers
    - Claim files and related policy/assumed contract files
    - Cash records applicable to claim and expense payments

Assess the Claim Staff. An analysis of the claim control log, claim register and aged listing of outstanding claims, along with the claim handling and diary system procedures outlined in the cedent's claim manual, should be indicative of the adequacy of staffing levels. Discussion with the appropriate claim personnel and review of the claim manual should indicate procedures used to assign claims to outside adjusters and the follow-up procedures used to keep the status on claims current.

A random sampling of claims from the loss registers should be made to determine files to be examined for the remaining portions of the audit. If specific areas or claims are suspect, these files can be requested and examined in addition to the random sample.

- Claims review generally will include the following:

- Determination of adequacy of file documentation, including notice of loss, adjusters' reports, attorneys' reports,[3] litigation releases and proofs of loss (including reinsurance notices)

- Verification of coverage of originating policy and reinsurance agreements as to term, risk, limits and other provisions

- Reconciliation of payments (loss and expense) to claim filed documentation

- Determination of third-party recoveries (salvage, subrogation, third-party deductibles and other reinsurance)

Claims accounting may require special attention. The auditor will want to verify the correctness of claim allocation by sampling allocation by claim registers and the cedent's retention. In some instances, a review of the claim registers for originating and ceded business may disclose problems in claim allocation.

3. Underwriting Audit

An underwriting audit conducted by the receiver of an insolvent company may differ from that performed by a reinsurer contemplating a continuing relationship with an insolvent cedent. Some vital areas that may be considered during such audit include verification that:

- Premium volume is within guidelines outlined in the reinsurance agreement, if any.

- Controls are in place to determine effective and complete reporting of premiums.

A sample of policy files may be selected (or the policy files that correspond to those used in the accounting or claims audit should be reviewed) to determine whether:

- Risks written conform to the specifications of the reinsurance agreement relating to class of business, types of coverage, exclusions and other warranties.

- Risks written conform to underwriting guidelines.

- Underwriter's approval has been properly executed in accordance with the reinsurance agreement and any related underlying agreement (e.g., managing general agents, brokers).

- Policy endorsements alter reinsurance obligations.

- Premiums have been properly developed to include reporting forms, business subject to audit and retrospectively rated business.

Auditing counterparties typically prepare summaries of their findings. The receiver will want to request and receive a copy of any such report.

4. Handling Audits of Receiver's Records

Because of the receiver's activity in collection of reinsurance balances claimed due, the receiver frequently receives requests for audit of his or her own records and those of the insolvent company. Allowing an audit is an important step in the ultimate collection of the insurer's reinsurance recoverables, but care should be taken that the audit process neither creates new defenses for reinsurers,

[3] Whether the reinsurer is entitled to these reports is the subject of frequent litigation, and the receiver should seek legal counsel before providing or not providing these reports.

disrupts the receiver's own efforts to manage claims and assets, nor violates any applicable statutory confidentiality provisions.

a. Preconditions to audit

After taking possession of the insurer, the receiver is entitled to adequate time to gain control and understanding of the insurer's affairs and records before being subject to audit by reinsurers. Reinsurers may make preemptory demands for audit well before the receiver can respond. The receiver should assure the reinsurer that it will have an opportunity to audit as soon as the receiver has had sufficient time to become familiar with the records he or she has inherited.

The receiver should consider developing a standard audit procedure to be followed. Once the receiver in consultation with triggered guaranty funds is prepared to schedule an audit by the reinsurer(s), several dates should be requested from the auditor, so that the receiver and guaranty funds have the opportunity to ensure availability of requested claim files, crucial staff and space, and possibly counsel. The receiver needs a firm commitment from the auditors as to the time required for completion of the audit, especially where the claims requested include claims that are open and ongoing with guaranty funds.

To facilitate the audit and ensure document control, the receiver should request a list from the auditor of all files to be reviewed. The receiver should contact affected guaranty funds and arrange for file shipment. The receiver should send a letter to the auditor outlining the procedures to be used for the audit and identifying the liaison between the auditor and the company. The receiver should also have the auditor and the reinsurer sign a confidentiality agreement before the audit to protect the interests of the estate and the insured.

b. Preparations for audit

The auditor may be asked to designate in advance the records to be reviewed, so that they can be located and retrieved. Someone on the receiver's staff or counsel is usually designated to become familiar, if they are not already, with the history, terms, accounts and major issues arising from the business being audited, and to serve as principal liaison between the auditors and the receiver. Arrangements should be made to provide the auditors with a designated space, ideally a separate room, to which records can be brought as requested. Control over records produced for the auditors is essential. Arrangements should be made to have copies (and/or screen shots of electronic or digitally stored material) made, at the reinsurer's expense, of any records or documents they designate, and the receiver should keep track of what is copied. Pricing and availability of copying services should be discussed with the auditing company.

c. Conduct of the audit and follow up

Members of the receiver's staff not personally involved in the audit should be advised that an audit is being conducted, and reminded that requests for information from auditors should be in writing and referred to the designated liaison to ensure correctness and consistency of the information provided.

The receiver should request, and often will receive, a copy of the auditor's findings at the conclusion of the audit.

H. Managing Assumed Reinsurance

Even though assumed reinsurance claims have a lower payment priority in liquidation, maintaining and processing assumed reinsurance claim activity may be vital for setoff purposes, to develop satisfactory support for any retroceded reinsurance that the insolvent insurer may have purchased, and to ensure that existing funded security is not improperly drawn down. Preparation of a schedule of reporting due dates for each assumed reinsurance treaty is helpful.

Pro rata reinsurance loss activity will be reported in a summary of all losses on individual policies reinsured. This summary report, or bordereau, should be accompanied by individual policy identification and loss data.

Initially, a reconciliation of the proofs of loss submitted by or on behalf of cedents may be undertaken with the physical inventory of pending or unprocessed assumed reinsurance claims. The receiver's staff should establish procedures so claims submitted by cedents conform with the terms of the reinsurance treaty, including dates of loss, coverage impacted such as lines or classes of business, and types of risks reinsured. Questions or problems may be referred to the reinsurance intermediary or cedent as appropriate.

Next, all assumed claims should be reviewed to ensure that they are being reported to the reinsurer in a manner consistent with the requirements of the reinsurance agreement, including issues of coverage, claim support, and timing of reporting. Each reported loss should also be reviewed to ensure there is an appropriate reserve. The receiver's staff should develop additional case reserves if required and, if appropriate, notify reinsurers and retrocessionnaires. The retrocedent should consider doing the following:

- Review (all) incoming loss advices.
- Match loss advices with treaty or facultative certificates.
- Confirm coverage.
- Create a file and enter data, calculating the appropriate share of paid and outstanding.
- Maintain a diary system, either manual or(preferably) electronic.
- Identify all applicable retrocessional treaties and transmit timely notice based on respective terms and conditions.
- Request updates, pertinent information, and documentation through the intermediaries as needed.
- Establish format for closing and eventual purging and storage, pursuant to applicable law and any litigation holds(s).
- Confirm that catastrophic losses are identified and reported (these should be accumulated with potential retrocessional recoveries in mind).
- Review each loss in detail and post any additional case reserves deemed necessary.
- Inquire as to any inuring reinsurance or common account.
- Monitor cedents' pursuit of subrogation, salvage, and other recoveries.
- A separate file is usually required for each facultative certificate or excess of loss treaty, and a separate claim file for each loss under a certificate or treaty may be desirable.
    - For pro rata reinsurance treaties, a single file encompassing one underwriting period should suffice, provided the bordereaux are informative enough for the technical staff to verify coverage.
- If annual aggregate coverage is involved, a system-produced report is helpful for tracking aggregate exhaustion.
- Develop forms for all the above.

I. Managing Ceded Reinsurance Collections

1. Direct Claims and Guaranty Funds

A primary consideration for the receiver is to prepare for the collection of ceded reinsurance for claims that will eventually be allowed by the liquidation court. To that end, the receiver should:

- If necessary, in addition to Uniform Data Standards (UDS), develop a reporting system to be used by the guaranty funds that conforms to the requirements of the insurer's reinsurance agreement(s).
- Reconcile the insurer's records to periodic reports from the guaranty funds.
- Promptly and adequately document the handling of direct claims that are not covered by guaranty funds so as to be able to notify and bill reinsurers
- Ensure there is adequate control over any claims settled at an amount in excess of the guaranty funds' statutory limits.
- Ensure that the guaranty associations are handling claims properly. This is generally done by audits of the associations.

2. Reports

Accounts rendered should be on forms mutually agreed upon by the cedent and reinsurer, and payments from the reinsurers should be made within the payment terms required by the treaty, without diminution because of the insolvency of the cedent.

The different forms of reinsurance contracts may have different reporting requirements. Because the reinsurer is not required to pay a loss unless the information to support the cedent's payment has been received, it is prudent that the receiver deliver this information as soon as possible. Developing this information often requires coordination with guaranty funds.

3. Insolvency Clause

A reinsurer is obligated to reimburse its ceding insurer for a covered loss after the cedent pays or becomes liable or responsible for underlying loss. This arrangement functions well in ongoing business; however, historically it raised practical problems when the ceding insurer became insolvent. Given the indemnity nature of a reinsurance contract, the receiver often could not demand the reinsurer pay its portion of covered claims until the receiver had paid the underlying claims. Typically, the receiver of a ceding insurer was not able to pay such claims prior to receiving the reinsurance payments and, therefore, had difficulty recovering reinsurance receivables.

In 1939, the New York legislature passed a law requiring that all reinsurance contracts contain an "insolvency clause" if the cedent desired to receive credit for reinsurance. Following the 1939 law in New York, many states enacted a similar requirement, and all states now require some type of insolvency clause, which comes into effect if the ceding insurer is found by a court to be insolvent in an order of liquidation. The insolvency clause obligates the reinsurer to pay recoveries it owes under the reinsurance contract on the basis of the ceding company's allowed claims, not on the basis of whether the insolvent cedent has actually paid the money it owes its policyholders.

Most courts recognize that the main purpose of the insolvency clause is to ensure that a receiver has the requisite access to reinsurance funds.

There may be unusual instances where the reinsurance contract does not contain an insolvency clause, but the contract provides that its interpretation or enforcement is subject to applicable state law (typically the ceding insurer's state of domicile). Many state insurance laws provide that a reinsurance contract must contain required terms before the ceding insurer may claim reinsurance credit for the reinsurance, and one of the required terms provides that the contract must contain insolvency clause language. Thus, a receiver should also determine if the applicable state law requires that reinsurance be paid without diminution because of the ceding insurer's insolvency, as this state law may allow for recovery in situations where an insolvency clause is not otherwise available for the recovery of reinsured claims.

4. Notice to Reinsurers

The insolvency clause usually provides that the reinsurer shall be given notice of the pendency of each claim against the company on the policies insured within a reasonable period of time after such claim is filed in the insolvency proceeding. The clause also provides that the reinsurer has the right to investigate each such claim and to interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defenses which it may deem available to the company or its liquidator.

V. TERMINATION OF REINSURANCE RELATIONSHIP

There are five principal methods for terminating a reinsurance relationship: commutation, cancellation, novation, rescission, and by operation of law. Before a receiver uses any of these methods, careful consideration should be given to whether the financial consequences will benefit the insolvent insurer and, consequently, the creditors. By assessing the potential benefits, a receiver will be able to prioritize efforts. If a receiver is considering terminating a reinsurance relationship in a life/health insurer liquidation, the receiver will need to coordinate with the affected guaranty associations. As noted above, both IRMA §612 and §8(N) of the NAIC's Life GA Model Act, as adopted in state laws, provide the life and health insurance guaranty associations the right to elect to continue and assume the rights and obligations of the ceding insurer with respect to reinsurance contracts that relate to guaranty association covered obligations, subject to the requirements set forth therein.

A. Commutation

A commutation is simply a mutual release from a contract in exchange for consideration. The mechanics of a loss commutation are that the reinsurer, by a cash payment to the cedent, discounted to present value, removes the outstanding reserves and IBNR from its books. The result on the cedent's books is that its surplus decreases by the amount of the difference between the cash received and the undiscounted reinsurance recoverable; the reinsurer's surplus is benefited in the same amount.

Commutation may be viewed as a special type of cancellation or as a means of ending the relationship after cancellation has occurred. Note that the New York Insurance Law requires commutation clauses to be included in life reinsurance agreements.

1. Commutation During Rehabilitation

It may be advantageous for the receiver to commute assumed business of an insurer or reinsurer in rehabilitations. Under certain circumstances, commutation could permit the receiver to expedite billing and collection from its reinsurers and retrocessionnaires. The alternative is to allow claims to remain open for an extended period, increasing the administrative burden and expense for both the receiver and the cedents. Note that the insolvency clause may apply, especially in property/casualty

Likewise, the receiver in rehabilitation may find a benefit in offering to commute outstanding losses with its reinsurers. There may be factors, such as knowledge of the weakened financial condition of a reinsurer, a desire to quantify IBNR relating to long-tail casualty business, or the ability to obtain immediate cash, which need to be considered when commuting with reinsurers and retrocessionnaires.

Early commutation may benefit the estate by bringing in cash and avoiding controversy and delay in collection. The receiver is unlikely to be as concerned as an insurer outside of receivership would be, with the loss of surplus inherent in discounting loss reserves to present value.

2. Commutation During Liquidation

Commutation of assumed business by an insolvent reinsurer is the equivalent of determining creditors' claims but may raise questions of priorities or preferences to creditors in rehabilitation as well as liquidation, because commutation terms may require immediate payment to a creditor class which otherwise may not share in distributed assets until a later date, if at all. Commutation of an insolvent insurer's ceded business should involve consideration of the factors discussed above for the commutation of ceded business by an insolvent insurer in rehabilitation. The receiver should consider the advisability or necessity of obtaining receivership court approval of commutation agreements.

The NAIC *Insurer Receivership Model Act* (#550) (IRMA) contains provisions regarding commutation of a reinsurer's liabilities. Sections 614 and 615 of IRMA allow a receiver to commence mandatory arbitration of commutation proposals after a certain amount of claims development or in the case of a reinsurer in financial difficulty (as defined by the state's RBC provisions). Section 614 requires receivership court approval for commutations having a gross consideration in excess of $250,000.

The provisions of IRMA outline the procedures, rights and duties of both receivers and reinsurers in the arbitration process and allow the formation of a reinsurance recoverable trust for the satisfaction of any arbitration award. State law should be consulted to ensure compliance with the specific applicable details.

3. Technical Aspects

a. Data

A successful commutation requires complete, accurate and current data. Therefore, the receiver of a ceding insurer should update loss and premium figures in collaboration with respective state guaranty associations and reinsurance intermediaries before attempting a commutation.

The receiver of a reinsurer is largely dependent on information provided by the ceding insurers and reinsurance intermediaries. As a result, the receiver should consider conducting an on-site review or audit of the cedent's records relative to the program or treaty in question. The purpose of the examination is to ascertain that the reinsurer's accounts accurately reflect the business that was or should have been ceded.

b. Evaluate Future Loss Development

Future loss development is necessary to estimate the cost of the commutation. Actuarial staff should provide the calculation. Three basic steps are involved:

- Project reported outstanding and IBNR losses to ultimate incurred commensurate with the risk reinsured (e.g., auto v. general liability and/or asbestos).
- Project the timing of payment of losses to ultimate incurred.
- Calculate the net present value of ultimate incurred losses based on anticipated payment dates. If the parties can agree on a net present value, that becomes the commutation figure.

B. Cancellation of Reinsurance Treaties

1. Term Treaties

The majority of facultative reinsurance agreements and some reinsurance treaties have a fixed termination date, often an anniversary of the date of inception. Nothing need be done to end coverage as of that date; it simply expires. These contracts often may be canceled as of an earlier date with 60 or 90 days' written notice to the other party, or as specified within the terms of the reinsurance agreement. Cancellation, however, does not usually end the reinsurance relationship, which continues until all claims are submitted and paid, particularly in respect of business written on an occurrence basis.

Non-life business in force at the date of receivership, including assumed reinsurance, is usually terminated within 31 days of the receivership order. Some categories of reinsurance agreements are difficult to terminate midterm (such as aggregate excess of loss and stop loss reinsurance agreements), due to loss accumulation period requirements under the contractual provisions. Under a rehabilitation proceeding, however, the receiver would have the option of continuing in-force reinsurance business during an appropriate run-off period instead of effecting a cut-off or early cancellation date.

2. Continuous Treaties

Most obligatory treaties and some facultative agreements have no fixed termination date and continue until terminated by one of the parties. Often, these agreements may be terminated by written notice 90 or 120 days prior to an anniversary of the inception date, or as defined by the reinsurance agreement.

3. Notice of Cancellation

While the form of the notice of cancellation is usually stated in the reinsurance agreement, there are certain aspects to the cancellation process that are not as obvious. The prudent receiver will consult competent legal counsel on the legality and/or effectiveness of a receivership triggered termination. Reinsurance treaties, both term and continuous, are reviewed annually in what is known as a renewal process. Either party may issue a provisional notice of cancellation while renewal negotiations continue. The provisional notice can be withdrawn once a new agreement is reached. Another means of accomplishing the same purpose is for the parties to agree to a reduced period for notice of cancellation.

4. Cut-off vs. Run-off Cancellation

Facultative reinsurance is generally coterminous with the underlying policy. Treaty reinsurance generally applies to policies incepting during its term, and therefore continues to apply as long as the underlying policies have losses reported the underlying policies are often canceled by a liquidation order, but claims will continue to be reported). This is referred to as "run-off." The receiver may also elect to cancel treaties on a "cut-off" basis, pursuant to which the reinsurer returns any unearned premiums and has no responsibility for losses that occur after the treaty terminates.

C. Novation

1. Definition

In novation, a new insurer is substituted for the existing insurer, and the insured must look to the substituted insurer for performance and must pay premiums to the substituted insurer. In a reinsurance context, the principles remain the same, although it should be a three-party agreement between the cedent, the reinsurer and the original policyholder.

Insurance terminology tends to call a novation "assumption and reinsurance." This term is more descriptive of implementation techniques but is inaccurate even in this limited role. The novation

usually takes the form of a reinsurance treaty but one with an unusual feature. Not only does the reinsurer assume 100 percent of the risk, the reinsurer also is substituted for the original insurer. It is the latter feature that distinguishes a novation from a reinsurance transaction.

2. Use of Novation

The principal purpose of a novation is to move an existing book of business from one insurer to another. Novation may be more efficient than having the original carrier not renew the business while the new insurer is soliciting the same insureds. Regulatory limitations on nonrenewal of certain lines of business and consumer protection may be primary reasons for novation.

3. Practical Difficulties

Traditionally, a novation requires the consent of all parties to the contract, the insured, the original insurer and the reinsurer. Some states exempt assumption/novation transactions in the context of a rehabilitation or liquidation from the policyholder consent requirement. It may be difficult to obtain the actual consent of thousands of policyholders who may not understand the process and who may not be sufficiently interested. There is considerable debate as to the level of notification and consent necessary for a novation. Some insurance departments have required mass mailings to insureds explaining the transaction and offering the opportunity to object or decline novation. However, in a receivership, a transfer of business can often be arranged under the receivership authority statute and/or the order of the receivership court.

4. Bulk Transfer Distinguished

In general, a bulk transfer is the reinsurance of all or substantially all of a book of business. Often, a bulk transfer requires notice to the cedent's state of domicile. A bulk transfer may or may not involve a novation, and a novation may or may not involve all or substantially all of an insurer's book of business. The difference is whether the prior reinsurer continues to retain any liability or ongoing obligation.

D. Rescission

1. Definition

It is important to distinguish "rescission" from "cancellation." Cancellation means to terminate the unperformed portion of a treaty. Rescission restores the parties to their original position prior to entering into the treaty. Rescission is a remedy available only under limited circumstances.

2. Technical Aspects

Typically, general contract principles apply to reinsurance contracts. Under general contract principles, rescission may be obtained by mutual consent of the parties, by a party that has been injured by acts of the other, or through litigation or arbitration proceedings Generally, reinsurance agreement rescissions occur because a party contends it has been defrauded or damaged. Most disputes arise because the reinsurer believes the cedent has made material misrepresentations respecting the nature, quality or volume of the business ceded. In these cases, a complete accounting or a reconstruction of accounts for the contract period may be required.

E. By Operation of Law

In some states with enabling legislation, insurance business may be transferred by operation of law. Since 2000, reinsurance counterparties in the EU have been able to transfer direct and assumed insurance

portfolios with continued coverage for re/insureds and a full release for the transferor without completion of either a novation process or concomitant opt-in/out rights for re/insureds. In the US insurance market, a small number of states offer one or both of the following two alternatives: insurance business division and insurance business transfer. Coordination regarding policyholder rights in other jurisdictions and other state laws is an important aspect that is receiving ongoing study in US Insurance regulators. See meeting materials, exposure drafts, and other documents of the NAIC Restructuring Mechanisms Subgroup[4] for updates in this area.

Business *division* (e.g., in Arizona, Connecticut, Delaware, Georgia, Illinois, Iowa, Michigan, Pennsylvania[5]) offers companies the ability to divide business operations into two or more entities upon the approval of the regulator; business *transfer* is effected via novation following judicial approval (e.g., in Rhode Island, Vermont and Oklahoma[6]); both mechanisms have regulatory and judicial components.

Oklahoma approved the first transfer in an intra-group transaction and Illinois approved the first US division, also in an intra-group transaction. Each of these is highly specialized, and review of the requirements to effect in, and/or the impact upon, a receivership should be undertaken with the advice of competent legal counsel.

VI. SETOFF

A. Overview

Setoff is a device that permits two contracting parties to net reciprocal debt obligations and pay only the remaining balance. It is an important element of any receivership. Setoff is an area of considerable controversy, and it is important to develop an effective approach for handling the various issues that will arise because of its application. It is important to begin this approach early in the receivership with a careful analysis of the applicable provisions of the governing receivership state law. Note that there are/may be unique issues arising from the organizational structure of counterparties; e.g., policyholder-owned reinsurers, fronting insurers, captives (including "pure," hybrid, and series captives), and special purpose vehicles. For example, "triangular" set-offs are not permitted. Thus, where A owes B, C owes A, and B and C are affiliates, A may not lawfully set off what it owes B against what C owes A.[7]

B. Recoupment and Counterclaims

The concepts of setoff, recoupment and counterclaim are often confused. Although each provides a means by which a debtor may attempt to limit the net amount of a creditor's recovery, it is important that the receiver have a basic understanding of the distinguishing features of each procedure, as well as the central concept of "mutuality" (and potential differences imposed by varying priorities of asset distribution) which are discussed in Chapter 9—Legal Considerations.

C. Procedural Steps in Administering Setoffs

The receiver should review the governing receivership state's current statute relating to setoff, and determine the past practices and procedures that have been utilized within the jurisdiction. It would also be prudent to review any court rulings and decisions relating to setoff to determine their applicability to various

[4] https://content.naic.org/cmte_e_res_mech_sg.htm
[5] *See, e.g.,* 215 ILL. COMP. STAT. 5-35B.
[6] *See, e.g.,* OKLA. STAT. tit. 36, § 1681-8
[7] *In re Orexigen Therapeutics, Inc.*, 990 F.3d 748 (3d Cir. 2021).

issues that may arise. The reinsurance agreement may also have provisions relating to setoff, although they may not override applicable statutes.

Once the receiver has elected a course of action for handling setoff issues, written policy and guidelines should be prepared, and coordinated with and reviewed by counsel. The receiver may file the setoff policy and its guidelines with the receivership court and communicate as soon as practicable to cedents, reinsurers, intermediaries and other interested parties.

It may also be necessary for the receiver to audit or review reinsurance account statements, including payments received and processed earlier by the receiver's internal staff, to ensure that there is a consistent application of the mandated setoff procedures. If it is determined that improper setoffs are being applied, communications to appropriate parties should be initiated, and if the matter cannot thereafter be mutually resolved, the receiver should consider mediation, partial or total rejection of a proof of claim, or appropriate legal action, including arbitration and litigation.

Some receivers require details about claimed set-offs to be included in proofs of claim.,

D. Setoff Against Insolvent Insurers and Reinsurers

To determine if the receiver has a right of setoff against an insolvent insurer or reinsurer, the insurance law of the state of domicile of the insolvent insurer or reinsurer may be applicable and therefore will need to be reviewed. It will be necessary to determine whether the receiver will be able to assert setoff under the other insolvent's domiciliary state laws. See Chapter 9—Legal Considerations.

VII. ARBITRATION CONTROVERSIES

An insolvent insurer will likely be involved in dispute resolution. There will be looming questions, however, of how the resolutions will occur, how the disputes will be resolved, how long they will take and how much they will cost. These are questions a receiver will face on a regular basis.[8]

The insolvent insurer has various options in settling disputes: negotiation, mediation, arbitration and litigation. As a general rule, negotiation is the fastest and least expensive option, and litigation is the most costly and time consuming.

Many reinsurance agreements contain clauses that require parties to a reinsurance agreement to resolve their disputes through arbitration. When one of the parties is in receivership, the issue of whether reinsurers may compel arbitration or are required to resolve their disputes in the receivership court is governed by local law.

A majority of reinsurance agreements provide for arbitration as the sole means of resolving conflict. Most courts, including the U.S. Supreme Court, favor enforcing agreements to arbitrate, but a small number of jurisdictions have held otherwise.Historically, arbitration awards were forthcoming much sooner than a similar decision from a court of law. The result was usually less expensive than litigation and had other advantages, such as being a confidential process, having expert triers of fact, offering broad ranges of relief, and other procedural and substantive benefits. However, there is no right of appeal *per se,* and successful challenges to arbitral awards are difficult to moiunt.

Arbitration rights within reinsurance agreements are enforceable under Section 105E of the NAIC *Insurer Receivership Model Act* (#550). If there is a balance payable to the receiver after offsets are considered by the arbitrator, that balance must be paid in cash. If, alternatively, the balance is in favor of the reinsurer, that balance becomes a claim against the insolvent insurer to be paid pursuant to the priority scheme, pro rata, when the insolvent insurer's assets are distributed.

[8] This is a very cursory discussion—please refer to the Legal Chapter for a detailed analysis of this subject.

VIII. LETTERS OF CREDIT

A. Nature of the Letter of Credit in Reinsurance Transactions

In general terms, the letter of credit (LOC) is an undertaking by a bank as issuer to honor a draft drawn upon it by a beneficiary (the cedent) in accordance with the terms of the LOC. The LOC is issued by the bank at the request of a the reinsurer, in furtherance of a separate agreement between the reinsurer and the ceding insurer. Reinsurers may also be beneficiaries of LOCs provided by cedents to collateralize future premium payment obligations and ensure financial statement credit.

The bank is obligated to pay on the LOC when the beneficiary presents a sight draft that complies on its face with the terms of the LOC. In many jurisdictions, compliance with the LOC terms must be exact to trigger the bank's payment obligation. In some jurisdictions, substantial compliance is sufficient to trigger the bank's payment obligation. The bank should not look at whether the underlying reinsurance agreement was properly performed before it pays on the complying sight draft. Any contractual disputes between the account party and the beneficiary involving the reinsurance agreement remain separate from the issuing bank's obligation to pay under the LOC.

In the insurance industry, LOCs are frequently used to enable the reinsurer to secure their obligations to the cedent under reinsurance agreements so that the cedent may take credit for the reinsurance on its financial statement, either as an asset or as a deduction from liability. This is permitted under the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786).

In the event of a failure of the reinsurer to fulfill its obligations under the reinsurance agreement, the cedent may draw down the LOC. The issuing bank must honor such a demand, unless the demand documents are forged or are otherwise tainted by fraud, or there was fraud in the underlying transaction. These exceptions must be distinguished from mere commercial disputes between the parties, which, as noted above, do not impact the bank's obligation to pay on a complying sight draft.

B. Basic Features of the Letter of Credit

The Credit for Reinsurance Model Law and Regulation are an accreditation standard, and as such the provisions for LOCs in each state's laws must be substantially similar. LOCs supporting reinsurance with certified or unauthorized must be "clean" (that is non-"documentary" under which certain evidence may be required), meaning the LOC must be payable on a sight draft without any supporting documents, and the LOC must be irrevocable, meaning it cannot be terminated prior to expiration by the account party without the beneficiary's consent.

Acceptable LOCs are required to contain an evergreen clause, which requires the bank to give specified advance notice (usually 30 days) of non-renewal to the beneficiary/cedent. Failure of the bank to serve notice of non-renewal prevents expiration, resulting in an automatic renewal of the LOC. On the other hand, non-renewal of the LOC while balances remain due to the cedent is grounds for the cedent to draw down the LOC.

In addition to these basic features, the bank issuing the LOC must meet certain standards in accordance with Model #785, Section 4. Other states require that the LOC be issued or confirmed by either a domestic bank, a foreign bank licensed in the United States, which is either on the NAIC Securities Valuation Office (SVO) list.

C. What Should a Receiver Know About LOCs?

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the LOCs and list them in accordance with the treaties collateralized and expiration dates. Any evergreen clauses should be noted on treaties under notice of cancellation.

Counsel should be consulted to confirm that the receiver has the power to draw down the LOCs, or if the receiver does not, this power should be immediately obtained from the supervisory court.

It is recommended that a receiver notify each issuing bank that the cedent is in receivership. The receiver should take whatever steps are necessary to ensure that only the receiver is empowered to draw down the LOCs and that the receiver will receive notices of non-renewal. The receiver should seek to have the LOC amended to change the name of the beneficiary to the estate.

Each reinsurer should be advised by the receiver that it must maintain the outstanding LOCs in accordance with the terms of the specific reinsurance agreement.

Once the above steps have been taken, the receiver should verify the liabilities secured by the LOCs. If an LOC is about to expire and leave outstanding obligations unsecured, the receiver should notify the reinsurer to renew the expiring LOC. If the reinsurer does not agree to renew, counsel should be consulted on the appropriateness of drawing down the LOC to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify all of the LOCs issued on behalf of the reinsurer and list them in accordance with the contract collateralized and expiration date. If any notices of termination have been issued pursuant to evergreen clauses, these should also be listed. Finally, if any collateral has been posted with an issuing bank to secure the LOC, the receiver should properly identify such collateral.

It is also recommended that a receiver notify each issuing bank that the reinsurer is in receivership, and identify the receiver to confirm that only the receiver is authorized to give the bank instructions with respect to the LOCs, which would normally be given by the account party.

The receiver should also communicate with all cedents in whose favor banks issued LOCs on behalf of reinsurers so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the LOCs will be maintained in accordance with the reinsurance agreement. The receiver should also take whatever steps are necessary to ensure that the LOCs will not be improperly drawn down.

Once the receiver properly identifies all of the outstanding LOCs and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the LOCs in order to protect the reinsurer's position by preserving its collateral. The receiver should ascertain the liabilities secured by the LOCs and guard against wrongful draws by cedents against the outstanding LOCs. A danger also exists that the collateral posted will be wrongfully used by the bank to gain a preference on other, unsecured debts allegedly owed to the bank by the reinsurer. The receiver can also protect the reinsurer's position by depositing any interest earned on collateral into the reinsurer's estate, assuming this power is consistent with the account agreement.

There also may be unique set-off issues.

IX. TRUST FUNDS

A. Nature of the Trust Fund in Reinsurance Transactions

A reinsurance trust fund is an arrangement between the reinsurer (the grantor) and the cedent (the beneficiary), under which assets are deposited with a trustee, pending the performance of certain contractual obligations between the parties. In some instances the cedent may be the grantor and the reinsurer may be the beneficiary. If the beneficiary makes a demand upon the trustee stating that the contractual obligations are unfulfilled, the trustee is obligated to pay in accordance with the terms of the trust. The Credit for Reinsurance Model Regulation (#786) contains minimum standards for how a trust should be established and operated.

In reinsurance, trust funds serve as an alternative to LOCs. Certified and unauthorized reinsurers establish and fund them to secure their obligations to the cedent. Trust funds serve as security for the risk undertaken by the cedent and ceded to the reinsurer, allowing the cedent to take reinsurance credit for the ceded risk. Only certain specified assets are generally permitted to be used to fund the trust, including: cash, certain readily marketable securities such as United States government obligations and nationally traded stocks, and clean, irrevocable letters of credit.

B. Basic Features of the Trust Fund

The administration of the trust fund is governed by the trust instrument that provides for the term, or duration, of the trust fund. It may also include a provision concerning control of the trust assets. The grantor is often given the power to substitute qualified assets, so long as the value of the corpus remains at the agreed level. The trust instrument may also include a provision concerning the ability to control investment of trust assets.

During the term of the trust fund, the principal will yield interest, and the trust instrument may contain a provision allocating the interest either to the grantor or the trust corpus. The trust instrument may also specify under what circumstances a demand can be made on the trustee, allowing the grantee to obtain trust funds. In the event that the grantor wishes to terminate the trust, the trust instrument will include a provision requiring the grantor to give advance notice to the trustee that the trust will be terminated. Finally, in the event that a trustee should resign or die, a provision may be included that allows for the substitution of trustees.

C. What Should a Receiver Do About Trust Funds

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the trust funds established in the cedent's favor and list them in accordance with the treaty collateralized and expiration dates. If any notices of termination have been issued on the identified trust funds pursuant to their termination provisions, these should also be listed.

The receiver should also ensure that he or she is empowered to remove assets from the trust funds if such removal is necessary to fulfill the reinsurer's obligations under the reinsurance agreements. Counsel should be consulted to confirm that the receiver has the power to remove assets and under what conditions assets can be removed, or if the receiver does not, such power should be immediately obtained from the supervisory court.

It is also recommended that a receiver notify each trustee that the cedent is in receivership, clearly identify the receiver, and take whatever steps are necessary in each case to ensure that only the receiver is empowered to remove assets from the trust funds that might otherwise be removed by the cedent.

The receiver should also communicate with each reinsurer on whose behalf a trustee holds a trust fund with the cedent as grantee so that each is aware that the cedent is in receivership. The receiver should assure each reinsurer that no improper removal of assets will occur. It should also be emphasized to the reinsurer that it must maintain the trust funds in accordance with the terms of the specific reinsurance agreement.

Once the receiver properly identifies all of the established trust funds and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the trust funds in order to protect the cedent's position by preserving its security. The receiver should ascertain the liabilities secured by the trust funds. If a trust fund is about to expire, and may leave outstanding obligations unsecured, the receiver should call upon the reinsurer to continue the expiring trust fund. If the reinsurer refuses to maintain the fund, counsel should be consulted on the appropriateness of removing assets from the trust fund to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify the trust funds established on behalf of the reinsurer as grantor and list them in accordance with the agreements collateralized and expiration dates. If any notices of termination have been issued pursuant to the termination provisions of certain trust instruments, these should also be listed.

It is also recommended that a receiver notify each trustee that the reinsurer is in receivership, clearly identify the receiver, and confirm that only the receiver is authorized to give the bank instructions with respect to the trust funds, which would ordinarily be given by the reinsurer.

The receiver should also communicate with all cedents in whose favor a trustee holds a trust fund with the reinsurer as grantor so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the trust funds will be maintained in accordance with the reinsurance agreement, although the receiver will probably be unable to comply with the demands for increases in trust funds or LOC balances due to the probability of creating an illegal preference. Occasionally, trust accounts and LOCs are in excess of amounts necessary to secure liabilities, and in cooperation with cedents, the receiver may be able to retrieve those excess amounts. The receiver should also take whatever steps are necessary to ensure that trust fund assets will not be improperly removed.

Once the receiver properly identifies all of the outstanding trust funds and takes the necessary steps to solidify his powers with regard to them, the receiver must then manage the trust funds in order to protect the reinsurer's position by preserving its assets. The receiver should ascertain the liabilities secured by the trust funds and guard against wrongful removal of assets by cedents. The danger that the assets will be wrongfully used to gain a preference on other, unsecured debts, should be addressed. The receiver can also protect the reinsurer's position by depositing any interest earned on the assets into the reinsurer's estate, assuming this power is consistent with the terms of the trust.

X. FUNDS WITHHELD

"Funds withheld" refers to an arrangement wherebythe fact that the cedent does not pay the premiums to the reinsurer; instead, the cedent "withholds" the premiums. Generally, this provision is only used with unauthorized reinsurers. The purpose of these provisions is to allow the cedent to reduce the provisions for unauthorized reinsurance in its statutory statement. The reinsurer's asset, in lieu of cash, is "Funds held by or deposited with reinsured companies." So in other words, the receiver will already have the funds under his exclusive control.

XI. INSOLVENT NON-UNITED STATES LICENSED REINSURERS

The estate may have ceded reinsurance with a non-United States licensed reinsurer[9] that is subject to a rehabilitation or liquidation proceeding in its domiciliary jurisdiction. In addition, that non-United States licensed reinsurer may also be subject to an ancillary proceeding under Chapter 15 of the United States Bankruptcy Code.

A. The Non-U.S. Proceeding

As in the United States, the non-U.S. proceeding may be either a rehabilitation, liquidation or equivalent (e.g., in the UK, there are voluntary arrangements, schemes of arrangement, and winding ups, among other mechanisms). In either event, particularly if ceded reinsurance is involved, the receiver should communicate with the non-U.S. receiver to ensure that the estate receives notice of the proceedings and is identified as a creditor. It will then be necessary to keep current with the proceedings to protect the interests of the estate. The procedures described in this chapter for dealing with ceded reinsurance will generally be applicable to these non-U.S. proceedings.

B. Chapter 15 Proceedings

Insurance receiverships are specifically excluded from the ambit of the U.S. Bankruptcy Code; however, the Code does have an influence on insurance issues in at least one important case: if an insurer purchased reinsurance from a non-U.S. reinsurance company, and that reinsurer has become insolvent.

Chapter 15 permits a representative of a non-U.S. proceeding to petition the United States bankruptcy court for relief and permits the court to: (a) enjoin proceedings against the non-U.S. licensed reinsurer, enforcement of judgments or the commencement or continuation of any action against the debtor; (b) order the delivery of the debtor's property to the representative; and (c) order other appropriate relief. Chapter 15 proceedings are limited in scope, do not commence a full bankruptcy proceeding, and confer broad discretion to the courts. Generally, following the adoption of a plan of rehabilitation or liquidation in the non-U.S. proceeding, the debtor requests the bankruptcy court to give full force and effect to that plan and make it binding and enforceable against all creditors in the United States.

Receivers should consider various approaches when faced with a Chapter 15 proceeding. A receiver should file a notice of appearance and request for service of notice to ensure that it receives copies of the filings made in the proceeding, including periodic status reports. Consideration should be given to participation on the creditors' committee if the amount due to the estate is material, and the expense and time to the estate justify participation. Evaluation of proposed schemes of arrangement may also need to be made to protect the interests of the estate. The estate should also continue to report claims as it did prior to the proceeding and should review and recognize any of its obligations under the existing agreements.

Chapter 15 of the Bankruptcy Code now states that a court may not grant relief under the chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable state insurance law or regulation for the benefit of claim holders in the United States. The purpose of the language is to make certain a bankruptcy court has no power over U.S.-based reinsurance collateral posted for the benefit of U.S. claimants.

[9] Also known as alien reinsurers.

