NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 7/14/22

Virtual Meeting

RECEIVERS' HANDBOOK (E) SUBGROUP
Tuesday, July 19, 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 November 18, 2021—*Kevin Baldwin (IL)*	Attachment One
2.	Consider adopting Chapters 1 & 2 of the *Receivers' Handbook for Insurance Company Insolvencies* after review of changes based on NCIGF/NOLHGA and ACLI's Letter—*Kevin Baldwin (IL)*	Attachments Two-Four
3.	Consider exposing Chapters 3-5 of the *Receivers' Handbook for Insurance Company Insolvencies—Kevin Baldwin (IL)*	Attachment Five
4.	Discuss Any Other Matters Brought Before the Subgroup —*Kevin Baldwin (IL)*	
5.	Adjournment	

Draft: 11/22/21

Receiver's Handbook (E) Subgroup
Virtual Meeting
November 18, 2021

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Nov. 18, 2021. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Toma Wilkerson, Vice Chair (FL); Joe Holloway (CA); Jared Kosky (CT); 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 June 14 Minutes.

The Subgroup met June 14 and took the following action: 1) adopted its May 26 minutes; 2) discussed the drafting group process; and 3) demonstrated the SharePoint Collaboration website to the drafting groups. Mr. Baldwin noted that the minutes from the June meeting were in the meeting materials.

Mr. Geckler made a motion, seconded by Ms. Wilson, to adopt the Subgroup's June 14 minutes (Attachment 1). The motion passed unanimously.

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

Mr. Baldwin thanked the volunteers who had participated in the drafting groups for Chapters 1 and Chapter 2 of the *Receiver's Handbook for Insurance Company* Insolvencies (Receiver's Handbook). Chapter 1 had extensive revisions and was 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. Chapter 2 was presented in the materials as a markup version of the original Receiver's Handbook chapter. The Subgroup considered public exposure of revised Chapter 1 and Chapter 2 for a 30-day period with all comments to be sent to Sherry Flippo (NAIC).

Mr. Holloway made a motion, seconded by Ms. Wilkerson, to expose Chapters 1 and Chapter 2 of the Receiver's Handbook (Attachment 2) for a 30-day public comment period ending Dec. 20. The motion passed unanimously.

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

https://naiconline.sharepoint.com/:w:/r/teams/FRSSolvencyMonitoring/RHSG%20Calls%20%20Meetings/Nov%2018%20CC/RHS%20111821%20Minutes%20TPR.docx?d=wf4f9e10218674d079cb61d8185221150&csf=1&web=1&e=XwQ0wq

Text for email from Barbara Cox containing NCIGF/ NOLHGA comment on Chapter 1

From:	Cox, Barbara
Sent on:	Monday, December 20, 2021 1:19:55 PM
To:	Flippo, Sherry <SFlippo@naic.org>
CC:	
Subject:	Handbook exposure draft - NCIGF/NOLHGA Comment

Sherry,

The first bullet on page 12, Chapter 1 did not make sense to us as written. NOLHGA and NCIGF suggest the following replacement paragraph:

- The amount of lead time needed for guaranty associations to prepare for a liquidation varies based on the facts and circumstances presented in each case. The guaranty associations need time in all situations to analyze the policy data and records and prepare to adequately protect policyholders when triggered to do so. More time is needed in complex situations or very large cases.

This REPLACES:

- The amount of lead time needed for guaranty associations to prepare for a liquidation varies based on the facts and circumstances presented in each case, including the type of insurance business written by the insolvent company. The property and casualty guaranty funds need to analyze the data to adequately protect policyholders - more in complex situations or very large cases. For complex life, health and annuity companies, the lead time needed may be substantially longer.

Thanks Sherry and Happy Holidays!

Barb

Barbara F. Cox

Attorney at Law

Barbara F. Cox LLC

ACLI
Financial Security for Life

Wayne Mehlman
Senior Counsel
(202) 624-2135
waynemehlman@acli.com

December 20, 2021

Kevin Baldwin, Chair
Receivers' Handbook Subgroup
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108

RE: Receivers' Handbook

Chairman Baldwin:

The American Council of Life Insurers (ACLI) would like to thank you for this opportunity to comment on the Subgroup's proposed revisions to the Receivers' Handbook. We are very supportive of its efforts to update and revise the Handbook to reflect recent model updates, changing expectations around technology, and our mutual commitments to the continuation of essential services.

As we reviewed the revisions to Chapter 2 (Information Systems), we noticed several process and technology provisions that could have an unfortunate side effect of limiting regulator and insurer flexibility and utilization of future technologies, most of which are detailed below. We would strongly recommend additional vetting by information and technology specialists as the Subgroup updates the Handbook in order to ensure that it is future-proofed and requires minimal updates to address changing technologies.

As to specific edits, we would recommend the following for Chapter 2:

Page 129 of the Handbook contains the following added sentence:

- *"In doing this, the receiver will need to look ahead to what systems requirements may be needed in the future and make arrangements so they are in place when needed."*

  While we support being forward looking, this language could be limiting. We believe it would be better focused on the receiver preparing for contingencies, as the future is hard to predict.

Page 133 contains the following additional language:

- *"Check references and criminal backgrounds prior to retaining new staff."*

We would suggest that "*and appropriate background screening*", or something similar, be used instead of "*and criminal backgrounds*" as local laws may prevent a blanket "criminal" screening and/or allow for 1033 waivers for insurance producers and agents. We want to ensure that the Handbook aligns with these local requirements and does not needlessly disqualify people from employment opportunities.

- *"For laptops that are used outside of the office require encryption and the use of a VPN to connect."*

  The specific denomination of a VPN may be too narrow a defined requirement insofar as a general call for 'secure connection' - including options that may yet be invented. It may be more appropriate to refer to a "secured network connection" instead.

- *"Disable USB ports on all company laptops and computers".*

  This could disrupt legitimate hardware uses and should be reconsidered.

Page 137 contains the following existing sentence:

- *"These systems will be commercially available systems that are closely related to hardware components."*

Large insurers may have legacy applications developed in-house that are not necessarily 'commercially available'. We would request additional flexibility within this language.

Pages 147-148 (Section IV.G.):

- With regard to the segregation of data requirements in Models #440 and #450, the ability to segregate affiliates' data may be very challenging. The architecture of a "Data Lake" or other multi-business data store (e.g., a comprehensive customer profile database for servicing or marketing) should note the provenance of data inflows, but true segregation of data within that data store in the event of a receivership could have practical impacts on the operation of such a system and may be problematic and interfere with ongoing operations. NAIC should consider adding a footnote(s) or clarification(s) that reminds regulators and insurers to ensure that the pulling of segregated data from related affiliate businesses from a comingled data pool does not harm other operations.

Page 149 (Section IV.K.1):

- This subsection should not be limited to computer servers – the "cloud" should be covered as well.

Thanks again for this opportunity to provide comments. If you have any questions, feel free to contact me at waynemehlman@acli.com or 202-624-2135.

Sincerely,

Wayne A. Mehlman

Wayne Mehlman
Senior Counsel, Insurance Regulation

OVERVIEW

Each state and territory have a statute that provides for the appointment of the state's insurance regulator as the receiver of an insurer that is placed in a delinquency proceeding. This Handbook is intended as a guide for insurance regulators and others who assist with carrying out the Receiver's duties.

The Handbook is organized by subject matter. Each chapter contains an introduction to the subject, followed by an in-depth discussion. In some chapters, checklists are included as an aid to implementing the actions described in the chapter.

References are provided to the applicable provisions of the NAIC model receivership laws and relevant case law in each chapter. As the legal references reflect the NAIC models and case law existing at the time the Handbook was drafted, a practitioner should always review the current state of the law.

While receiverships typically share essential principles and elements, there are important variances:

- Each state's receivership statute may contain unique provisions that are not derived from an NAIC model act or shared with other states.

- Case law interpreting the statutes governing receiverships can vary between states.

- A receivership is a court proceeding, and the judicial process is governed by the state's court system and rules of procedure.

- Each state insurance department is structured to meet the circumstances of the particular state, and the administrative process for handling receiverships may differ between the states.

- As receiverships vary in size and complexity, a range of approaches may be appropriate.

A practitioner should be aware of the process for handling a receivership in the relevant state, and how it may differ from the examples provided in this Handbook. As described above in the Disclaimer, this Handbook is not an instructional manual for handling a receivership but should be viewed as guidance.

Contents

*Page numbers in TOC will be updated in final publication.

CHAPTER 1 – COMMENCEMENT OF THE PROCEEDING

I. INTRODUCTION

Insurer receiverships are governed by state law rather than federal bankruptcy law. Although the proceeding is governed principally by the law of the state in which the insurer is domesticated, the laws of the various states and other jurisdictions in which an insurer conducted business, has assets, or has creditors, may also be implicated. Consequently, during the commencement and administration of proceeding involving a troubled or insolvent insurer, it is important for the receiver to consider the laws of those states and jurisdictions.

Most states have enacted statutes that govern the conservation, rehabilitation and liquidation of insurance companies that are patterned at least in part after one of three model acts that have been adopted by the NAIC over the years: the Uniform Insurers Liquidation Act ("Uniform Act"); the Insurers Rehabilitation and Liquidation Model Act ("IRLMA"); and the Insurer Receivership Model Act ("IRMA")[1]. In this handbook, the model acts will be referred to collectively as the "NAIC Model Acts."[2] Because of their widespread influence, the NAIC Model Acts are basis for discussion of issues involved in the commencement and administration of troubled or insolvent insurers. Even so, the laws of the individual states may deviate from the models, in whole or part. In some jurisdictions, affiliated service providers (e.g., agencies, premium finance companies, administrative service providers) whose purpose is to provide services solely to the insolvent insurer may be subject to the laws that apply to impaired or insolvent insurers.[3]

Receivership proceedings[4] are usually commenced against an insolvent, financially impaired or otherwise troubled insurer in the insurer's domiciliary state (the state in which the insurer is incorporated) and in specific courts within that state, generally either the court in the judicial district encompassing the state's capital or the judicial district of the insurer's principal office. The NAIC Model Acts require that the chief insurance regulator of the insurer's domiciliary state be appointed receiver of the insurer to administer the receivership under court supervision. The chief insurance regulator in the individual state may be referred to as commissioner, treasurer, superintendent, or director. For purposes of this handbook, the term "regulator" is used to encompass all such officials. If the insurer is an "alien" insurer admitted to the U.S. market through a "port of entry," the state through which the insurer was admitted will administer the receivership.

See Chapter 9 – Legal Considerations for each type of proceeding.

II. FORMS OF PROCEEDINGS

A. ADMINISTRATIVE SUPERVISION

Most states authorize the regulator to issue short-term administrative supervision orders against insurers operating in a manner that poses a hazard to policyholders, creditors, or the public. Under such orders, the regulator or their special deputies serves as administrative supervisor of the insurer. In states

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[1] Refer to Appendix XXX for a chart outlining key differences between the Uniform Act, the Liquidation Model Act and IRMA.

[2] Refer to NAIC website for state charts that provide state law citations to determine which version of IRMA a state has adopted. https://content.naic.org/model-laws. Note that some states that have not adopted IRMA in full; but may have adopted specific provisions from IRMA.

[3] In 2021, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) that bring affiliate service providers deemed "integral" or "essential" to an insurer's operations under the jurisdiction of a rehabilitator, conservator, or liquidator for purposes of interpreting, enforcing, and overseeing the affiliate's obligations under the service agreement.

[4] The NAIC Global Receivership Information Database provides publicly available information about insolvent insurers including receivership orders (conservation, rehabilitation, and liquidation). https://isiteplus.naic.org/grid/gridDisc.jsp

where administrative supervision orders may be issued without formal court proceedings, the orders are subject to administrative review and are often confidential. Administrative supervision can enhance regulatory oversight while the insurer overcomes what is envisioned as a temporary challenge, such as a crisis in the broader economy. It is also useful in temporarily stabilizing a deteriorating situation prior to the entry of an order of rehabilitation or liquidation. Where administrative supervision is authorized, statutes typically empower the regulator to prohibit the insurer from doing any of the following during the period of supervision, without the prior approval of the regulator:

- Dispose of, convey, or encumber any of its assets or its business in force;
- Spend over specified spending limitations;
- Close any of its bank accounts;
- Lend any of its funds;
- Invest any of its funds;
- Transfer any of its property;
- Incur any debt, obligation, or liability;
- Merge or consolidate with another insurer;
- Enter into any new reinsurance contract or treaty;
- Terminate or cancel reinsurance;
- Terminate, surrender, forfeit, convert, or lapse any policy or contract of insurance (except for nonpayment of premiums due) or to release, pay or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy or contract;
- Make changes in the senior management team; and
- Make extraordinary changes in staff.

In addition, supervision orders frequently impose heightened regulatory reporting requirements, such as monthly financial reporting, increased market conduct reporting, and specified special reporting such as changes in reinsurance or performance of invested assets. Supervision is often also a vehicle for more intense analysis of an insurer's affairs and condition. If the insurer fails to comply with the order of administrative supervision, other grounds exist under the applicable statute, or the company is found to be insolvent, the regulator may petition for a receivership order.

B. SEIZURE ORDERS

In many cases, the proceeding begins with a seizure order (see IRMA §201). Some statutes enacted prior to IRMA may use different terms for this order, such as a conservation or receivership order. In IRMA, this order is referred to as a seizure order; the term conservation order refers to an order entered under IRMA §301.

In the majority of states, the regulator may obtain a seizure order from a court of competent jurisdiction. Generally, a petition for a seizure order must allege: 1) the existence of one or more statutory grounds justifying a formal delinquency proceeding, and 2) that the interests of policyholders, creditors or the public is endangered by a delay in entering such an order. Specific requirements for obtaining a seizure order vary. The thrust of a seizure order is preservation of the insurer pending further analysis and proceedings. Such orders are not intended to be the final stage in regulatory action for a troubled insurer.

In the rare case in which further analysis reveals the absence of grounds for additional proceedings, or that the problems have been corrected, the regulator will move for dissolution of the seizure order and return control of the insurer to management. More frequently, analysis leads the regulator to seek commencement of formal receivership proceedings.

A seizure order may be issued by the court *ex parte*—without notice—and without a hearing upon allegations of statutory grounds. However, in such cases, a hearing is typically set shortly thereafter to permit the insurer to demonstrate that seizure is not appropriate.

Following issuance of a seizure order, if the regulator determines that further court orders are necessary to protect policyholders, creditors, the insurer or the public, the court may hold hearings to extend or modify the terms of the order. However, the court must vacate the seizure order as soon as practicable or where the regulator, after having had a reasonable opportunity to do so, has failed to institute rehabilitation or liquidation proceedings.

Most state statutory schemes allow the regulator to apply to the court *ex parte* for an order of seizure. In these circumstances, the proceedings are often sequestered and remain confidential until the court orders otherwise. The *ex parte* application allows the regulator to take over the insurer without giving notice, thereby preventing the potential diversion of funds and dissipation of assets, while the continued confidentiality of the proceedings allows the receiver to assess the insurer's current status. Confidentiality allows the receiver to discharge the seizure and, if appropriate, return to normal business operations without public knowledge and the resultant harm to the insurer's business. A seizure order gives the regulator the power to make an immediate hands-on determination of an insurer's condition as well as preserve and protect its assets. The order is designed to maintain the status quo of an insurer while the regulator decides whether to release the insurer or initiate formal receivership proceedings, whether conservation, rehabilitation, or liquidation. State statutes may require that all records and papers relating to a judicial review of a seizure be confidential (IRMA, §206(A)).

If the regulator determines that formal receivership proceedings are not needed, or if the regulator is successful in resolving the insurer's difficulties, he or she can release control and return the insurer to its previous management without seriously damaging the insurer's business. If, however, creditors and the public become aware of an insurer's potential problems, the insurer could suffer irreparable harm even though the condition requiring seizure has been removed.

C. RECEIVERSHIP PROCEEDINGS GENERALLY

IRMA incorporates three distinct receivership actions—conservation, rehabilitation, and liquidation. In many states, the statutes only contemplate receivership proceedings for rehabilitation or liquidation.

A receivership order authorizes the receiver to conserve, rehabilitate or liquidate the insurer, with various statutory and judicially imposed restrictions that may vary from state to state and case to case. Subject to these restrictions and to the supervision of the court, the receiver controls all aspects of the insurer's operations, from the initial order until the receiver is discharged. The receiver's responsibilities extend to policyholders, creditors, regulators, and other interested parties. The receiver should communicate with these parties and keep them informed of the progress of the receivership.

IRMA §207 lists 22 independent grounds, any one of which suffices for the issuance of a receivership order. Many of the same grounds support such orders in most states. A troubled company does not move systematically from one form of receivership to another, but rather, the regulator may choose to petition for the form of receivership appropriate to the circumstances at any given time.

Receivership proceedings are commenced at the behest of the regulator. In some states, creditors and other interested persons may also request that the commissioner be appointed receiver. Such proceedings may seek rehabilitation or liquidation of the insurer or may initially seek conservation, deferring election of one of these other paths until a later day.

1) Control of the Insurer

Per IRMA §104.X the Receiver in a receivership proceeding means liquidator, rehabilitator, conservator, or ancillary receiver, as the context requires. IRMA §209.C states a receiver may appoint special deputies that have all the powers and responsibilities of the receiver.

A seizure, conservation, or other receivership order that vests in the receiver control of the insurer also has the effect of making the receiver responsible for the company. Even while conducting further analysis to ascertain the company's financial condition and prepare for any hearing, the receiver must implement measures to safeguard the insurer's property and affairs. Such measures include:

- Providing for physical security for the insurer's facilities, including proper controls and limits on staff access;
- Establishing security for information systems and obtaining a forensic backup of company information;
- Familiarization with company staff responsibilities, capabilities, and potential to interfere with receivership proceedings;
- Identification of cash flow pressures;
- Control of company investment, financial institution accounts, and other assets;
- Notification of policyholders, claimants and other interested parties as ordered by court or allowed by statute;
- Communication with landlords and other providers of essential services;
- Court filings necessary to impart notice to the public, and
- Other measures identified as necessary for the preservation of the *status quo*.

2) Preparation for the Hearing

Apart from relying on documents in the insurance department's control (such as filed financials and examination reports) and those available from third parties, much of the case in support of receivership may consist of the insurer's own documents. It is important that receivership or supervision staff consult with counsel about the manner of gathering and preserving such documents so that they will be admissible evidence. At the same time the key problems should be identified, and steps taken to assure that they don't worsen pending resolution of the challenge to the receivership.

3) Contents of the Order

Generally, the receivership order directs the regulator to take possession and control of the property, books, accounts, documents and other records and assets of the insurer. Further, the order usually gives control of the insurer's physical premises to the regulator. The order is usually accompanied by an injunction prohibiting the insurer, its officers, directors, managers, agents, and employees from disposing of property or transacting business, except upon the regulator's permission or further court order. The order may enjoin anyone having notice of its provisions from interfering with the receiver or the proceedings, may suspend pending litigation involving the insurer, and may require that all claims and proceedings against the insurer be brought exclusively in the receivership court. In addition, the order may include special provisions like moratoria on cash surrenders, authority for disavowal of executory contracts, and prohibition of creditor self-help.

4) Duration

The duration of a seizure order can vary. In rare cases, the order will specifically prescribe the time period that it is to remain in effect. Typically, however, the order prescribes that it will remain in effect pending the court's further orders or for such time as the receivership court may deem necessary for the regulator to ascertain the insurer's condition, and to request authority to rehabilitate or liquidate the company.

5) Review

If the proceeding commenced with a temporary seizure order and the insurer wishes to contest the proceeding, it may petition the court for a hearing and review of the order. IRMA, §201(F), provides that the court shall hold such a hearing within 15 days of the request.

6) Conservation of Property of Foreign or Alien Insurers

Most states also authorize the regulator to apply to the court for an ancillary order to conserve the property of an alien or foreign insurer (IRMA, §10015). The grounds and terms of such an order generally include those necessary to obtain a similar order against a domiciliary insurer, but there may be some differences. Usually, if the foreign or alien insurer has had property sequestered by official action in its domiciliary state or a foreign country, or if its certificate of authority in the state has been revoked or had never been issued, the regulator may seek an order of seizure or conservation.

Commencement of the proceedings may be by agreement with company owners and management (uncontested) or may be contested vigorously when the insurer maintains that there are insufficient grounds for receivership under applicable law. Most frequently, such contested cases focus on disagreements over the insurer's financial condition and prospects. When the proceedings are contested much of the work done before the hearing will be in preparation to establish the adequacy of grounds for receivership. That work can also commence during the insurer's supervision.

D. CONSERVATION

In some states, a court of competent jurisdiction may enter an order of conservation upon the petition of a regulator (IRMA, §301). An order of conservation is designed to give the regulator an opportunity to determine the course of action that should be taken with respect to the troubled insurer. Within 180 days (or up to 360 days if allowed by the court) of the issuance of the order, the regulator/conservator must file a motion to release the insurer from conservation or petition the court for an order of rehabilitation or liquidation (IRMA, §302). Unlike a seizure order, a conservation, rehabilitation, or liquidation order constitutes the commencement of formal receivership proceedings, which is not an *ex parte* proceeding.

E. REHABILITATION

A rehabilitation proceeding is a formal proceeding, commencing with a complaint filed by the regulator (IRMA, §401). Rehabilitation can be used as a mechanism to remedy an insurer's problems, to run off its liabilities to avoid liquidation, or to prepare the insurer for liquidation. The regulator will allege the specific statutory grounds in a complaint for placing the insurer in rehabilitation based on the grounds cited in the state's receivership act. The insurer is served with a complaint and summons. The insurer may respond and must be afforded an opportunity to be heard. When judgment is entered, the losing party may appeal. Note that in some states, the time for filing notice of an appeal may be much shorter than in other causes of action—perhaps just a matter of days.

Refer to Chapter 9 of this Handbook for further description and guidance regarding rehabilitation.

1) Coordination with Guaranty Associations

Early coordination with the life and health insurance guaranty associations and the property and

[5] Under IRMA, the proceeding is referred to as an ancillary conservation and the commissioner is appointed as conservator.

casualty guaranty funds (collectively the "guaranty associations") is essential for maximizing protections and achieving optimal outcomes for policyholders and claimants whenever guaranty association covered business is involved. The importance of early coordination with the guaranty associations is reflected in IRMA and was also the subject of a 2004 NAIC Whitepaper.[6] Ideally, such coordination should begin as soon as it appears that there is a significant possibility of liquidation. As noted in the NAIC Whitepaper, the need for coordination among regulators, receivers and guaranty associations may occur even before the insurer is placed under administrative supervision or in conservation or rehabilitation.

At a minimum, IRMA §208 requires notice to all potentially affected guaranty associations upon issuance of any order for conservation, rehabilitation, or liquidation. IRMA also specifically contemplates and requires consultation and coordination with potentially affected guaranty associations upon entry of an order of conservation or rehabilitation *to determine the extent to which guaranty associations will be impacted by or may assist in the efforts to conserve/rehabilitate the insurer,* and *to provide appropriate information to the guaranty associations to allow them to evaluate and discharge their statutory responsibilities*. See IRMA §303, §404-405. Confidentiality agreements, addressed both in IRMA and in the NAIC Whitepaper, are commonly used to protect the information disclosed.

This early coordination is essential for several reasons:

- On the life and health side, advanced planning and coordination provides opportunities for guaranty associations to obtain necessary policy data and related information to evaluate, develop and implement strategies for maximizing consumer protections and avoiding disruption to the provision of policy benefits. These strategies could involve negotiated assumption reinsurance transfers of covered blocks of business, which may be timed to coincide with the liquidation order or having in place the infrastructure (including third party administrators, where applicable) needed for seamless policy and claims administration by guaranty associations immediately upon being triggered. In the case of covered health business, policy administration could involve the retention or replacement of providers, such as hospitals, health care providers and pharmacy benefit networks as well as pre-certification and other related service providers. In certain circumstances, the life and health insurance guaranty associations have created captive insurers to administer large blocks of covered business. While guaranty associations have in some cases had to respond to a liquidation with short notice, the best outcome for policyholders occurs when guaranty associations have the lead time necessary to identify, develop and prepare to implement strategies that will maximize value for policyholders and avoid any disruption in benefits. Whatever solution or approach is used, it will require time to coordinate, plan and execute the necessary steps to provide coverage to policyholders on a timely basis.

- On the P&C side, successful, secure data transition is essential for policy and claims administration. Data is typically voluminous in modern insolvencies and may reside on unique or legacy data processing systems which may be under the control of one or more third parties and in different locations. Working together, the receiver and guaranty funds can effectively transition data and work out any third party contractual or practical issues that may arise. However, this must be done well in advance of liquidation in order to avoid disruption in benefits and claims payments. The property and casualty guaranty funds and NCIGF utilize the Uniform Data Standards (UDS) and have developed processes to facilitate UDS data transition that may be helpful and result in cost savings for the transition process.

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[6] The NAIC's Receivership and Insolvency Task Force (RITF) published a Whitepaper dated August 12, 2004, and titled "Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System."

- Modern insurance policies and coverage programs can be complex – for example, there may be blocks of cyber liability business, large deductible policies, variable annuity policies with guaranteed living benefits or long-term care policies that have unique policy terms or servicing obligations. There may also be related, ceded reinsurance treaties in place that would have to be evaluated and considered for purposes of life and health insurance guaranty association election rights to assume such reinsurance. Identifying and understanding these complex policies and programs to assure uninterrupted policy and claims handling can require extensive advance planning, coordination, and due diligence.

- The amount of lead time needed for guaranty associations to prepare for a liquidation varies based on the facts and circumstances presented in each case, including the type of insurance business written by the insolvent company. The property and casualty guaranty funds need to analyze the data to adequately protect policyholders - more in complex situations or very large cases. For complex life, health and annuity companies, the lead time needed may be substantially longer.

- In addition to the benefits of early coordination to prepare for liquidation, NOLHGA and the life and health insurance guaranty associations can provide valuable technical expertise and assistance to receivers and regulators considering possible non-liquidation solutions. This includes analyzing financial issues, evaluating reserves, and identifying potential acquiring entities for blocks of business.

See Section F(4) below for a discussion of guaranty association triggering and Chapter 6 on the guaranty associations' role and specifics of coordination and information sharing.

The threshold criteria that a proposed plan of rehabilitation must meet is that claimants against an insolvent estate will fare at least as well under the proposed rehabilitation plan as they would if the insurer were placed into liquidation. *See Neblett v. Carpenter*, 305 U.S. 297, 304, 59 S. Ct. 170, 173–74, 83 L. Ed. 182 (1938) ("The order of the Superior Court recites that the [rehabilitation] plan makes adequate provision for each class of policy holders, for the creditors, and for the stockholders; that the plan is fair and equitable; that it does not discriminate unfairly or illegally in favor of any class of policy holders; that the intangible assets conserved by the plan are worth several million dollars and that if the old company were dissolved and its assets sold their value would be substantially less than the amount which will be realized from them under the plan.") The so-called Carpenter rule, named after the aforementioned United States Supreme decision, provides that a rehabilitation plan must be fair and equitable, and that it does not discriminate unfairly or illegally in favor of any class of policyholders; *see also, Foster v. Mut. Fire, Marine & Inland Ins. Co.*, 531 Pa. 598, 613, 614 A.2d 1086, 1093–94 (1992) ("Under *Neblett,* creditors must fare at least as well under a rehabilitation plan as they would under a liquidation,…"); and *In re Frontier Ins. Co.,* 36 Misc. 3d 529, 532, 945 N.Y.S.2d 866, 869 (Sup. Ct. 2012) (*Neblett* "requires a plan of rehabilitation to provide claimants with no less favorable treatment than they would receive in liquidation.").

F. CONSIDERATIONS COMMON TO BOTH CONSERVATION AND REHABILITATION

1) Issues to be Addressed

The receiver's review of the insurer's operations should be made at least in part with a view toward identifying and developing a plan to remedy its weaknesses. Areas to be considered include:

- Undercapitalization;

- Mismanagement by directors and officers;

- Uncollectible assets;

- Assets of minimal value;

- Dishonest or incompetent agents;
- Insolvent or weak reinsurers;
- Reinsurance disputes;
- Intercompany, affiliate or subsidiary indebtedness;
- Unprofitable business;
- Long-tail or long-term liabilities;
- Rate increases needed on business and insurer's ability to secure those increases from regulatory authorities;
- Marketing;
- Deceptive or misleading practices;
- Insurance management experience;
- Claim adjustment experience for lines of business being written;
- Risky investments;
- Non-admitted assets;
- Software and hardware problems;
- Inadequate reserves;
- Reserving practices;
- Excessive operating expenses;
- Staffing problems;
- Backlog of mail and filing problems;
- Market conduct studies;
- Unfunded agents' balances or finance notes;
- Management of the insurer's assets and investments;
- Numerous/recent changes in Information Technology or software applications, particularly accounting, claims or policy management systems;
- Failure to collect all outstanding reinsurance receivables;
- Failure to collect all balances due from agents; and
- Failure to collect outstanding judgments in favor of the insurer.

In addition, the receiver may bring causes of action on behalf of the estate, including to prevent or reverse preferences; voidable transfers; fraudulent transfers; other improper conveyances; fraud; misrepresentation by directors, officers, management, and auditors; and negligence, gross negligence and mismanagement by directors, officers, management, and auditors. *(See Chapter 4—*

Investigation and Asset Recovery). The receiver also may diversify the insurer's investment portfolio, coordinate with guaranty associations, and prepare the insurer for future business operations for sale or liquidation

In cases of limited liquidity, the receiver should evaluate which assets can be marshaled and which liabilities compromised in order to provide sufficient cash flow to administer the insurer's day-to-day operations. Generally, the receivership prevents the insurer from incurring further liabilities and increasing the impairment or insolvency. Conversely, it is essential that the insurer's profitable lines of business be identified and maximized for underwriting profit, cash flow and possible sale to investors. A determination should be made whether there is an opportunity for a contribution by the owner, an outside investor or purchaser to stabilize the insurer's cash flow problems pending a comprehensive corrective action plan to conserve or rehabilitate the insurer. Once the insurer's cash flow is stabilized, the receiver should continue efforts to marshal the insurer's assets and reduce outstanding liabilities.

2) Operational Issues

The receiver may need to make periodic budget projections and cash flow studies to establish whether the insurer has sufficient cash flow for its operational needs and to determine the amount of money that would be required from an investor to fund the insurer's future operations and meet statutory surplus requirements. The rehabilitation of the insurer might depend upon the valuation of certain assets or the future profitability of the insurer's book of business. It may be necessary to value those assets in accordance with Generally Accepted Accounting Principles ("GAAP") and Statutory Accounting Principles ("SAP") to determine their value in a rehabilitation, acquisition, merger, or asset sale. It may be prudent to prepare a balance sheet based on current market values. *(See Chapter 3—Accounting & Financial Analysis and the exhibits thereto.)* A determination may need to be made as to the diversification of the receivership's investment portfolio as of the date of the receivership.

The receiver should assess the marketability of the insurer or its assets, including its subsidiaries and investments in affiliates. There should be some focus on the value of the insurer's book of business and its agency network. A decision needs to be made as to whether the insurer will write or limit new or existing business. The strengths and weaknesses of the business need to be determined. Actuaries may need to be retained to perform rate studies and other evaluations, including an evaluation of whether new or pending changes in the law will affect the profitability of the insurer's products (e.g., no fault laws).

In order to preserve the value of the books of business, the payment of claims and cash surrender requests (if applicable) need to be carefully analyzed by the receiver. In some situations, claim handling may be continued in the normal course of business. In life and health insolvencies, the receiver should also consider whether a moratorium on cash surrenders, policy loans and dividends should be imposed.

3) Possible Sale of Insurer

During conservation/rehabilitation, the sale of the insurer to outsiders may be considered, if allowed by state law. A plan for the sale of the insurer should identify the areas that a receiver or investor should cover in any bid or proposal to acquire or invest in the insurer. Among those subjects that should be addressed in a proposed acquisition are the following:

- The purchaser/investor's financial stability and ability to fund the transaction from existing or readily available funds;
- The source of the funds for the acquisition;
- The identity and background of the acquiring party;
- The ability of the purchaser to comply with statutory and regulatory requirements;

- The expected impact of the transaction on the insurer's policyholders and creditors;
- The likelihood of success in completing the transaction;
- Whether the transaction presents other regulatory or public policy concerns; and
- Whether the proposed transaction would adversely impact guaranty association/guaranty fund coverage available to policyholders in the event of a future liquidation.

G. LIQUIDATION

The regulator may petition the court for an order of liquidation when any of the grounds set forth in the applicable statute exists (see IRMA §207), or, if the company is in rehabilitation or conservation, the regulator believes that further attempts to rehabilitate or conserve the insurer would substantially increase the risk of loss to policyholders or the public or would be futile. In liquidation, the liquidator must identify creditors and marshal and distribute assets in accordance with statutory priorities and dissolve the insurer.

1) Order of Liquidation

Once a petition for liquidation is filed, the company will have an opportunity to defend itself, which can result in a trial or an evidentiary hearing. If the court determines that the regulator has sufficiently established any of the statutory grounds for liquidation, it shall enter an order of liquidation, appointing the regulator as the liquidator of the insurer and vesting the liquidator with title to all of the insurer's assets and records. The order enables the liquidator to control all aspects of the insurer's operations under the general supervision of the court. Orders of liquidation may be appealed by management and/or shareholders of the insurer.

Statutes in most states provide that upon issuance of the order, all of the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of liquidation. State statutes may describe the effect of the order of liquidation upon contracts of the insolvent insurer.

Upon entry of the order of liquidation, the receiver is charged with the duty to secure, marshal, and distribute the assets of the estate. The power to perform these duties is provided by the order of liquidation and the state receivership statute. It is important for the order of liquidation to include certain other items, which should be determined by applicable provisions of the law in the state of domicile of the insurer. These items typically include provisions for: the appointment of the liquidator; delineation of the powers of the liquidator as provided by state statute; the immediate delivery of all books, records, and assets of the insurer to the liquidator; and enjoinment of other parties from proceeding with actions against the liquidator, the insurer, or policyholders. In addition, it may provide for notice to policyholders and cancellation of policies.

2) Effect on Policies

The cancellation of policy obligations raises several legal issues with respect to the obligations of property/casualty insurers and the cancelable obligations of life insurers. In general, the courts enforce the statutes that provide for the cancellation of insurance policies upon liquidation. Several cases have considered the question of whether a policyholder's claim would be accepted if filed after the bar date established in the order. Courts have held that the order of liquidation effectively cancels outstanding policies and fixes the date for ascertaining debts and claims against the insolvent insurer. However, the insolvency of a life insurer presents a unique situation. The NAIC Model Acts provide for the continuation of life, health, and annuity policies. Typically, life and annuity contracts (and, to a lesser extent, health contracts) are transferred to solvent third-party insurers.

3) Powers and Duties of the Liquidator

The liquidator is granted certain powers by statute and/or court order, which include the following:

- Vesting the receiver with title to all assets;

- Authorizing the receiver to marshal assets;
- Authorizing the receiver to sue and defend in the receiver's name or in the name of the insurer;
- Enjoining lawsuits in other courts, whether in the same jurisdiction or elsewhere;
- Enjoining interference with the receivership;
- Enjoining creditor self-help;
- Appointing one or more special deputies;
- Authorizing the retention of attorneys, consultants, accountants, and other specialists as necessary;
- Authorizing the sale, abandonment, or other disposition of the insurer's assets;
- Borrowing on the security of the insurer's assets;
- Coordinating with guaranty associations;
- Coordinating with NCIGF and/or NOLHGA, as necessary; and
- Entering into and canceling contracts.

Most jurisdictions hold that the liquidator generally steps into the shoes of the insolvent insurer and possesses the rights and obligations of the insurer. There is also authority for the proposition that the standing of the receiver is broader than that of the insurer to the extent he or she also represents the interest of policyholders and creditors. Several cases have focused on the liquidator's specific duties. These cases allow liquidators to compound or sell any uncollectible or doubtful claims owed to the insolvent insurer, to disaffirm fraudulent conveyances, to disavow leases and other executory contracts, to act as statutory receiver of the insolvent insurer's property, to sell the insurer's property, to conduct business using the insurer's assets, and to control bonds and mortgages held as collateral security.

4) Triggering of Guaranty Associations

As a general rule, the guaranty association laws provide for the mandatory triggering of coverage by guaranty associations upon the entry of an order of liquidation with a finding of insolvency against a member insurer. Advanced coordination with affected guaranty associations and/or NOLHGA (in life and health cases) or NCIGF (in property and casualty cases) with respect to the liquidation petition and proposed liquidation order will help to ensure consistency in triggering in multi-state insolvencies.

On the life and health side, there are a small number of states where mandatory triggering may also occur, under certain circumstances, during rehabilitation if the member insurer is not timely paying claims. In property and casualty cases, guaranty fund triggering normally occurs upon an order of liquidation with a finding of insolvency. There are a minority of states that can be triggered with a finding of insolvency only.

Most of the state life and health insurance guaranty association laws also provide a mechanism for permissive triggering, at the discretion of the association, where a member insurer has been placed under an order of rehabilitation or conservation. (Generally, no such permissive triggering exists in the property and casualty state laws.) These provisions are based on the NAIC Life and Health Insurance Guaranty Association Model Act, Section 8(B), which provides the guaranty association discretion to provide coverage if a member insurer is an impaired insurer (i.e., placed under an order of conservation or rehabilitation). This authority is 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 in the guaranty association's state. Some state statutes also provide life and health guaranty associations limited discretion to act in cases where the impaired insurer has been deemed by the Commissioner to be potentially unable to fulfill its contractual obligations. This language dates back to the original definition of "impaired insurer" in the 1970 version of the NAIC Model Act. This language was later removed from the model act as part of the 1997 amendments but still remains in a small minority of state statutes.

Given the possibility of subtle variations in triggering provisions in place from state to state, it is important to coordinate with affected guaranty associations and NOLHGA or NCIGF for purposes of confirming guaranty association triggering. Refer to Exhibits 1-1 and 1-2 for recommended liquidation order language to ensure consistent guaranty association triggering.

5) Notice

Most state statutes set forth the minimum requirements for notice to creditors and all persons known, or reasonably expected, to have claims against the insurer. The receiver must give notice to the regulator of each jurisdiction in which the insurer does business, affected guaranty associations, the agents of the insurer, and policyholders at their last known address. The liquidator may also be required to give notice by publication, usually in a newspaper of general circulation in the county in which the insurer has its principal place of business. Potential claimants are required to file their claims on or before the bar date specified in the notice.

Disputes may arise when the claimant alleges that he or she did not receive notice of the liquidation. The cases addressing this issue turn on the specific facts. Courts have allowed late claims where the receiver should have known of the claimant's existence and should have provided notice.

See Chapter 5 – Claims for additional discussion.

6) Deadline for Filing Claims

Unless established by statute, the court establishes a deadline for the filing of claims against the assets of the insolvent insurer. In IRMA, the date is not later than 18 months after the entry of the liquidation order, unless extended by the receivership court (IRMA, §701(A)). The liquidator may be required to permit a claimant to file a late claim under certain circumstances (IRMA, §701(B)). If a claimant does satisfy the criteria for filing a late claim, the claim will be subordinated to a lower distribution priority (IRMA, §801(I)). Some statutes enacted prior to IRMA may provide that such a claim is barred from participating in a distribution. Policyholders covered by guaranty associations typically are not required to file claims with the liquidator.

See Chapter 5 – Claims for additional discussion.

7) Ancillary Proceedings

Liquidation of an insurer is conducted by the liquidator in the insurer's state of domicile. When an insurer is licensed to do business in another state, that state may have authority to establish an ancillary receivership. Receivership statutes typically permit the commissioner of a state where an insurer is licensed to commence an ancillary proceeding if the insurer is placed in liquidation in the domiciliary state. Some statutes also require the commissioner to commence an ancillary proceeding upon the request of certain residents of the state who have claims against the insurer. If the court grants the petition for an ancillary proceeding, the commissioner of that state is appointed as the ancillary liquidator.

The ancillary liquidator is generally entitled to recover the insurer's assets in the ancillary state and pay claims of residents in the state with such assets. Some statutes permit a claimant who resides in an ancillary state to file a claim in either the domiciliary or ancillary proceeding.

Owners of secured claims can be affected when there are one or more ancillary proceedings. The owner of the secured claim is entitled to surrender his security and file his claim as an unsecured

creditor. Any deficiency in the claim is treated as a claim against the insurer's general assets on the same basis as claims of unsecured creditors.

IRMA clarified the procedures for ancillary proceedings and the handling of deposits. Under §1001 of IRMA, the need for an ancillary receivership has been curtailed. IRMA allows the appointment of an ancillary conservator under limited circumstances. A domiciliary receiver is automatically vested with title to property in any state adopting IRMA, and the test of whether a state is a "reciprocal state" has been eliminated. IRMA also clarifies the procedures for handling deposits; however, most states have not adopted §1001.

While an ancillary proceeding is required in limited circumstances, the regulator often has discretion to initiate it. When deciding whether to commence an ancillary proceeding, several issues should be considered, particularly if it involves a pre-IRMA statute. As an ancillary proceeding requires the separate administration of the insurer's assets and claims, it generally will increase costs. It can also complicate the processing and payment of claims, and potentially confuse claimants. Separate distributions to claimants from ancillary and domiciliary receiverships may differ, which can result in disparate payments to creditors in the same class. Finally, the insurer's debtors may be reluctant to pay amounts owed to the insurer due to the potential for competing claims by domiciliary and ancillary liquidators. To address these potential problems, the domiciliary and ancillary liquidator can enter into an agreement to facilitate the coordination between the proceedings. An agreement could cover matters such as bar dates, claims procedures, the liquidation and disposition of deposits, and the collection of other assets.

See Section E(9) of Chapter 9 – Legal Considerations for additional discussion.

III. INTERESTED PERSONS

A. GUARANTY ASSOCIATIONS

Guaranty associations have been established in each state, as well as the District of Columbia and Puerto Rico, to provide a measure of protection to policyholders in the event of the impairment or insolvency of an insurer. When guaranty association covered business is involved, it is beneficial to begin coordination as soon as it appears there is a significant possibility of liquidation or that guaranty associations will be triggered.

See II(D)(2) in this chapter and Chapter 6 for additional discussion.

B. PARENT COMPANY AND AFFILIATES

An insurer may have a parent company and/or affiliates that may or may not be insurance companies. The interaction of these companies should be reviewed and analyzed carefully including any service agreements, management agreements, pooling agreements, tax sharing agreements and reinsurance agreements. Under certain circumstances, the receiver may want to obtain control of these other entities thru substantive consolidation.

See Chapter 4 – Investigation and Asset Recovery and Chapter 9 – Legal for further discussion.

C. GOVERNMENT AGENCIES

Federal, state, and local government regulations may require notice of the proceeding and are potentially creditors.

The Federal Priority Act (31 U.S.C 3713) imposes personal liability on the representative of persons or estates to the extent that other debts are paid (or otherwise compensated) prior to claims of the federal government. A 3713 Release from the United States of America through the Department of Justice may be requested. As much of the information required for the release is historical, the Receiver should start collecting the information at the inception of the liquidation.

See Chapter 5 – Claims, Chapter 9 - Legal and Chapter 10 – Closing Estates for additional

discussion of federal government involvement.

IV. RECEIVERSHIP ADMINISTRATION

A. PLANNING

The regulator who expects to successfully administer a receivership action must become familiar with the insurer's operations and business as soon as possible. The checklists included in the exhibits at the end of this chapter include a list of documents that should be reviewed.

1) Identify Problems

It is critically important to meet with the regulator's staff before the receivership order is entered, to discuss the perceived causes of the insurer's difficulties and the potential for a successful rehabilitation or liquidation. While state statutes may prevent regulator's staff from sharing documents not available to the general public with non-regulators, insight from financial examiners, financial analysts, market conduct examiners and licensing agents might assist in determining the causes of the insolvency.

It is also important to meet with the insurer's officers and/or directors, when possible. These meetings are usually clear indicators of how cooperative or hostile the insurer's management will be after appointment. Hostile environments require additional personnel and security measures at the company location to secure the assets and records. In some circumstances, it may be important to maintain confidentiality about an intended action, in which case a meeting with management may not be possible.

2) Identify Key Transitional Elements

As previously discussed, coordination with guaranty associations is essential. When liquidation is reasonably foreseeable and guaranty association covered business is involved, that coordination becomes critical to maximizing protections and achieving optimal outcomes for policyholders and claimants. With proper confidentiality arrangements, this can and should occur even while liquidation is a possibility but there are still other alternatives that might salvage the company. Particular attention should be given to definitions of "covered claim" or "covered policy" for each guaranty association.

The insurer's officers, directors and employees may be willing and able to advise about the existence of service providers and outside consultants employed by the insurer, including legal counsel, accountants, and actuaries. Access to the insurer's records and contracts with all consultants and service providers should be secured and determination made which, if any, of the various service providers to retain. It should also be determined if the insurer is a member of a FHL Bank and, if so, identify key individuals at the insurer and at the FHL Bank.

It is also beneficial to obtain employee agreements and other documents regarding personnel arrangements. The receiver will have to develop a plan to maintain required positions and retain key staff. *See X. Personnel in this chapter for additional discussion*.

Additional steps to consider during the planning phase are in the checklists included in the exhibits at the end of this chapter.

3) Working Business Plan

During the planning phase of a receivership, it may be helpful for the receiver to develop an internal working business plan with reasonable timeline and objectives that consider multiple paths, taking into consideration claimants, policyholders, taxpayers, and stakeholders (e.g., lenders, shareholder, affiliates, etc.) The development of a multi-option plan (e.g., option A, B or C) in order of most beneficial may help in planning for and supporting each phase of the receivership process and in ultimately developing the Rehabilitation Plan required by the Rehabilitation Order.

4) Monitoring and Progress Report

Once the receivership proceeding commences, the receiver should consider maintaining weekly or monthly progress reports that serve as high level report cards of the key issues and the progress made in servicing policyholders and the effectiveness of the working business plan. The progress reports include a view of the whole insurance company–financial and operational, highlights key data about company activities of each division and also identifies critical compliance areas for financial, operational, legal, and statutory guidelines. Included in this monitoring process may be specific accomplishments and updates that should be made available to policyholders and claimants and the courts. Depending on complexity of the receivership a weekly meeting of managers/staff is recommended to exchange information between the receiver and the managers/staff.

B. RECEIVERSHIP ORDER

A receivership order may be issued because the insurer is impaired (generally, a conservation or rehabilitation) or insolvent (liquidation or, in special circumstances, a rehabilitation). The order may also be issued to protect an insurer operating under severe financial impairment, as evidenced by a variety of factors, such as investments in an undiversified portfolio of stocks or bonds, writings to surplus in excess of the allowable amount, issuance of total insurance business by one MGA or TPA or entering into non-risk bearing surplus relief contracts. A receivership may also be instituted if current management is found to be detrimental to the management and/or financial stability of the insurer.

Some common issues addressed in receivership orders are:

- Writing of new or renewal business;
- Handling of reinsurance;
- Dividends or transfer of assets without the receiver's approval;
- Payments to affiliates;
- Limitations on new investments;
- Seizure of physical and liquid assets;
- Liquidation of certain investments;
- Change or dismissal of officers and/or directors;
- Ownership of records and data of the insurer or related entities;
- Cancellation of certain MGA, TPA or general agency agreements;
- Limitations on funding by premium finance companies;
- Injunctions;
- Payment of loss and loss adjustment expense, etc.;
- Triggering of the guaranty associations, if intended;
- Provisions to pre-pay ongoing claims benefits such as workers compensation indemnity benefits while claims data is being transitioned to the guaranty associations;
- Moratoria on claims, cash surrenders, withdrawals, policy loans, etc.;
- WARN (Worker Adjustment and Retraining Notifications) State and Federal - if layoffs of existing staff are anticipated; and

- Hardship provisions (refer to state statutes, state guaranty associations or to www.ncigf.org and www.nolhga.com).

Once the receivership order is entered, the receiver is empowered to operate the insurer. Officers may be retained or terminated, and directors may be relieved of duties, though these actions must be carefully evaluated because of possible adverse effects on litigation involving directors and officers. In fact, a careful evaluation prior to termination of any employee is recommended. An immediate determination may be made as to the need for outside consultants or professionals, such as accountants, actuaries, computer specialists, attorneys, investment counselors, etc.

The insurer may remain in receivership for a fixed period of time or until the occurrence of specified events, e.g., the rehabilitation of the insurer or the liquidation of the estate and the discharge of the receiver.

C. NOTICES

Notice of the insurer's status should be in accordance with the receivership court's direction. The court may direct the notice to be issued by mail and/or by publication in a newspaper of general circulation. In the case of a conservation (under IMRA) or rehabilitation, the notices may be issued to assist the receiver in informing the policyholders and sustaining the business of the insurer. Notice may be sent to the following persons, among others, when the court requires, as their rights or interests are affected:

- Policyholders and beneficiaries;
- Agents;
- Guaranty associations;
- State insurance departments;
- Third-party claimants;
- NAIC;
- Internal Revenue Service;
- U.S. Department of the Treasury;
- U.S. Department of Justice;
- State and local offices;
- Banks;
- Brokerage or investment banking firms;
- Managing general agents, general agents, and all agents of record;
- Reinsurers;
- Intermediaries;
- Creditors, including secured creditors; (including the Federal Home Loan Bank, if applicable)
- Claim adjusters;
- Third-party administrators;
- Premium financiers;

- Vendors;
- Accountants, actuaries, lawyers and other professionals;
- Landlords and tenants;
- Officers and directors;
- Stockholders and other equity holders; and
- Other necessary parties.

Notice may vary depending upon whether the insurer is in rehabilitation or liquidation. Under IRMA, conservation is similar to rehabilitation, and the notice requirement is the same. If the notice is pre-approved by the court, it will avoid potential claims of non-disclosure or omission of material facts.

D. IMPLEMENTATION OF THE ORDER

The order typically includes provisions that enable the receiver to prevent additional financial drain. Throughout this period, the receiver should pay particular attention to preventing illegal preferences, unauthorized set-offs, fraudulent transfers and improper conveyances or distributions.

It is vital that the order be served immediately on the insurer. The receiver should take steps to maintain the integrity of the insurer's assets, books, and records as of the date of the order and to control the insurer's operations so that the assets, books, and records are not removed, dissipated, or destroyed. The checklists at the end of this chapter include some of the initial steps that may be taken to ensure the receiver's control.

E. ASSETS

1) Initial Asset Control

A principal objective in the initial phase is to identify and secure the assets and determine the liabilities of the insurer. The insurer's annual and quarterly statements, along with the current general ledger and chart of account listings, should help in locating some of the assets.

Once the assets have been identified and secured, the short-term emphasis shifts to the cash and invested assets, those being the most liquid. These assets should be tightly controlled to prevent any theft or misappropriation. Examples of the various types and forms of assets, as well as immediate actions that can be taken, are provided in the checklists at the end of this chapter. However, as stated, the primary emphasis at this stage should be assets easily converted to cash, such as petty cash, operating bank accounts and investments. Usually, the remaining illiquid assets will be addressed in the ongoing management and administration of the estate. These types of assets will be the focus of various accounting, collection, and legal efforts in the endeavor to marshal all assets of the estate.

It is important to immediately institute appropriate controls and procedures for the processing of cash and cash receipts. The objective of controlling all cash receipts and subsequent processing is to ensure that cash, the most liquid asset, does not disappear. This requires more stringent controls, including immediate deposit of all cash and an accurate daily accounting. Therefore, the receiver should immediately institute procedures for routing of daily cash receipts (create receipt log). With respect to life and health insolvencies (including HMOs if covered by the triggered guaranty association), consideration should be given to coordination with the guaranty associations and/or NOLHGA regarding the treatment of premium billings, reinsurance payments and any other matters necessary to keep the policies in force, pending the sale of the business or assumption of the business by the guaranty association(s). In the case of an HMO insolvency, direct coordination with the entities providing health care protection to the members is crucial. The receiver may find it necessary to open bank accounts in the name of the receivership in order to have complete control of the cash. In a health insurance related insolvency, the receiver should check on the status of

coordination of benefits (cob) receivables, hospital credit balances and check the state's treasury department to see if any providers have escheated funds on behalf of the health insurer. In order to ensure no misappropriation of funds, the receiver must also institute effective controls over disbursements. This includes instituting new check issuance procedures, including the establishment of new check signing and wire transfer authority, and the issuance of new passwords for electronic banking.

The valuation and control of the remaining assets in the estate will necessarily fall into the continuing management and administration stages. Those assets are less liquid in nature and are, therefore, more difficult to value, marshal and misappropriate.

2) Administration and Ongoing Asset Management

Once the initial phase has been accomplished and control has been instituted over the liquid cash and other invested assets, attention should be directed toward the remaining assets and potential assets of the estate. Immediate identification of some of the remaining assets may be accomplished by reviewing the balance sheet, general ledger, and chart of accounts. The identification of these assets has been accomplished to a degree in the initial phase. The receiver should take a physical inventory including laptops and mobile devices, office equipment, computer hardware and office furniture. The various checklists at the end of this chapter provide details of types of assets to look for and steps to take with those assets.

Aside from the traditional or listed assets on the balance sheet, insurer operations need to be reviewed to identify any potential non-traditional assets. Simply stated, the receiver is responsible for identifying value in the operations and evaluating the potential for the recovery or collection and conversion of this value. This concept will become clearer as the various categories of assets are revealed. Some of the issues to be considered include the following:

- Reinsurance

With respect to life insolvencies, it is critical that the receiver immediately analyze whether to continue or cancel ceded reinsurance contracts. The Life and Health Insurance Guaranty Association Model Act, the life and health guaranty association statutes in most states and IRMA give the life and health guaranty associations the authority to continue ceded reinsurance contracts that relate to covered obligations of the associations in order to facilitate a sale of the business or to minimize the association's exposure. The affected guaranty association must make the election to allow a particular treaty to expire or continue within a statutorily established time. If the treaty is continued, the guaranty association becomes liable for the payment of the ongoing premiums. The guaranty association may transfer the reinsurance agreement to a solvent insurer that assumes the underlying policies. (See IRMA §612 and NAIC Life and Health Insurance Guaranty Association Model Act §8N.)

- Audit premiums

Certain property/casualty premiums are based on loss experience, sales volumes, or payroll amounts. This criteria will differ depending on the type of policy being issued. For example, a "minimum" or "deposit premium" is paid upon issuance of the policy. Final premiums are billed after audit on the basis of loss experience. The additional premium generated is known as audit premium or retro-rated premium and may represent a significant asset of the estate.

Life insurance premiums may be affected by the amounts of dividends paid or by the difference between current billed premiums and maximum billed premiums allowed by the contractual guarantees in the policies. In life insurance insolvencies, the receiver should consider the possibility of Phase III tax liability. (See Chapter 3—Accounting and Financial Analysis, Section VIII.)

- Taxes

Value to the estate may be generated through the sale of the corporate charter or shell. An analysis of any net operating loss situation and qualification under IRS rules should be made with the advice of tax experts, both in the accounting and legal fields.

Also review the validity and correctness of other state and local taxes paid. A review of prior returns and state tax authority records may uncover overpayments and possible recoverable amounts.

Tax sharing agreements with affiliates and any prior consolidated tax returns should be secured, if possible, and reviewed to determine if any refunds paid to the parent should be remitted to the estate.

- Property/casualty salvage and subrogation

With respect to property/casualty insurers, a determination should be made as to how the insurer identified and recovered salvage and subrogation. This amount will not be readily identifiable from the statutory statements, as statutory principles prohibit the recognition of salvage and subrogation until it is collected. However, many insurers maintain salvage/subrogation logs, which are a good source for identification of such receipts or potential recoverables. Salvage and subrogation on claims where reinsurance has been received may be held in a segregated account. Because these aggregated funds may be subject to setoff, a portion of the funds may be due the reinsurer.

- Indemnity

A surety, prior to issuing a bond, will usually require indemnity agreements from the principal and other indemnitors in order to secure the surety from any claims that may be made against the bonds. The agreement is a contractual obligation that provides security for the surety. The indemnity agreement sets forth and expands upon the separate common law obligations between the principal and the surety. A separate indemnity agreement may be issued for each bond. However, more frequently, the parties enter into a general indemnity agreement covering any bonds that the surety may issue to that principal.

Accordingly, all indemnity agreements should be secured and reviewed to identify potential recoverables.

- Deductibles

Many property and casualty insurance policies contain deductibles that are to be paid by the insured. If the insurer (or a guaranty association) pays the full amount of the loss to an injured third party, the amount of the deductible becomes a claim against the insured. The receiver should evaluate the likelihood and cost of collection, and if appropriate, attempt to recover the amount paid within the deductible. It is important that the collection process be resumed as quickly as possible. Most often the receiver is best situated to continue the collection process as he or she is in possession of the related records. In some cases, the insured will have posted some form of collateral to secure its obligations under the deductible. Pursuant to statute in some states, or agreement between the receiver and the applicable guaranty associations, the amount collected is delivered to the associations that paid the claim. For a fuller discussion of large deductibles, see Chapter 6—Guaranty Associations.

- Excess expense payments, especially over-billed loss adjustment expenses

A complete review of historical expense payments should be made, paying close attention to the rates charged, hours worked, necessity of work performed and supporting documentation for expenses itemized in defense attorney bills. Reimbursement should be sought, as appropriate.

- Voidable preferences/fraudulent transfers

Early in the administration of an estate, the receiver should review the insurer's recent pre-receivership transactions for purposes of determining whether potential voidable preferences or

fraudulent transfers of assets were made. See Chapter 9—Legal Considerations, Section VIII, C and D for a discussion of voidable preferences and fraudulent transfers.

F. TAKE CONTROL OF BOOKS AND RECORDS

One of the receiver's first steps should be to locate, control and organize certain files. Securing and organizing the records of an insurer in receivership is of paramount importance to successfully completing the receivership.

A plan to deal with records, including all electronic records, should be developed. The plan should provide for the creation of a records inventory. The plan should identify the data to be captured from the insurer's records, i.e., the names and locations of insureds, reinsurers, etc., and should deal with both the location and maintenance of the files.

It is best to have experienced personnel and legal counsel with an insurance operations background develop this plan. In crafting the plan, the receiver should consider:

- Establishing a central clearing house for all records or having the receiver's staff review records in each department to identify and secure key records. In this manner, the receiver will be able to ensure that all records are recovered, reviewed, and appropriately maintained for further use.

- Determining the location of various records, such as those of MGAs, TPAs, agents, independent adjusting firms, attorneys, branch offices and subsidiaries.

- Determining the various categories of documents—such as policies, claims, data processing, banking, accounting, corporate, state, and federal tax, marketing, personnel files, reinsurance files, and administrative files—and how they should be maintained.

Checklists found at the end of this chapter identify items that should be secured and organized under each area.

It is important to limit access to the premises or other facilities to preserve the integrity of the books and records and to prevent the dissipation of receivership assets. It is also essential to provide notice to consultants used by the insurer—such as accountants, actuaries, and lawyers—of the receivership order, demanding that all records of the insurer in their possession be turned over to the receiver. Failure to turn over the insurer's records to the receiver is a violation of most state statutes (IRMA §118A). In the event a consultant is unwilling to turn over records of the insurer, the receiver should consult with legal counsel.

G. INVENTORY

The receiver should inventory the assets, books, and records as soon as possible. This inventory may not only be required by state law, but it may also be useful in determining whether items have been misplaced or were later removed from either the insurer's premises or the receiver's offices and facilities. The inventory should be conducted at the insurer's offices. The items listed in the checklists included in the exhibits at the end of this chapter should be itemized and secured.

While conducting the inventory of books and records, the receiver should begin identifying documents relative to the cause of the insurer's insolvency. Statute of limitations vary by state. The receiver may have a limited amount of time to file actions against other parties. The NAIC and FBI have developed a questionnaire to be used by a receiver in reporting fraud and other white-collar crimes to the United States Department of Justice for the purposes of initiating a criminal investigation (See Exhibit 1-3). Among the typical causes of insurer insolvency are:

- Undercapitalization;

- Uncollectible, illiquid, or inflated assets;

- Insufficient loss reserves for risks assumed;

- Misappropriation or conversion of insurer funds by management, affiliates, agents, TPAs, or others;
- Commitment to unprofitable business by uninformed or undisciplined agents;
- Collectability of reinsurance;
- Negative cash flows due to unprofitable lines of business;
- Poor underwriting;
- Unnecessarily risky investments;
- Fraudulent transactions; and
- Other forms of mismanagement.

Any indication of fidelity bonds, directors and officer's policies, error and omission policies or other indemnification coverage should be identified, segregated, and made accessible to the receiver and receivership counsel. The documents should be reviewed immediately, and carriers placed on notice to preserve the rights of the estate.

H. MOVE TO CONSOLIDATE

Consolidation of the receivership's offices and storage facilities could result in increased productivity and reduction of labor and storage costs. For that reason, an assessment of the value of maintaining the insurer's offices and storage sites should be made in the early days of the receivership. Consolidation of the books and records should take place only after: 1) an inventory is completed; 2) the receiver has considered the impact upon the insurer's ability to handle claims in an orderly and efficient manner; and 3) the receiver has considered the potential impact upon the insurer's relations with any existing agency network. If the insurer is in conservation or rehabilitation, the receiver should weigh the effect a consolidation might have upon the insurer's marketing program.

I. COORDINATION WITH ANCILLARY RECEIVERS

Any assets of an insurer in liquidation that are held by a non-domiciliary state should be returned to the domiciliary receiver of the insurer. Under §1001 of IRMA, the need for an ancillary receivership has been curtailed. IRMA allows the appointment of an ancillary conservator under limited circumstances. A domiciliary receiver is automatically vested with title to property in any state adopting IRMA, and the test of whether a state is reciprocal has been eliminated. IRMA also clarifies the procedures for handling deposits.

The NAIC models prior to IRMA permit reciprocal states to establish receiverships ancillary to the domestic state's receivership. Typically, an ancillary receivership would be established to distribute assets in the ancillary state (i.e., statutory deposits) to claimants residing in that state. However, an ancillary receivership may be established for purposes unrelated to claims handling. In certain instances, the domiciliary receiver may request that an ancillary receivership be established for a variety of reasons, e.g., to assist the domiciliary receiver in selling real property located in the ancillary state or to assist the domiciliary receiver in handling litigation pending in the ancillary state.

State statutes based upon NAIC models prior to IRMA allow or may require ancillary receiverships under certain circumstances. If an ancillary receivership is not required by statute, it should be opened only after carefully evaluating the additional administrative costs that would be incurred by the insolvent insurer. The activities of the domiciliary and ancillary receivers should be coordinated to minimize the cost of the ancillary proceedings.

Domiciliary receivers must consider the following issues, which commonly occur between the domestic and ancillary receivers:

- The security of the insurer's assets and records;
- The security of the insurer's out-of-state offices or storage facilities;
- Consistency and reciprocity of authority;
- Coordination of the transfer of policy/claim files to guaranty associations;
- The need for a receivers' agreement (see discussion below regarding receivers' agreement);
- The need for local counsel in other jurisdictions;
- The status of litigation by the ancillary receiver; and
- The method of funding and payment of approved ancillary claims.

To facilitate coordination, the ancillary receiver should request copies (certified, if available) of all domiciliary pleadings and orders, together with the names, addresses (including e-mail addresses), and phone and fax numbers of personnel in the domiciliary state.

Legal counsel for the domiciliary receiver should review the proposed ancillary petition and order as soon as they are received to assure that: 1) under the order, the rights of the ancillary receiver are subordinate to the rights of the domiciliary receiver; and 2) the ancillary receiver's bar date is no later than the bar date established by the domiciliary receiver. Some state statutes permit ancillary receivers to establish shorter claim filing periods but prohibit claims deadlines that exceed those established by the domiciliary receiver.

In the event that the proposed ancillary order is not acceptable to the domiciliary receiver, the domiciliary receiver should request a revision. If the ancillary receiver refuses, the domiciliary receiver may be required to file an objection in the ancillary proceeding, asserting that the ancillary order violates the law of either or both states.

1) Receivers' Agreement

In some situations, it may be possible to negotiate a receivers' agreement, with the goal to consolidate functions and to clarify the authority and obligations of the domestic receiver and the ancillary receiver concerning:

- Coordinating the preparation of a jointly acceptable proof of claim form;
- Filing and processing proofs of claims;
- Funding and maintaining an account for payment of approved claims;
- Identifying and locating TPAs and MGAs licensed by the insurer in each state;
- Identifying and locating all bank and financial accounts;
- Locating outstanding claims files and arranging for shipment of files between states;
- Coordinating policy cancellation and impairment order dates;
- Collecting agents' balances;
- Controlling director and officer litigation by the domiciliary state;
- Administering and closing out-of-state offices;
- Marshaling assets located in the ancillary receiver's jurisdiction;

- Determining the disposition of assets collected by the ancillary receiver;
- Controlling and securing information (e.g., claim files, policy files, premium volume in the ancillary state, etc.) that is essential for the orderly administration of the estate; and
- Coordinating the oversight of the insurer's out-of-state litigation.

2) Claims Handling

When there is no ancillary receivership, citizens of non-reciprocal states should file their claims in the domiciliary state. Some pre-IRMA state statutes provide that a resident of an ancillary state has the right to file a claim in either the domiciliary or the ancillary proceeding. Other states leave the decision to establish a claims procedure in the ancillary state to the discretion of the ancillary receiver.

3) Ancillary Proceedings Without a Domiciliary Receiver

Ancillary receiverships are usually established only after a domiciliary receiver has been appointed. However, some states do not have the limitations imposed by IRMA and, even when no domestic receiver has been appointed, do permit the establishment of an ancillary conservatorship or liquidation, provided that the non-domestic regulator can prove one or more of the grounds required to establish a domestic receivership. Nonetheless, the ancillary receivership order operates only upon the assets found in the ancillary jurisdiction.

V. ACCOUNTING

Please refer to Chapter 3—Accounting and Financial Analysis and Chapter 4—Investigation and Asset Recovery when reviewing this section.

Upon taking control, one of the receiver's primary responsibilities is to secure the insurer's assets—particularly the most liquid assets, such as cash and securities. This responsibility includes identifying lines of credit, limiting, or removing access to company credit cards and preparing an inventory of all accounting records and documentation as soon as possible. The accounting area will also be responsible for financial statement analyses to determine the true status of the insurer and the continued reporting of financial information for internal decision-making processes.

A. SECURE ASSETS

Because cash and securities are liquid, the receiver must quickly identify, locate, and secure assets. The receiver should immediately notify all depositories and custodians of the receivership order, provide the new authorized signatories, and establish the procedures to be implemented for all financial transactions. Letters of credit should be identified and secured by the receiver. Once the assets are secure, the receiver will evaluate and value them.

B. INVENTORY ACCOUNTING RECORDS

As soon as practical, the receiver should identify and secure the on-site and off-site books, records, systems, and documents necessary to maintain and review the accounting functions of the insurer and to determine the actual financial condition of the insurer. These should include most recent insurance department examination workpapers if allowed under state law and CPA audit workpapers.

C. INVESTIGATION OF INSURER'S FINANCIAL STATEMENTS

The receiver should develop an understanding of the accounting organization, including evaluation of the staff. Flowcharts and narratives of the accounting procedures should be obtained or completed with particular attention to the areas of cash receipts and cash disbursements focusing on decision points and internal controls. To the extent procedures need to be modified to protect the assets, new procedures should be put in place as quickly as possible. From the information developed here, the receiver should begin to investigate the make-up of the balance sheet line items, validate the existence of the assets, and value them.

D. FINANCIAL REPORTS

Accounting and financial reporting by the insurer will continue to be necessary and important. Financial reports will be required by the receivership court, and cash flow and budget information will be essential for the day-to-day operations of the receivership. Continued filing of the various types of tax forms is mandatory (although some may be eliminated) during the existence of the estate. Additionally, the continued reporting of paid claim information for reinsurance billing and actuarial reserving will also be crucial.

At the beginning of the receivership, the appropriate parties should determine the type of information to be reported to various entities, the frequency of the reporting and the formats the information should take.

VI. INFORMATION SYSTEMS AND TECHNOLOGY

Please refer to Chapter 2—Information Systems when reviewing this section.

This section highlights the activities that should take place for a receiver to understand and take control of the insurer's systems. To the extent possible, the receiver should not allow anyone access to the insurer's computer system until a complete backup of the system is complete. It is not uncommon for the insurer's computer systems to be intertwined with that of its affiliates; therefore, legal consultation is advised prior to taking any action that may impact the affiliates' operations.

Detailed tasks are listed in the checklist included in the exhibits at the end of this chapter.

A. EVALUATING HARDWARE/SOFTWARE

For any hardware/software owned by the insurer, the receiver should determine whether to maintain it or sell it. Prior to the sale of any equipment, the receiver should determine if that equipment is required to support any ongoing or contemplated litigation. A sale may require court approval.

B. SYSTEM SHUT DOWN

The receiver should arrange for the orderly shutdown of the computer system. Prior to shut down, the receiver should ensure that all records have been updated and all final reports have been run. It is suggested that a data processing checklist of all reports and programs to be run be completed prior to the shutdown period.

With all data updated, the receiver should make certain the information systems department performs a full system backup prior to the clearing of all files on the system. Once completed, the system may be powered down.

VII. CLAIM OPERATIONS

A. TAKE CONTROL OF CLAIM PROCESSING AND PAYMENT

A receiver should plan to put in place appropriate controls over claim processing and payment authority of the insurer's claim department and establish the capability to control and review the insurer's claim records. Claim records may be contained in hard copy files, electronic records, or a combination of both, and may be under the control of the insurer's claim department at its main office, branch offices, or by a TPA.

Some of the initial goals in establishing control may include a review of claim policy and procedure manuals, the coverage confirmation process, claim reserving methodology, settlement practices, and applicable electronic claim processing systems. If written documentation of the insurer's claim policies and procedures does not exist, a receiver may wish to interview key claim personnel to develop and document claim processing procedures.

For Health receiverships additional considerations include prior authorization requirements, capitated arrangements and referrals, and outside claims handling by PBM mental health and or durable

medical equipment]

B. DEVELOP AN UNDERSTANDING OF CLAIM OPERATIONS

A receiver needs to understand the operations of the claim department, including its organization and workflow, processing systems and data, type, and nature of claims, and gather key information on the number of pending claims and outstanding reserves by category of business.

C. REVIEW OF CLAIM HANDLING

A receiver may wish to review the claim handling process by obtaining or preparing an overview of the typical workflow for processing a claim. This workflow might include a summary of all key interactions between claim personnel and other departments. If workflows vary by claim type and product line, the preparation of a separate workflow summary for each product line may be necessary.

The receiver should determine whether the insurer uses an active diary system for claims. Such a system monitors the claim handling process and records the dates of each step in the process. As part of the claim diary system investigation, obtain an overview of the diary functions, including the relationship between the manual and the electronic elements of the processing system.

With a basic understanding of claim handling policy and procedures, a receiver may wish to determine whether there are any constrictions in the claim resolution process such as:

- Setup of new claims;
- Correspondence files;
- Claim diaries;
- Indemnity payments;
- Loss adjustment expense payments;
- The handling of insurance department complaints;
- Reinsurer claim inquiry;
- Reporting to reinsurers;
- Subrogation and salvage recovery; or
- Inventory of unprocessed claims including those claims not yet entered on the claims system.

D. REVIEW OUTSIDE INVOLVEMENT IN CLAIM HANDLING

In addition to TPAs, several other types of outside parties may participate in claim handling, e.g., legal counsel, independent adjusters, appraisers, investigators, etc. A receiver should review these roles and determine whether to confirm or reject contracts with such vendors.

E. CLAIMS HANDLING IN CONSERVATION/REHABILITATION

Depending upon the insurer's financial position and liquidity, circumstances may require a receiver to impose a moratorium on the continued ordinary payment of claims, defense of insureds, cash surrenders, policy loans or dividends. In such circumstances, consideration may be given to hardship exceptions for claims that meet certain established criteria for continued payment or partial payment, such as claim category or payment percentage. Hardship exceptions to a claim payment moratorium should be approved by the supervising court and based on exigent circumstances such as disability of an employee or policyholder, the impoundment of an automobile undergoing repairs, or the future availability of guaranty association coverage.

For detailed information on how to handle claims in a liquidation, see Chapter 5—Claims.

F. UNIFORM DATA STANDARDS

In December 1993, the NAIC adopted the Uniform Data Standards (UDS) for use in reporting policy and claim information between property and casualty guaranty associations and receivers for property and casualty receivership estates. UDS is a defined series of electronic data file formats that facilitate data exchange between receivers and guaranty associations related to the insurer's unearned premium, claims, and loss adjustment expense. The UDS Operations Manual provides an explanation of the current reporting format. A copy of the Uniform Data Standards Operations Manual P&C ("Claims Manual") can be downloaded from the National Conference of Insurance Guaranty Funds website (ncigf.org) for free.

Refer to Chapter 2—Information Systems and Chapter 6—Guaranty Funds for further information on UDS.

VIII. REINSURANCE

Please refer to Chapter 7 - Reinsurance when reviewing this section.

Understanding reinsurance is critical to the receiver's ability to marshal this asset. With respect to property/casualty insurers, reinsurance receivables usually represent the largest asset of the estate. With respect to life insurers, reinsurance may be critical to the rehabilitation or liquidation proceeding, and generally all ceded reinsurance agreements should be continued. See §612 of IRMA and Section 8(N) of the Life and Health Insurance Guaranty Association Model Act. This asset may require immediate attention upon commencement of the receivership.

A. LOCATION OF REINSURANCE DOCUMENTS

Before the receiver can begin to marshal reinsurance receivables, it is necessary to understand the reinsurance relationships of the insurer. To accomplish this, the receiver must first locate and categorize the various documents reflecting the reinsurance arrangements of the insurer. The receiver should take control of original reinsurance contract documents. These records should be secured, copied, or scanned and then inventoried. The receiver may create working copies for use during the receivership. The integrity of the original records should be maintained in the event they are needed in the future.

B. LETTERS OF CREDIT AND TRUST AGREEMENTS

Letters of credit (LOC) and trust agreements must be located and placed in a secure area. These documents should be reviewed as soon as possible to determine whether any immediate action is necessary to ensure the continuation of the LOC or trust agreement. Under certain forms of letters of credit, the LOC may expire by its own terms, although it is more common that they renew automatically. In some instances, the original LOC must be presented to the issuing financial institution to draw against the letter of credit.

C. ROLE OF INTERMEDIARIES

It may be in the best interests of the receivership to continue working with intermediaries. The intermediary has at its disposal detailed information that the receiver may not have. The intermediary should be notified of the insolvency proceedings immediately and instructed as soon as possible on duties and responsibilities it should continue to perform for the receiver.

The duties of the intermediary need to be clarified. The receiver may decide to instruct the intermediary to take one or more of the following actions:

- Advise all reinsurers or cedents of the status of the insolvent insurer;
- Turn over all funds in their possession due the insurer;
- Turn over original LOCs;

- Continue to render accounts to receivers and reinsurers;
- Assist in the collection of funds from reinsurers;
- Transmit claims and other notices to the receiver and the reinsurers;
- Establish procedures for the handling of reinsurance inquiries; and
- Cease netting of accounts among insurers.

Under certain circumstances, the receiver may find it preferable to discontinue the use of the intermediary. In this event, the receiver should deal directly with the reinsurers, with appropriate notice to the intermediary.

D. IDENTIFICATION OF FUNDS HELD

The receiver should prepare a list of insurers that are holding funds of the insolvent insurer, as well as a list of insurers for which the insolvent insurer is holding funds.

E. PAYMENTS TO REINSURERS

One of the key issues facing the receiver in the short term is whether to continue to pay reinsurers on a current basis and/or cure prior defaults. This may be necessary to continue the reinsurance in effect, particularly if there have been pre-receivership defaults. This is a legally intensive problem, and the receiver needs to engage legal counsel on these matters as soon as possible. The decision will depend on an array of factors, including the terms of the reinsurance agreements, applicable state law, and the payment status of the contract.

IX. HUMAN RESOURCES

A. OPEN LINES OF COMMUNICATION

The commencement of a receivership can be difficult for an insurer's employees. Many employees are not aware of the circumstances that have led to the receivership. Productivity and employee morale often decline. Meetings with employees at the commencement to explain the receivership process as well as the receiver's current objectives can be very important. Establishing an open dialogue and clear lines of communication will minimize the spread of misinformation and can mitigate untimely staff departures.

B. PERSONNEL, PAYROLL AND BENEFITS

It is important that a receiver assume oversight of an insurer's direct employees, payroll, and employee benefits with minimal disruption to existing processes. A receiver may also need to assume oversight of pension or 401(k) plans, over time, establish new benefit programs for direct employees, and consider whether to continue, replace, and wind-down existing employee benefit programs. A summary of the critical human resource tasks is contained in the checklists included in the exhibits at the end of this chapter.

Employees may be employed by an affiliate or holding company, rather than as direct employees of the insurer. In such cases, a receiver will need to review existing cost-sharing arrangements or contracts for reimbursement with the affiliate. In such instances, a receiver typically would not have direct responsibility for the employee benefit programs pertaining such employees.

C. STAFFING PLAN

One of the receiver's responsibilities will be to develop a staffing plan for the receivership that identifies both short- and long-term personnel requirements A receiver may wish to develop an organizational chart, comprehensive job descriptions, and personnel files for receivership staff. As responsibilities and job functions may change during the receivership process, including transitions from conservation, rehabilitation, and liquidation, a receiver may be required to periodically assess and update the receivership staffing plan.

D. LEGACY STAFF RETENTION

Legacy staff can be well positioned to provide a receiver with institutional and operational knowledge that will benefit the future operations of a receivership estate. A receiver may accordingly wish to look to legacy staff to augment the short- and long-term receivership staffing plan. Staff resignations and reductions in force are typical during a receivership as certain operations begin to wind-down and the insurer is no longer perceived to be a going concern. A receiver's staffing plan may also include the retention of certain legacy employees until their requisite knowledge and expertise are no longer necessary for the operation of the receivership estate. In such instances, retention incentives may be required to achieve the receiver's staffing objectives. Retention incentives may include one or more of the following:

- Maintenance or adjustment of existing benefits, including severance;
- Performance and salary review process;
- Retention bonuses;
- Educational or tuition reimbursement; and
- Providing outplacement services.

E. OTHER PERSONNEL ISSUES

The receiver should identify any personnel related litigation and other disputes to include equal employment opportunity complaints, workers' compensation claims and wage and hour complaints, etc. These matters should be managed by the receiver's personnel consultants and/or legal counsel.

X. CLOSURE OF THE ESTATE

Please refer to Chapter 10 – Closing Estates when reviewing this section.

The best time to start planning for closure is at the start of the receivership. Since the receivership process may take several years, the receiver may wish to prepare a closure task list or checklist. A partial list can usually be developed through a review of the receivership statute of the domiciliary state. The following are some of the general tasks that should be accomplished before a liquidation estate can be closed:

- All assets have been marshaled;
- Litigation has been resolved;
- Ancillary proceedings have been closed or resolved to a point that will not impede closure of the domiciliary receivership;
- Guaranty association claims against the estate are finalized to the extent that a final distribution can be made to the associations;
- All claims have been allowed or disallowed by the supervising court;
- Appropriate distributions have been made to creditors;
- Where appropriate, the dissolution of the corporate entity has been resolved; and
- Final tax returns have been prepared and filed with the federal government and financial settlements prepared as required.

A. GUARANTY ASSOCIATIONS

The claims of guaranty associations may not be completely certain at the time non-guaranty-association-covered claims (including contested claims) are adjudicated by the liquidator. The covered

claims that the guaranty associations handle are subject to a number of variables. Prior to making a final distribution, the liquidator may, where appropriate, consider policy reserve calculations as a basis for valuing guaranty association policy level claims (e.g., through the use of present value method). If early access payments were excessive, overages will have to be returned prior to processing the final distribution.

For a discussion of guaranty associations, see Chapter 6—Guaranty Associations.

B. ANCILLARY RECEIVERSHIPS

Closure of an ancillary receivership is generally less complicated than closing a domiciliary proceeding. Ancillary receiverships should be closed before the domiciliary receivership begins closure proceedings. Some state statutes provide that special deposits are established for the benefit of the policyholders in that state, who will either be paid in full or will share *pro rata* in the special deposit. If excess special deposit assets exist, the excess should be returned to the domiciliary receiver for distribution to the creditors.

Distributions to ancillary special deposit claimants are subject to the rule that all claims at that priority level share at the same percentage to the extent possible. If distributions in the ancillary proceeding will be made beyond the policyholder claimant level, the domiciliary liquidator should arrange for the excess unpaid portion of the ancillary special deposit funds to be returned to the domiciliary estate.

C. TAX RETURNS

When the receivership is required to file tax returns, scheduling the filing of the final return may be difficult. The filing of the final return will follow the application and order for closure. Counsel and tax advisors should be consulted to determine the best method for handling the filing of a final return for a particular receivership. The timing of the dissolution of the entity should be carefully considered because valuable tax attributes may be lost.

See Chapter 3, Section VIII for further discussion.

D. FINAL ACCOUNTING MATTERS

1) Adjusting and Closing Entries

Timing adjusting and closing entries with regard to the final report can be difficult. Generally, the liquidator will want to have the accounting books closed prior to the issuance of the final report and the filing of an application for closure with the supervising court. But there usually will be some accounting activity that must take place after either the final report or closure order.

During the early phases of the receivership, efforts are centered on determining what the assets and liabilities of the insurer were on the liquidation date. After the liquidator has written off any uncollectible assets, marshaled all the available assets, and distributed all the monies that can be paid, there may remain assets to be written off and unpaid claims as unsatisfied liabilities. Provision should be made for dealing with outstanding checks, escheat funds and post-closure recoveries that do not justify reopening the estate.

2) Reserving Final Expenses

Expenses may be incurred after the closure order has been issued; therefore, funds may need to be reserved for administrative expenses. These expenses may include final lease payments; employee withholding and taxes; storage charges; transportation charges; final tax preparation; bank charges; legal, accounting and data processing consulting expenses; postage; court costs; and salaries. In preparation for closure, it is necessary to have all administrative expenses current.

E. ABANDONED ASSETS AND CAUSES OF ACTION

There may be both assets and causes of action that may not be cost-beneficial for the liquidator to pursue. Since the duties of the liquidator include marshaling the assets and liquidating them for the benefit of the creditors of the insolvent insurer, it is advisable for the liquidator to obtain court approval of any decisions regarding abandonment. The liquidator may also wish to consider negotiating with guaranty

associations for the transfer of assets and causes of action to the guaranty associations as distributions in kind, potentially reducing their claims against the state.

F. FINAL REPORTS AND APPLICATIONS OR MOTIONS

A final report on the liquidation must be made to the supervising court. This final report may be filed before, after or with the application or motion for closure of the estate. *(See Chapter 9—Legal Considerations.)* Prior to closure, there may be a need to have the supervising court approve, to the extent it has not already done so, the following actions:

- Expenditures;
- Reserves set for final and post-closure expenses;
- Amounts to be paid in final distribution to creditors;
- Arrangements for destruction or storage of records;
- Valuation of any distributions of assets-in-kind to any claimants; or
- Any other significant transactions or procedures.

G. FINAL CLAIMS MATTERS

1) Final Distribution

The final distribution percentage is calculated by dividing the assets available for distribution by the amounts allowed for claims filed and approved by the supervising court. The receiver must reserve sufficiently for administrative expenses that may be incurred after the distribution has been made.

There may have been interim distributions from the estate that will need to be considered when calculating the distribution percentage applicable to the final distribution. Also, early access payments made to guaranty associations should, by order of the supervising court, be treated as distributions and taken into account when the final distribution is made. If there is a need to have guaranty associations return any portion of the early access payments, it must be identified when the receiver starts calculating the final distribution percentages.

2) Former Insureds with Unsettled Litigation

Ongoing litigation of non-guaranty-association-covered claims may impede closure of an estate. Some states provide that the insured's claims can only be paid based on the lower of: (1) the recommended and allowed amount assigned to the claim; or (2) the amount established in the underlying claim against the insured. This may require that the receiver waits for all claims against former insureds be settled or barred before making final distributions and moving the estate to closure.

3) Reducing Reserves or Recorded Allowances on Claims

After a distribution has been made, the record of allowed claims may need to be adjusted for tax purposes or to enable additional distributions to be made.

4) Unclaimed Dividends and Escheated Funds

The receiver may not be able to locate all claimants. Also, there are claimants who will refuse to accept their liquidation distribution because they are involved in litigation and believe that accepting payment would prejudice their case. State statutes may require special treatment of funds related to unclaimed distributions. Further, after a certain time period, funds held for unclaimed distributions will escheat to the treasury of the domiciliary state. *(See Chapter 9—Legal Considerations, Section III.)*

H. CLOSING THE OFFICE

After all the records have been either destroyed or sent to the appropriate archives, any separate office maintained for the liquidation will need to be closed. One of the items related to closing the office may be cancellation of any remaining lease term and insurance coverage on staff, equipment, and the office space itself. In many cases during a liquidation, the office will have been closed early in the receivership process to reduce expenses.

I. POST CLOSURE MATTERS

There may be inquiries for records and information made by former agents, insureds, and other interested parties after the closure of the estate. Usually, these will be referred to the domiciliary insurance department, and basic insurer information may be posted on the domiciliary insurance department's website. If the request is for pre-insolvency financial data, the request will probably be handled by the department. Arrangements should be made to brief someone on the permanent receivership staff or in another division within the department of insurance so that post-closure questions can be answered.

J. POTENTIAL REOPENING OF ESTATE

Some statutes provide for the reopening of an estate upon the occurrence of certain events. For example, assets not previously discovered or written off may become available, making an additional distribution possible. However, a careful analysis should be made to determine whether an additional distribution would be cost-effective.

CHAPTER 2 – INFORMATION SYSTEMS

*Page numbers in TOC will be updated in final publication.

I. INTRODUCTION

A. Information Systems ─ Requirements and Considerations

The management of an insurance company in receivership is, to a great extent, the management of information. To successfully perform receivership functions and fulfill all obligations and responsibilities, the receiver must effectively utilize system resources.

The nature of the receivership, conservation, rehabilitation or liquidation will affect systems requirements. The type of business written by the insurer, whether Life, Annuity, Accident & Health, Property, Casualty, Liability, Surety, Title, Workers' Compensation or other lines, will also affect systems requirements for the receiver. Systems needs, and the timing of those needs, will be different in a conservation or rehabilitation process than in a liquidation process.

Because of the importance of securing the data of any company subject to a receivership, immediate attention must be given to obtaining a backup of the data, and consideration given to obtaining a complete backup of the systems.

In all conservation and rehabilitation efforts, the immediate focus is ongoing insurance company operations and the changes necessary to help ensure the viability of the company. A priority focus will be on analysis and management of information to support decision-makers. Realizing potential opportunities such as mergers, divestitures and loss portfolio transfers will require considerable information on all aspects of the business. Throughout the conservation or rehabilitation process, it is necessary to continually consider potential future requirements, such as release of the company to existing management, transferal to new owners (of the insurance business or the entire company) or transition to liquidation. In doing this, the receiver will need to look ahead to what systems requirements may be needed for other contingencies and make arrangements so they are in place when needed.

Liquidation processes will require a focus on timely conclusion of normal operations and an accurate final statement of assets and liabilities. Systems support will be required for estate liquidation processes, including interfaces with guaranty associations, management of claims against the estate, recovery of all receivables, pursuit of causes of action to benefit the estate, and disposition of physical assets. Compliance with all legally required processes and documentation to support compliance are crucial.

B. Overview

The chapter has been divided into the following parts:

- Taking Control
- System Management and Control
- Information System Deliverables
- Implementation

These sections are in the order that anticipated issues may arise during the receivership process. Insurers will vary in size and degree of system sophistication. Each insurer will present varied problems and issues dependent on the situation. In general, companies going into receivership have often neglected internal controls which may have resulted in many control issues related to the company, its systems, and completeness and accuracy of its data. The guidelines, considerations and checklists provided herein are very broad in nature. Management judgment will best determine the appropriate degree of applicability or whether alternate processes are required.

Generally, though, the receiver will first have to gain full control over the systems. Then the receiver can develop a more in-depth knowledge of processes to determine the best manner to meet the needs of the receivership.

This chapter provides suggestions and guidelines as to management of systems, issues resolution and problem avoidance in support of receiverships. While this chapter is intended to be as comprehensive as possible, it is not all-inclusive. Other methodologies may be employed to achieve the same goals in a satisfactory manner, and issues not addressed here may arise. In every receivership, no matter the size or characteristics, the receiver must exercise judgment beyond that which can be given by texts and checklists. Still, the materials provided here should assist in the exercise of that judgment.

This chapter focuses on issues primarily related to automated information systems. When considering the scope of information systems, however, it is important to apply a holistic perspective that considers systems as being made up of processes and procedures—both automated and manual, including human judgment—in performing tasks.

Other chapters of this handbook, specifically the accounting, claims and reinsurance chapters, address many issues related to information and manual processes. Information systems are an integral part of the operations of an insurance company and any receivership. However, not every system need must be met with a fully automated solution. Costs and benefits must be carefully analyzed.

There are detailed information systems checklists in Chapter 1 that should be consulted in advance if possible and then throughout the receivership process.

II. TAKING CONTROL

This section covers the activities necessary for a receiver to take control of an insurer's information systems in an effective manner. Generally, the checklists provided address a worst-case scenario: an information systems department that lacked control, where many key people have departed, and where documentation is incomplete, inaccurate or non-existent. The checklists should be completed for documentation purposes, noting those areas of the checklist that do not require action.

A. Assurance of Data Maintenance and Availability

The insurer's data will be in records and files stored within the computing infrastructure. It is important for the receiver to determine location, purpose, structure and content of data files related to all business applications. Given the complex and detailed nature of this information within the context of a contemporary liquidation as well as the security concerns that have increased significantly, it is desirable that the receiver have relevant background information prior to the signing of a liquidation order if possible. Ideally, this information would be shared with the affected guaranty funds in advance of liquidation. These steps will greatly enhance efficiency once liquidation is underway and result in even more dependable and timely protection of policyholders. A good starting point to gather pre-takeover information is the systems summary grid and any IT related workpapers from the company's most recent financial examination. Reviewing this information in advance of takeover will give the receiver a head-start for what to expect. It is essential that the receiver's information systems personnel work with the other departments within the insurer to assure that all the available information has been captured and can be retrieved and reviewed at a later date. All system storage devices, including database servers, Web servers, file servers, application servers and related storage media should be reviewed as sources of company information. End-user computing (EUC), such as spreadsheets, databases, etc., that are maintained by business departments should also be considered. EUC applications can easily fall through the cracks if there is no central repository of the EUC applications and there is turnover of personnel who maintain the EUC.

Regardless of system ownership issues, it should be the practice to immediately back up all available data on all systems. Where possible, employee workstations, including laptops, should be backed up as well.

At a minimum, key employee workstations and laptops as determined by receivership management should be backed up.

For each major application, the receiver should obtain the following information:

- Name of application program;
- Vendor contact information, if applicable;
- Vendor contracts
- Sources of data (automated or manual);
- References to and storage of source data;
- Complete tables of all codes used (database schema and data dictionary, when available);
- Type and frequency of processing cycles;
- Narrative descriptions, in non-technical language, of capabilities and use;
- Administration procedures, including responsibilities of staff;
- Administrative user names and passwords for the application (also, if administration is restricted to a particular workstation or terminal);
- Systems error messages and appropriate actions;
- Distribution of output reports and samples if possible;
- Usage and control of reports;
- Links to other system modules; and
- Backup procedures including storage and retention schedules

B. Security and Data Privacy

One of the highest priorities of the takeover phase of systems operation should be the review or initiation of system and data security procedures. The existing data may be the most reliable or only record of the assets and liabilities of an estate, and the need for securing this information is vital. In general, when the receiver takes control of the insurer's IT systems, access should be restricted until the receiver is confident that data cannot be altered by unauthorized parties. The receiver should identify the levels of access given to employees and any third parties for all applications and limit access as necessary. Remote access should be restricted to authorized users and only to users with encrypted laptops from trusted networks, such as corporate offices, virtual private networks (VPNs), etc.

In conducting a security review, the receiver is cautioned that relevant and important data records may reside on mainframe computers, servers, PCs, tablets, cellular phones on the systems of contractors or any combination of all of these. Historical information systems records in the form of backup tapes, which may be stored off-site, may be of equal or greater importance and should not be overlooked. The insurer may also maintain a website (see section G—Internet/Intranet/Website), which should also be included in the security review.

One of the primary purposes of the security program is to obtain and safeguard all required data records, which entails the identification and securing of this data. Such a program should include the creation and implementation of a plan to limit access to the systems and data to those with a proven need. The program should enable the receiver to identify changes made to the system and the individual responsible for these changes. The ability to track changes to systems may be limited by the existing company software applications. The information systems checklist in Chapter 1—Takeover will provide the receiver with an overview of the most important aspects of a proper system security program.

In addition to securing the data of the company for conservation, rehabilitation or liquidation information, it is essential to ensure the secure handling of non-public personal information. Insurance companies and other financial institutions are subject to a variety of state and federal statutes and regulations regarding the protection and non-disclosure of non-public personal financial and health information. Some specific requirements are imposed by federal statutes such as the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, among others. Additional requirements may be found in state statutes, data security breach laws and in state insurance regulations, including those based upon the NAIC Privacy of Financial Information Regulation 2000. Ongoing compliance with applicable data privacy and security laws and regulations is essential to help further the primary goal of all insurance receiverships—the protection of insurance consumers.

Accordingly, the receiver should take steps to ensure the security and confidentiality of customer records and information; protect against any anticipated threats or hazards to the security and integrity of such records; and protect against unauthorized access to or use of such records, any of which could result in substantial harm or inconvenience to insureds or claimants.

The company may have included cyber security self-assessment or audits/ review as an integral part of its enterprise risk management program. If so, the receiver can obtain recent IT audits/ reviews such as: e-commerce areas, self-assessment and IT related reviews of significant third-party vendors. These reports could be in the form of audits/reviews (e.g. internal audit, external audit, SOC type I and II reports, or other contractor affiliate audit reviews. In the absence of a company policy that meets these criteria, it is essential that the receiver implement a data security policy and procedures suitable to the particular receivership. The procedures should be appropriate for the size, complexity and structure of the company and its data. There is guidance contained in the NAIC Receivership Data Privacy and Security Procedures for Property and Casualty Insurers in Liquidation, should address potential security threats in three areas: administrative, technical and physical.

See https://content.naic.org/cmte_e_receivership.htm for this document and other helpful receivership tools, such as the NAIC receivership Data Privacy and Security Procedures policy. Since staffing is often not available to write a new data security policy specific to each receivership, the NAIC's security policy and procedures document referenced above may serve as a guideline which could be edited for purposes of individual receiverships.

Administrative Safeguards

- Designate an individual who is responsible for oversight and compliance with security procedures.

- Publish a written policy statement setting forth the company's (receiver's) intention to protect the confidentiality of sensitive customer data from anticipated threats or hazards. The receivers' policy should include two important components, namely incident handling and communications protocols should an incident occur. Incident handling – General and specific procedures and other requirements to ensure effective handling of incidents, including prioritization, and reported vulnerabilities. Determine if there are procedures related to handling cyber-security incidents. 2) Communications – Requirements detailing the implementation and operation of emergency and routine communications channels amongst key members of management.

- Prepare and distribute written procedures to appropriate personnel and service providers outlining specific steps that must be followed in storage, transmission, retrieval or disposal of sensitive customer information.
- Require all employees and other users to sign an agreement to follow the data privacy and security standards.
- Evaluate potential security threats from existing staff, e.g., disgruntled employees.
- Evaluate service providers regarding the handling of sensitive customer information.
- Train and instruct employees as to their individual responsibilities regarding data privacy and security.
- Train staff to recognize potential security threats, including intentional or inadvertent downloading of malware.
- Check references and an appropriate background screening prior to retaining new staff.
- Periodically test and monitor the effectiveness of the security procedures.
- Evaluate and adjust the security procedures in light of changing circumstances.
- Use appropriate oversight or audit procedures to detect improper disclosure or theft of customer information.
- Implement procedures for notifying appropriate authorities and affected individuals if non-public personal information was subject to unauthorized access.
- Impose disciplinary measures for breaches of privacy and security rules.
- For laptops that are used outside of the office require secure network connection
- Establish a remote work policy for remote workers which includes policies for where work is to be performed with a secured network connection only and safeguards that must be in place associated with their computer and other data (paper files, etc.) used outside of the office.
- Add multi-factor authentication where possible, including email, application servers and company networks.
- Consider disabling USB ports on all company laptops and computers. if appropriate.

<u>Technical Safeguards</u>

- Use password-activated screensavers.
- Use strong passwords unique and independent of any personal passwords.
- Change passwords periodically.
- Prohibit posting of passwords anywhere except for a secure password manager.
- Sensitive information must be encrypted both in transit and at rest.

- Limit or do not allow storage of sensitive information on portable devices such as laptop computers or removable drives or other storage media; if sensitive information is stored on mobile devices, it must be encrypted.

- Limit access to customer information to employees who have a business reason for seeing it.

- Store electronic customer information on a secure server that is accessible only with a password.

- Avoid storage of sensitive information on a machine with an Internet connection.

- Transmit data electronically only through secure, encrypted connections.

- Implement procedures for the prevention, detection and response to attacks, intrusions or other system failures.

- Regularly check with software or systems vendors to update security patches.

- Maintain up-to-date firewalls.

- Back up all customer information regularly.

- Ensure that former employees do not have access to any information systems.

- Ensure that remote access to all information systems is limited to authorized users.

Physical Safeguards

- Lock rooms and cabinets where sensitive data or data storage equipment is kept.

- Ensure the area where data storage equipment is kept is well ventilated, is capable of maintaining an appropriate temperature for the equipment is free from water hazards and is not visible through a window to the outside the office.

- Allow access to information storage areas only to those individuals with a need for access.

- Require employees to secure sensitive information in their work areas whenever they are not present.

- Dispose of sensitive information in a secure manner.

    - Hire or designate a records retention manager to supervise the disposal of records containing non-public personal information.

    - Shred sensitive information recorded on paper.

    - Destroy or effectively erase all data when disposing of computers, diskettes, magnetic tapes, hard drives, copy machines, fax machines, flash drives, or other storage media containing sensitive information.

- Ensure that storage areas are protected against physical hazards such as fire, flood or physical intrusion.

- Maintain a current inventory of all computer equipment.

- Collect keys, computer equipment and other storage devices from employees and disable employee access to company systems prior to termination.

- Develop a computer disposal policy/procedure which includes a strategy for the maintenance and tracking of hard drives.

C. Systems Processes for Conservation, Rehabilitation and Liquidation

Systems emphasis for a conservation or rehabilitation effort typically focuses on timely and accurate processing, resolution of issues and providing information for management. The additional considerations regarding liquidations outlined below may apply in some conservations or rehabilitations.

In a liquidation action, beyond timely processing and termination of operations, there are additional considerations related to accurate identification and valuation of all assets and liabilities of the insurer:

- Liquidation notices and proof of claim processes;

- Policy cancellation and/or non-renewal notices;

- Unearned or return premium calculation;

- Agents' balances calculation and collection;

- Unearned commission calculation and collection;

- Policyholder contract assessment calculations, where applicable;

- Reinsurance recoverable tracking and collection;

- Transmission of claims data between guaranty associations and receivers See Section IV. M. in this chapter for unique standards such as UDS and others that apply to the different types of insurers.

- Salvage and subrogation accounting and collections;

- Inventory and liquidation of physical assets; and

- Transmission of policyholder records and data to assuming insurer for life and health insurer receiverships.

Some systems will have built-in capabilities for creation of the above items, others may not and an extract from the system may need to be taken and manipulated to achieve desired results. Also, when using Company data to create reports, it is important to discuss the completeness and accuracy of the data with company staff since often companies in receivership may have issues where systems are not working properly or other reasons why it is known that the data on the system may not be complete and accurate.

D. Staff

Assuming control of the insurer's information systems is critical to a successful receivership. Gaining control of the information systems usually will be most cost-effectively accomplished through use of the existing staff. Since it is important to gain control of these areas at the onset of the takeover process, it is best to assess the staff at the inception of the receivership to determine how they can assist in the receivership process. In some cases, a plan may need to be devised to provide information systems personnel with incentives to continue their employment as the receiver requires. Even so, it is often

difficult to retain IT personnel, so it is important to perform as much knowledge transfer as possible at the onset of a receivership.

After assessing the experience, potential contribution, commitment and cost of the staff in the context of the goals of the receivership, the receiver may choose to reduce staff. The allegiance of the systems staff, as with other functional areas, may be questionable, and the possibility of sabotage exists. Sabotage of information systems is hard to detect and may be extremely expensive to repair. Because of the potential exposure to loss of critical data, the systems staffing decisions should be made quickly and decisively. Where possible, restrict full access to any systems, equipment or work areas until staffing decisions have been made and implemented.

E. Hardware

In taking control of systems operations, frequently the first concern of the receiver is to inventory and secure the hardware. The hardware may be owned, leased or shared, and arrangements should be made for continued use to the extent the receiver finds necessary to maintain continuity, especially at the onset of the receivership. The receiver will also want to identify collateral equipment located at branch operations, the homes of employees, related entities, storage facilities, other insurers and agencies. All equipment should be inventoried, including all types of portable computers, tablets, cellular phones, and communication equipment.

Contingency plans may need to be developed in case the receiver must cease use of the systems in order to liquidate components.

Maintenance of the hardware should be done on schedule, and the environment should be maintained to prevent loss of data or system outage.

The configuration of the hardware should be specifically identified and cataloged. The computing hardware environment may be made up of a combination of mainframes, mid-size computers, client servers and PC-networked equipment.

For mainframe or mid-size computers, the most important components of their configuration will be:

- CPUs (central processing units);
- Data storage devices;
- Printer(s);
- Tape drives;
- Terminals;
- Data communications equipment; and
- Any other peripheral devices.

Similarly, all PC-network configurations should be identified and may include:

- Network servers, firewalls, intrusion detection devices, routers, switches, etc.;
- Mail servers;
- Web servers;

- Imaging servers;
- PCs and laptops;
    - Make and model
    - Internal storage devices
    - RAM
    - Clock speed
- External storage devices;
- Printer(s);
- Keyboards and other input devices, e.g., scanners, microphones and pointing devices such as a mouse, track ball, touch pad or other sensor;
- Monitor(s);
- Any LAN-connected devices (high-performance cables, terminals, file servers, printers, modems, etc.);
- Data communication equipment such as cell phones, tablets, and any other internet connected devices; and
- UPS (Uninterruptible Power Sources) and generators.

F. Systems Software and Application Software

Systems software includes broad and varied types of software such as operating systems, utility systems, database management, virus protection, e-mail systems, and any other software that is not classified as business application software. These systems are typically commercially available systems that are closely related to hardware components.

Application software directly supports business functions and may be licensed, commercially available software or may be custom-developed including legacy applications developed in-house.

Taking control of the software requires a different approach than that applied to most of the other assets of the insurer. This is especially true for custom-developed software. Control of the software initially means knowledge of the software in place and its intended purpose to the insurer. For licensed software, it is necessary to have an accurate inventory of the software, to have proof of licenses and status of maintenance contracts to ensure authorized legal use, and to obtain updates from the software vendor. In the case of custom-developed software, it is necessary to identify the developer(s), whether contract or in-house, and any relationship with the insurer. It may be necessary to retain an intellectual property attorney to determine the company's rights to the software. The program source code must be physically located; whether on the company's servers or elsewhere, and rights to the source code must be determined. Succession planning information should be obtained for software developed by a sole proprietor contractor.

It will be necessary for the receiver to identify the applications that address the following functional requirements:

- Marketing and sales management;

- Agency interface;
- Customer service;
- Claims management;
- Policy issuance and endorsement processing;
- Premium billing and accounting;
- Reinsurance;
- Policy receivables and payables;
- Cash receipts and disbursements;
- General financial management and reporting;
- Investment management;
- Data warehouse
- Word processing and publishing;
- Company Web site; and
- External interfaces and data sources.

G. Internet/Intranet/Website

Increasingly, insurers are utilizing the Web as a tool for their business and have Web-based technologies implemented. The receiver should review the company's Internet content and application processes. The receiver should also ascertain what Web services are being provided by the insurer and to the insurer by external vendors. Internet service providers should be documented and service contracts obtained and reviewed. The receiver should assume the role of Web-master or make arrangements with a third-party vendor. This may require that external Internet service providers be notified of the change and new passwords issued. Firewalls, Web servers and proxy servers, routers, and other Web- and network-related items should be reviewed for legal, data, ownership, confidentiality and security issues. Integration with the receiver's own Web usage and applications should be reviewed and considered.

If premiums are being collected over the internet the receiver should ascertain the Company is PCI compliant. PCI compliant organizations will have an annual PCI assessment. If the Company is not PCI compliant it is recommended that areas of non-compliance be mitigated or the ability to take electronic payments removed. The receiver should also understand the process for collecting electronic payments and what if any action needs to be taken by company or receiver personnel to collect and record such payments.

H. Newer Technologies

As emerging technologies become more common in the field of insurance, the receiver should be aware of newer technologies that may have been implemented by the insurer.

Imaging systems and distributed processing of underwriting, claims, collections and other operations all have special requirements that the receiver will need to address. An analysis will be needed to determine system ownership, hardware and network components used to support these implemented technologies,

and vendor involvement in the support and maintenance of these systems. These should all be reviewed by the receiver to determine risk, cost benefit of continuation, conversion and receivership issues.

I. New Business Strategies

The receiver should ascertain system ownership and system usage issues such as leased systems, outsourced contractors or vendors performing work or services for the insurer, system availability, and security. The receiver should verify that there will be sufficient access to data and functions necessary to perform the receivership processing. The receiver should identify all the involved parties, what services, hardware and software have previously been provided, what is currently being provided and at what cost.

J. Remote Work

In 2020, the COVID-19 pandemic not only created new challenges for the administration of receiverships where activities were carried out remotely from the insurer's corporate offices, but also brought about changes in how insurance companies operate. Specifically, more insurers have allowed staff to move to remote work or hybrid (partially remote) work environments, as well as to rely more on paperless electronic records and less on (or even eliminate) hardcopy documents. This has led to the need for use of platforms that allow for secure remote access by authorized staff and enhanced data security.

A few IT considerations for the receiver, if the insurer has staff who work remotely, or if the receiver's access to on-site IT systems is limited due to a disaster, include but not limited to:

- Review the insurer's Disaster Recovery and Business Continuity Plan for remote access and maintenance of systems
- Identify and understand the critical automated systems that need to continue operating to support business functions, the persons responsible for critical systems, location and back-up systems (i.e., colocation data center).
- Review the insurer's Work-From-Home Policy to gain an understanding of the roles and responsibilities of staff working remotely
- Understand which employees have remote access to systems and/or may have company owned equipment at home (i.e. laptops, monitor, printers and office furniture)
- Understand what business systems, programs, technology, (e.g., virtual private network (VPN), phone/communication systems) that have been established for employees to work remotely and the internal controls over those systems
- Understand the insurer's cybersecurity controls and data security protocols that are in place to facilitate secure remote access to the requisite systems and data by off-site staff

III. SYSTEM MANAGEMENT AND CONTROL

The preceding section of this chapter dealt with the first task facing the receiver when taking over a distressed insurer—establishing control. This section will guide the receiver through a more detailed continuation of that process by identifying the areas of management and control.

A. Systems Operations

The hardware, software and personnel who keep systems running make up the systems operations. In many mainframe computer operations, the users of the application software may never have seen the actual data center and its various related equipment. Systems operations are typically supported by an internal or external help desk support and network administration.

B. Input/Output Controls

Many application systems both receive and send data to and from other application systems, which can be internal, external or both. This data may be in the form of removable tapes or disks that are visible, or may be in the form of files/databases that reside on non-removable disks and are created by one application system, then later input or electronically transmitted to another application system or cloud storage The input, output and transmission of all data should be subject to controls, which may range in form from a simple notation indicating the application name/date/time to a more complex procedure (manual or automated) that balances or validates record counts and control totals. Controls may also be part of the application program and be unseen until an error or notification prompt occurs.

The receiver should verify that these internal and external controls are in place and fully documented. After the urgent control matters have been addressed, areas where these controls might be improved will be noted through the operation of the receivership.

C. Maintenance/Updates

Some licensed software is automatically maintained and upgraded by its vendor. In many instances, the end user or owner identifies the availability of, and acquires, updates. The receiver should be aware of the availability of updates to software used by the insurer. For some mainframe and mini-computer configurations, current maintenance costs may exceed the cost of converting to a PC-based system. The inventory made of the software and its licensing is important to ensure proper maintenance and may impact business decisions regarding continued utilization of the existing system.

D. Networks

Network systems in which an on-premises file server, cloud server or central processing unit forms the hub of a network of interrelated PCs are now common. The age and adequacy of the networks should be ascertained and the availability of maintenance and updates determined. Networks may include not only the insurer, but other affiliates or holding company of the insurance company; thus, the ability to separate the network into independent components may be problematic. See also Section III.G. below regarding segregating commingled records and data.

E. System Location

The physical location and management of the computer system is also an important issue. Many computer systems are completely internal to the insurer. That is, all of the hardware and software components of the system are within the insurer's premises and control. The benefit of this is that the information systems operation is entirely dedicated to, and focused upon, the objectives of the insurer. However, this also requires that all aspects of the systems operation be managed and controlled by the receiver. To maintain and control an entirely in-house operation, it is vital that the receiver have sufficient systems staff in place. In instances where the receiver has determined that the responsibility and expense of an in-house information systems operation are not desirable, he or she may look to alternative arrangements, such as out-sourced operations.

1. Outsourced Operations / Hosted Systems

A service provider may have performed some or all of the data processing functions. The arrangements for this service may vary from hosted systems to a service provider maintaining the company's internal systems. The receiver's staff should perform an evaluation of the facilities and

competency of the service provider. The receiver should verify that existing contracts will provide sufficient flexibility and accessibility to meet the receiver's needs; new contracts may need to be executed.

2. Shared System

The insurer may share data processing systems with affiliates or other companies, or have its data is hosted and handled by a third party The receiver should ascertain to what extent the system will be available and whether confidentiality will be compromised. The legal issues arising with shared systems should be carefully considered. In the event that the receiver determines that a shared system is not adequate for the receivership's needs, a plan will need to be developed to migrate the insurance company data to another system or dedicated cloud under the control of the receiver or a host company that is independently contracted with the receiver. The receiver may wish to retain an independent consultant to assist with the migration. See also Section III.G. below regarding segregating commingled records and data. See Chapter 9, Section VII for discussion of legal issues relating to information systems and data processing.

3. Affiliate Functions

Some information systems functions may be performed internally, while others are performed by affiliates. Again, the receiver should verify that there will be sufficient access to data and functions necessary to the receivership proceeding. The receiver should also review the cost of any services provided by affiliates. See also Section III.G. below regarding segregating commingled records and data.

F. System Ownership

Systems may be owned outright by the insurer, leased from a third party, leased from an affiliate or provided by a vendor on a fee-for-service basis. Further, various combinations of these possessory interests can exist. However, regardless of the ownership of the systems, the records and data of the insurer held by an affiliate are and remain the property of the insurer and are subject to control of the insurer.

In most straightforward ownership situations, the insurer owns the hardware and software, and the insurer's employees maintain the systems. Possibly the most difficult situations to unravel are where: 1) a related party owns the hardware and leased it to the insurer; 2) another party developed the software and leased it to the insurer; and 3) the staff who operated the systems are on another entity's payroll.

The insurer may own, lease or have borrowed its software from a third party. The ownership of the software should be determined, as ownership affects the receiver's rights to use the software. A contractor may be able to provide services using certain software, but the receiver may not directly use the same software. That is, software licenses may not be assignable to the receiver. Where this is the case, the receiver may have to purchase its own license or use an information systems contractor.

The receiver should identify the service providers, the services performed, hardware and software provided, and all of the applicable costs. The receiver should also arrange for temporary continuation of the information systems services that are critical to the continued operation of the insurer (in a conservation or rehabilitation) or to protect the estate. Whatever the system ownership situation, it should be a practice to immediately back up all available data on all systems, including all active PCs.

G. Conversion

It may be desirable or necessary to relocate the insurer's systems operations or physical servers to a new facility; therefore, the ability to relocate the existing servers or systems should be ascertained. If determined necessary bur are unable to relocate, recreation, cloning or converting data to a new system

into the receiver's environment may be a possibility. The receiver should determine the cost of and ability to create a clone prior to implementing a plan to relocate an office. Sufficient planning and testing by the receiver should be undertaken prior to any decision to move, migrate, clone and/or convert company data.

H. Common Systems Applications

The insurer or estate can put information systems to many uses. The most common are listed below. In each instance, the receiver should ascertain the adequacy of the system and the need to update or enhance it for the tasks that will be unique to the receivership.

1. General Ledger and Accounting Books

The accounting and reporting functions of the insurer or receivership are frequently handled through the information systems. The books of the insurer may not be books at all but rather entries recorded in the information systems. Chapter 3—Accounting and Financial Analysis specifically notes the types of records that may be kept electronically. The subledgers, cash receipts and disbursements records, registers, journals, claims, reinsurance, and Tax records may all be computerized. The related software system may be designed so that all of these records are integrated. Common source documentation for related records may be stored once and linked to each of the related records, cutting down on unnecessary duplication. That is, data is only entered once, and each subsystem can access that data without manual intervention. The receiver should be aware of how the system is integrated and where manual intervention can occur and be cognizant of linked data if attempting to bifurcate or move only a subset of the existing data.

2. Claims

The claims records will likely be kept in an information system to accommodate reporting, statistics and control of the claims process. (See Chapter 5—Claims.) In a conservation or rehabilitation, control in this area is critical and systems support is vital.

In a liquidation, the claims information system is usually a key component to the notice process and may be critical to the adjudication of claims. Where the insurer has an automated claims system, data will most likely need to be extracted and imported into the receiver's claims administration system to facilitate the proof of claims process, communication with the guaranty associations and reinsurance recoveries. Where the receiver elects to use the company's existing system to process estate claims, it will need to be modified to accommodate several new data elements, including, but not limited to, proof of claim numbers, priority classifications, types of claims (third party, guaranty fund, etc.) and Uniform Data Standard (UDS) conversion when transmitting claims data to property and casualty guaranty associations. (See Chapter 2, Section IV. M. -- Liquidation Considerations.)

3. Accounts Current

Some insurers will have systematic tracking of their agents' accounts. In a conservation or rehabilitation, prompt and efficient accounting to agents can improve cash flow. The receiver may need to evaluate blocks of business for retention or disposal. The information from the accounts current can be used to help make this determination.

Detailed electronic records of agents' balances for premium, commissions, collections, endorsements, cancellations and remittances can be extremely useful in a liquidation to determine the fixed rights and liabilities of the managing and producing agents. Collecting monies due the estate from agents is dependent on the availability of sound data supporting the amounts due.

4. Premium Financing

The receiver should examine this area for the same reasons as Accounts Current. The receiver should look for affiliate companies that use or share the insurer's information systems for premium financing For reconciliation and UDS purposes.

5. Marketing

Marketing functions may be important in a conservation or rehabilitation, but in liquidation, there generally is no ongoing marketing function. This is not to say that the marketing database and records should be discarded. These records can be useful in determining what caused the insurer's financial distress. Further, the files and reports related to the marketing function usually are closely related to the agents' files and reports and the account current systems.

6. Investments

Information regarding the insurers' investments most likely will be found on a PC or internal drive in the accounting or executive offices. The receiver's staff should check to determine if backups or subsidiary systems exist and whether subscriptions to specific services need to be continued.

7. Reinsurance

Usually, reinsurance receivables will be the largest asset of the receivership, and collection is highly dependent on reliable premium and loss information. Use of information systems in recording and tracking this information is fairly common. Depending on the level of integration of the systems, this may be part of, or at least closely connected with, the claims system or accounting system of the insurer.

Increasingly, a third-party hosted web application or system is utilized to track reinsurance receivables. Continued use of the application or system by maintaining or modifying existing contractual relationships with third-party vendors may be utilized. Alternatively, an attempt to clone or recreate the system within the receiver's environment may be viable options.

8. Email

Virtually every insurer uses an industry standard email system. Emails are important company records that must be preserved. In addition to performing a backup of the email server at the start of the receivership, it is also good practice to extract individual email boxes of key employees at that time as well. Consideration should be given to periodically backing-up these files throughout the receivership to insure preservation of communications. Email backup restoration often requires the use of outsource computer forensic experts. Extracting email boxes in readable format at the outset of a receivership will save costs down the road should email records be required for litigation purposes.

If the insurer is part of an affiliate insurance group or pool which includes employee e-mail correspondence pertaining to other insurance companies that are not entering into receivership, the receiver may need to execute a confidentiality agreement with the surviving entity(s) in order to obtain the troubled insurance company's electronic correspondence.

9. Large Deductibles

Large deductible recoverables can be a large asset of the receivership, and, like reinsurance, collection is highly dependent on reliable policy and loss information. Use of information systems in recording and tracking this information is fairly common. As with reinsurance, this system may be a part of, or at least closely connected with, the accounting or claims systems , or information may be tracked in a separate application or system.10. Other

There may be other information systems, including PC-based calendar and tickler systems, time tracking and personnel systems, salvage and subrogation systems, imaging systems and litigation support systems on either PCs or larger computers. Further, through Web sites and online services, computers now serve as important common communication devices. The company's Web site can be used to provide and gather useful information about the company in receivership.

The receiver may need to acquire utility programs to perform such functions as restoring deleted data or backing up data in a compressed format. The administration of some receiverships can be litigation-intensive. Case management or other information systems in support of legal activities should be considered for those receiverships.

Another use of information systems that is important to note is project management. Application programs for project management are widely available and understandable to the average user. This software can be put to excellent use in identifying what needs to be done to administer the receivership in the most cost-effective manner.

Finally, the use of electronic data for all documents is becoming more common. Documents may have been scanned and the originals destroyed or kept in a manner that makes them difficult to use. In the event of liquidation, the receiver may be compelled to export these electronic documents to the receiver's systems or external hard drive for safekeeping, as they serve as the only official company records.

11.End User Computer (EUC) Applications

End user computing (EUCs) "applications" (spreadsheets, databases, etc.) are often used as part of reserving, reinsurance, investments, modeling, forecasting, and other areas. Critical "applications" may get overlooked because they often do not fall under the IT department's management and/or control structure. Rather they are managed and updated by the business unit. Companies with good internal controls will have a centralized repository of EUC or User Developed Applications, but often troubled companies do not have this information. If an "application" is critical in producing the information needed by the receiver or guaranty association, the receiver should identify the "application," ensure that change management is in place and guard against loss of institutional knowledge loss if the business unit employees are terminated (i.e., that the receiver has staff able to run the program.) The receiver will need to inquire with personnel in the Company's various business units to identify these "applications" and should create a list of the various applications. If these applications are password protected, the receiver should also obtain the password. Before using these "applications" to make receivership decisions, the receiver should review the application to determine its accuracy, for example, checking formulas in an Excel spreadsheet.

IV. INFORMATION SYSTEMS DELIVERABLES

The purpose of this section is to assist the receiver in determining what deliverables and services will be needed from the information systems. There will be generic requirements that are applicable to all receiverships. However, to a larger extent, the receiver's information systems requirements will reflect the characteristics of the subject insurer. The receiver will need to look at the full scope of historical operations, as well as the new requirements that are specific to the receivership proceeding, to determine the data processing tools that are essential to carry out the receiver's obligations, keeping in mind what the receiver has inherited from the insurer in terms of disposal and acquisition costs.

It may be necessary to perform a detailed study of a receiver's data processing requirements and compare this to the level of systems functionality and security provided by existing systems. If this level of functionality or security is deemed to be unacceptable, the receiver will need to modify the existing systems or replace them.

This section provides a checklist of the functions associated with insurance, reinsurance and receivership that should be considered when evaluating system requirements, including software, hardware and security considerations. Software considerations will include any accounting, claims, imaging or policy applications, the management of email and/or instant messaging platforms, along with any other tools that provide data capture, processing and reporting capabilities. Hardware requirements will include computing power of application servers and data storage devices, including both on premises and cloud hosted, as well as peripheral equipment and related items, such as network capabilities. Security considerations will include data protection, endpoint protection, user access controls, network security and physical security.

By definition, any list of standard requirements may fail to address requirements unique to an individual estate. This checklist will serve as the basic outline of a systems requirements study that should be supplemented by the receiver and information systems staff.

A. Considerations Regarding the Insurer's Historical Business Practices

It is important for the receiver to quickly develop an understanding of the business practices of the subject insurer. This understanding will affect decisions regarding the receiver's ongoing information systems requirements and will provide the parameters for future information systems needs of the receivership.

B. Volume and Geography of Business

A preliminary task is to determine how many policies were written per year and for how many years, and in most cases, the geographic breakdown of the policies. The number of transactions (accounting, claims, reinsurance, etc.) associated with each policy should be considered along with the corresponding costs. This information is commonly requested by the receiver's staff immediately after the commencement of a receivership. The following items should be considered in determining the volume of the insurer's business:

- Policies;
- Claims;
- Claim transactions;
- Claimants;
- Premium volume;
- Reinsurance agreements;
- Reinsurance participants;
- Brokers/intermediaries/agents;
- Face value of the policies (Life);
- Cash surrender value (Life);
- Policy limits (P&C); and
- Geographic distribution:
    - by state, whether one or many;
    - territory, county or zip code breakdowns within a state;

- by guaranty fund; and
- worldwide (with foreign exchange requirements).

C. Types of Business Written

Initially, it will be necessary to identify general characteristics of the insurer's business practices and the insurance/reinsurance. If the insurer wrote only direct or primary insurance, the ability to process assumed reinsurance may not be of immediate concern to the receiver. However, if the insurer ceded reinsurance, the ability to track and control ceded placements may need to be considered in the systems requirements. Also, if brokers or intermediaries processed reinsurance (assumed, ceded and/or retroceded), the receiver may need to determine if these arrangements are to be continued, or if this function needs to be brought under the direct control of the receivership. If it is not brought under direct control of the receiver, the receiver should carefully monitor this function and work closely with the intermediary.

This analysis of insurer's business practices and the insurance/reinsurance written will provide a general idea of systems sizing and related requirements and should include an analysis of:

- Lines of business – The lines of business underwritten and the characteristics of this business may have a substantial impact on information systems requirements. If it is a business in which claims will develop quickly, the requirement may be quite different from long-tail business in which claims will take a long time to develop. If the business includes large-deductible or loss-sensitive features such a retrospectively rated premiums, there will be additional system demands. This also will impact the amount of historical information that must be maintained in the systems.

D. Corporate Structure

The type of corporate structure of the insurer (single stand-alone company or one of several affiliates) and how many offices it has are factors to be considered when evaluating the information systems.

E. Sources of Production

The manner in which a company acquired its business (e.g., was it a direct writer, did it use MGAs, brokers or both) will have an impact on the location and source of critical data.

F. Claims Handling

The way a company handled claims will affect information systems requirements as well. Claims can be handled exclusively in or in a combination of the following:

- In-house;
- External adjusters;
- TPAs;
- Agent/MGA; and
- Other subsidiaries, related operations.

G. Affiliated Companies

Different companies with a common parent often use a single, centralized system, which can result in data security and privacy concerns. Certain data of the insurer and the affiliate may be comingled within the same systems. The receiver or the affiliate, should segregate the data of the company in receivership from the affiliates' data.

On Aug. 17, 2021, the NAIC adopted revisions to the *Insurance Holding Company System Model Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) addressing data and records of the insurer that are held by an affiliate[1]. Specifically, the Model Act #440 revisions clarify the following:

- 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[2], 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:
    - 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 Model #440 and #450 revisions also describes 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.
- Model Regulation #450, Section 19 revisions update and expand on provisions that should be included in agreements for cost sharing services and management services between the insurer and an affiliate.
    - Revisions specific to records and data clarify, similarly to that of the revisions to Model Act #440, that records are 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.

[1] Although in 2021 the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#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.

[2] . Model 440/450 addresses the insurance groups' responsibility to ensure that data is segregated or readily capable of segregation. Receiver should ensure that the process for segregating data does not interfere with ongoing operations.

- 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.

H. Foreign Exchange Considerations

If a significant amount of the subject insurer's business is international, it may be necessary to include foreign currency exchange considerations in a systems requirements study.

I. Existing Systems

The receiver's staff (or an independent consultant) needs to determine if the existing systems adequately process the business or if those systems must be supplemented with additional processing. If it is the latter, the receiver should then determine whether the level of supplemental processing required is acceptable, in terms of accuracy and the cost of processing. This will establish whether the existing system(s) are adequate to provide the receiver with the amount and types of information required.

The receiver may require various types of information in the administration of an estate. Especially with systems that do not permit online inquiry, it is imperative that reports which are adequate for the receiver's purposes be produced. At a minimum, the existing systems should have the capability of generating a wide variety of reports. The receiver's staff should carefully examine the available reports to determine whether they are adequate or if custom reports need to be developed, assuming the data stored in the systems can support custom reports. Reports are normally required for the following types of information:

- Policies and contracts;
- Accounting;
- Claims;
- Accounts receivable/payable;
- Cash;
- Reinsurance;
- Guaranty fund claims counts and reserves by state; and
- Earned and unearned premium.
- Large Deductible Collections and Collateral

The following types of documentation should exist for all of the company's systems:

1. Systems Documentation

   Systems documentation shows how the system operates from a technical perspective. Documentation should include file structures, record layouts, data model and related data dictionary and systems administration information pertinent to running the system and producing reports.

2. Process Documentation

Process documentation consists of narratives and diagrams of the processes involved in the major functions of the systems—imaging, policy administration, claims administration, reinsurance reporting, accounting and billing, etc. Documentation should include the interaction of various systems and feeds to and from outside entities.

3. User Documentation

User documentation shows users how to operate the system to perform their jobs. Documentation should include sections that are specific to particular functions, e.g., claims, accounting, etc. Note that in many off-the-shelf systems, the only user documentation that exists is the online help.

J. Data Validation

The systems should perform basic data verification functions, such as ensuring that the date of loss falls within the coverage period. The system should also provide some form of validation to ensure that data entered conforms to predetermined values and formats (e.g., all dates or dollar values are numeric, etc.). This helps ensure the accuracy of the data and allows the receiver to predetermine acceptable data standards.

K. System Requirements

The performance characteristics of the information systems as they relate to the processing requirements of the receivership need to be analyzed. If the system does not have sufficient resources to process the volume of data required, it may be necessary to enhance or replace the related computer hardware with higher capacity hardware. Conversely, if the computer system exceeds requirements, the receiver may wish to consider the cost benefit of system sharing or, provided company data is appropriately segregated, downsizing.

1. Application Servers

Company systems run on local or cloud-based application servers, which must be analyzed to ensure sufficient computing performance. Further, because servers are prime targets for malware, technical staff should analyze company servers to make certain patching is current, malware protection is implemented, the local firewall only permits the minimum necessary services and that all servers are being backed up out-of-band3. On premises servers should be physically secured with least privilege4 access applied.

2. Networks

Company switches, routers and firewalls will need to be analyzed to ensure sufficient performance when systems and users access web-related services, such as a cloud-based hosted email service. Network tools are an essential layer of defense for the security of company systems. Technical staff should review network protocols to verify that entries onto the company network is properly authenticated (two-factor authentication strongly preferred) and that data is being backed up out-of-band.

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[3] Communication between parties utilizing a means or method that differs from the current method of communication (e.g., one party uses U.S. Postal Service mail to communicate with another party where current communication is occurring online). Sources: NIST SP 800-32 under Out-of-Band.

[4] The principle that a security architecture should be designed so that each entity is granted the minimum system resources and authorizations that the entity needs to perform its function. Source: NIST SP 800-12 Rev. 1 under Least Privilege.

3. Data Storage Requirements and Sizing

Modern storage devices can be managed on premises or in public/private cloud-hosted environments. Technical staff needs to consider the volume of historical, current and anticipated future records that will need to be stored on the computer system. Note that imaged records like PDFs and JPEGs are significantly larger than other document types, which can increase storage requirements as a company reduces its reliance on paper processes. Technical staff must ensure company data repositories are secure, encrypted, and that access is administered on a least privilege basis. Backups of company data should follow similar protocols and should be tested by technical staff to ensure viability in the event of a data loss.

L. Additional Considerations

Other systems considerations to address in assessing systems requirements include:

1. PCs, Laptops and Terminals

To operate the system, an adequate number of PCs, laptops or terminals need to be available. The determination of that number will be affected by the type of system as well as the number and functions of staff members required to process the volume of business. Technical staff should determine whether endpoints are encrypted, properly patched, limited by the company firewall and malware protection is applied.

2. Environmental Considerations (Climate Control)

Computers, whether mainframe, mini, or PC-based servers, generally require a stable temperature and humidity-controlled environment in which to operate. Failure to provide adequate air conditioning and/or heating can cause catastrophic systems failure. Incorrect humidity can cause excessive static, which is especially dangerous due to static discharge. It is therefore necessary to balance the computers' thermal output with a temperature control system capable of maintaining the operating temperatures and humidity specified by the computer manufacturer(s). A water alarm is also a good investment, especially if raised floors are used. Physical access to the computer room should also be restricted and carefully monitored.

3. Environmental Considerations (Power Consumption)

Data processing and networking equipment is sensitive to the quality of the electrical power supplied to it. Surges, spikes and brownouts of any kind can damage equipment, cause systems to crash or, in some cases, corrupt data. Most data centers and their attendant equipment are equipped with power conditioning of some type. (PCs usually have surge suppressors for this reason.) Power conditioning can take various forms, but data centers usually have as a minimum an Uninterruptible Power Source (UPS) that filters the power before distributing it to the equipment. A UPS may also have a backup battery that will power the equipment for a short interval while waiting for power to stabilize or allow a graceful shutdown. Emergency lighting should be provided with enough battery time to allow a safe shutdown and evacuation of the area, if necessary. Emergency shutdown procedures should be available to personnel. Finally, a UPS may be coupled with an auxiliary generator which will supply electricity during a power outage.

In addition to special power and heating, ventilation and air conditioning, many dedicated data centers have fire suppression systems. These systems may be stand alone or tied into a building fire detection panel. The receiver should become familiar with how the fire suppression system operates and how it should be tested. Failure to keep these systems in good working order and to follow procedures could be deadly. It is important that testing and training be carried out regularly and that procedures be posted and read by data center personnel. Additionally, the fire suppression system must, at a minimum, comply with local fire and safety codes.

M. Liquidation Considerations

In liquidation, there are several special considerations as a result of the fixing of rights and liabilities and the involvement of guaranty associations. In nearly all liquidations, guaranty associations are the initial direct handlers and payers of most policyholder claims or other policyholder contractual obligations. In certain instances, guaranty associations are required to provide some level of continuing policyholder coverage. The receiver should consider the ability of the information systems to supply information required by guaranty associations. Most of the data should already be in the company records, but the information systems will need to accommodate the unique needs of the insolvent insurer and the guaranty associations.

1. Property and Casualty Guaranty Funds

For property and casualty insolvencies, this information must be in compliance with the Uniform Data Standards (UDS) in order to allow the guaranty associations to meet their statutory obligations. Therefore, UDS expertise is needed to determine whether the systems meet all of the applicable UDS record requirements. The receiver may elect to have an analysis of the system data elements performed by a representative of one or more of the guaranty associations or outside consultants.

2.Compliance with UDS

The UDS is a precisely defined series of data file formats and codes used by receivers and property/casualty guaranty associations to exchange loss and unearned/return premium data electronically. These formats were developed by a group of personnel representing both receivers and guaranty associations and submitted to the NAIC. The NAIC originally endorsed the use of UDS effective March 31, 1995. The formats were revised and updated during 2003/2004 with an implementation date of January 1, 2005. Since this time, several additional updates have occurred. UDS and the UDS Manuals are managed by the UDS Technical Support Group (UDS-TSG).

The National Conference of Insurance Guaranty Funds (NCIGF) developed a secure process for transferring UDS data from the property and casualty insurance guaranty associations to insurance receivers. The concept proposed by the California Liquidation Office in 2005 and the process advanced by the NCIGF in 2007 is known as Secure Uniform Data Standards (SUDS) utilizes Secure File Transfer Protocol (SFTP). SUDS provides cost savings by creating greater uniformity and efficiency in how UDS data is transferred from guaranty associations to insurance receivers. SUDS also provides privacy protection through the use of a secure server. In 2012, the NCIGF developed a web-based application that allows receivers to quickly and easily create UDS records for distribution to the guaranty associations through SUDS. The application is known as the UDS Data Mapper[5]. The NCIGF, through its subsidiary, Guaranty Support, Inc. (GSI), maintains both SUDS and the Data Mapper and makes them available to insurance receivers or the guaranty associations at no charge.

The NCIGF maintains and provides updated copies of the UDS Manuals. For further details about UDS as it applies to claim records or the implementation of UDS, please refer to the UDS Operations Manual[6]. Information and formats relating to UDS financial reports from the guaranty associations

[5] The UDS Data Mapper is available at https://udsdatamapper.com

[6] https://www.ncigf.org/resources/uds/uds-claims-manual/

are contained in the UDS Financial Manual[7]. The site also includes a helpdesk request form, which emails questions to members of the UDS-TSG[8].

B. Insolvency Data Transfers

Guaranty associations become statutorily obligated to pay covered claims when the court enters an order of liquidation with a finding of insolvency. The goal of every insolvency is to transmit relevant company claims and policy data to the guaranty associations on the date of liquidation. The guaranty associations and their coordinating body, the NCIGF, have established experts and tools to assist receivers with the transmission of insolvent company data.

(i)Evaluation

Company data will be spread across multiple information systems (claims, policy, accounting, imaging, etc.) oftentimes managed by third party administrators. Each information system is a unique source of data requiring independent attention to extract, process and convert to UDS. On average, each source takes roughly two weeks to process. Getting access to company data managed by third parties can be complicated when it is commingled with noncompany data. Working with information system administrators to segregate company data pre-insolvency can save precious time when an insolvency is imminent. In the event policy and claims data cannot be transmitted to the guaranty associations on the day of liquidation, providing remote access to those systems can help them address hardship claims and other urgent matters.

(ii)Extraction

Beyond the generation of reports, most information systems are not designed to export significant portions of data. This is especially true of imaging applications, which are used in "paperless" offices. Extracting the relevant data from these systems requires specific technical training and oftentimes server access. Data extraction by competent IT professionals can take days or even weeks to complete though various factors can increase the extraction time. If the system is administered by a third party, several factors can add additional delay, such as the administrator not having been paid, company data being commingled with third party data, or the administrator has insufficient staff to extract company data in a timely manner. Obtaining regular backups of all company data from the administrator can help ameliorate some of these concerns. Technical staff should examine the backup data to determine if it is sufficient to create usable UDS records upon liquidation. Further, if company data is segregated pre-insolvency, technical staff or third-party vendors can extract the relevant data without inadvertently accessing or disclosing non-company data.

(iii)Processing

Once extracts of company claims and policy data are obtained, technical staff will need to process the files before they can be loaded into the UDS Data Mapper. Data must be formatted into comma-separated values (CSV). Date and currency values must be normalized to a single format per file. The CSV files must use latin1 encoding and have characters outside the scope of this encoding removed or replaced. The receiver will then create a map that coordinates fields from the source data with their corresponding field in the UDS standard. The UDS Data Mapper will report errors encountered while ingesting data to guide other necessary cleaning steps.

(iv)UDS Production

[7] https://www.ncigf.org/resources/uds/uds-financial-menu/
[8] https://www.ncigf.org/resources/uds/

After the data is ingested by the UDS Data Mapper it may then be reviewed and edited within the application, then sent to the relevant guaranty associations. This process creates the UDS files and notifies the guaranty associations that they may pick up their files, which are provided via SUDS. For the receiver's own purposes, CSV files of the produced UDS records are also provided via SUDS.

CPriority of UDS Records

All UDS records serve a valuable purpose and are important. However, the timing of some of the UDS records is more critical than others because guaranty associations need them to perform their statutory responsibilities of covered claims. Below is a general guide regarding the level of criticality of the various UDS records.

Highest Priority

A Record (Claim File) - confirms the existence of policy with insolvent insurer; necessary to confirm coverage.

F Record (File Notes) - adjuster's claims notes; needed to quickly grasp essential nature of claim and current issues.

G Record (Transactions) - necessary to understand what has already been paid to timely continue any future payments owed and avoid duplication.

I Record (Images) - contains the contents of the insurer's claim file including report of incident, claim history, investigation notes, treatment history, photos, medical records, and other essential information.

Very High Priority

C Records (Guaranty Fund Loss Claims) - guaranty association monthly reporting; typically commences within 30 days of the association's receipt of critical claim information.

High Priority

B Records (Unearned Premium) - the importance of unearned premium reimbursement may vary depending upon the nature of the insolvency; in a liquidation with substandard auto insurer, timely refund of unearned premiums is often critical because many insureds cannot afford to purchase replacement coverage. In such instances, the production of the B Record should be assigned a higher priority.

Medium Priority

D Records (Guaranty Fund Expenses) - important for the reimbursement of the guaranty association's administrative expense claims but secondary to the records that are essential to the timely payment of covered claims.

Low Priority

E Records (Closed Claims) - important to enable guaranty associations to re-open claims; can be managed on a case-by-case basis until higher priority records are delivered.

M Records (Medicare Secondary Payer Reporting) - allows parties to verify that pre-liquidation MSP reporting was made by company; assists guaranty associations in identifying open or re-opened files where guaranty associations will become responsible for future MSP reporting.

1. Life and Health Insurance Guaranty Associations

The life and health insurance guaranty associations do not utilize the UDS reporting system because the data needs of the life and health GAs are much different than those of the property and casualty funds, both in terms of timing and the types of data needed. This is due both to the types of contracts covered and the particular nature of the statutory obligations of the life and health GAs. Because the life and health GAs continue coverage, they need the data and the lead time necessary for putting in place the agreements and infrastructure required to either *transfer* or *continue administration* of the insolvent company's business. In either event, NOLHGA and its member GAs need data files at the earliest possible opportunity, and well in advance of liquidation, in order to evaluate options and develop a plan for meeting GA statutory obligations while minimizing disruption to policyholders. Policyholders are best served if the GAs can be ready to implement a plan for assumption transfer or for seamless administration of the business immediately upon entry of a liquidation order.

If preliminary data suggests that an assumption transfer may be feasible, a NOLHGA task force will develop a Request for Proposals ("RFP"), which will be sent to prospective carriers, subject to their execution of a Confidentiality Agreement. The RFP will include a description of the business to be assumed, along with summary policy, claims, and financial information. Policy-level detail is not typically required at this stage.

If assumption transfer is not feasible, the GAs must prepare for runoff administration. This typically requires contracting with a TPA and, in the case of health business, retention of the company's health care provider networks, pharmacy benefits providers, and all related service providers. Policy-level data is essential for policy and claims administration for all lines (life, health, annuity, disability, LTC).

Getting this information can be particularly challenging if the insolvent company has been using one or more outside TPAs. Data may reside on different platforms and systems and can take longer to gather. Other challenges arise when a company has been using one or more legacy systems with outdated software or hardware, making data extraction and transfer more difficult. In those cases, some consideration may need to be given to keeping the legacy systems in place. if short term data conversion is impractical. It may be necessary to contract for access to the existing administration platform, at least on an interim basis, which in many cases will involve the receiver as successor to the insolvent company's operations but may also include affiliates of the insolvent company or the company's outside TPAs.

A. Specific Data Needs

Specific data needs will depend on the facts and circumstances of each case, as well as the types of business involved. Initial, critical data needs typically include all relevant summary policy and reserve information. Typically, 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.

Other data needed for runoff administration, depending on the lines of business involved, typically includes the following:

- In-force files/counts (by state and by line of business)
- Policy values (face amounts, cash surrender values, policy loans, interest crediting rates, rate crediting history, etc.)
- Policy forms
- Claim files/claims history (including plan of care and related information for LTC lines)
- Premium files (and status indicators such as Reduced paid up, or Waiver status for LTC)
- Rate files/history
- Reserves, by line
- Provider/vendor agreements

B. Timing Considerations

Initial data files (Policy Master records) are needed at the earliest possible opportunity, but preferably at least 6 months in advance of liquidation, so that the GAs can evaluate the business and any coverage issues, assess the feasibility of one or more assumption deals, initiate an RFP process for assumption of the business, and negotiate and prepare to implement related agreements.

The lead time needed for policy level data will vary depending on the size and complexity of the business, as well as the lines of business involved. Typically, 4-6 months minimum lead time is needed in order to evaluate the business, negotiate TPA agreements, and get claims reporting and funding arrangements made for runoff administration. In the case of health lines, additional time is needed to evaluate, retain or replicate healthcare provider networks and related services. If an RFP process is needed to find a replacement TPA, additional lead time may be required for that as well.

C. Secure Data Transfer

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 secure access to the data needed. Otherwise, NOLHGA (or a designated TPA or consultant) will establish a secure file portal where designated users can securely upload records.

V. IMPLEMENTATION

This section describes various courses of action to meet the receiver's needs once it has taken control of the insurer's information systems. The course of action selected will vary according to many factors, including the size and needs of the insurer and whether the insurer has its own information systems staff.

The receiver will be faced with several options as to how to meet the needs of the receivership. These may include: extraction or bifurcation of comingled system data; retaining the present system; enhancing the present system; replacing the system with either a new system or the receiver's system; or relying on a third-party vendor. The receiver must be prepared to justify a cost-benefit basis expending limited estate assets in pursuing any option other than retaining the present system. The following should be of assistance to the receiver in the formulation of a plan to select and implement the most effective option.

A. Retention

The current system's ability to meet the receiver's needs should be carefully evaluated prior to making a decision to retain it. If the system hardware is to be sold, a plan should be developed and executed to move the necessary data to a system that can be accessed by the receiver. The plan to sell existing system hardware should also include safeguards to ensure that any data on the system is erased before the sale. No sale of system hardware should take place without first determining ownership and consulting with the receiver's legal counsel. The retention policy and decisions should be consistent with the Liquidation Order.

1. Verify Capabilities

Through examination of available reports and interviews with systems staff, management and operational staff or other sources, the current capabilities of the system should be identified, listed and documented. The system's capabilities, thus identified, should be compared to the previously identified needs of the receiver. Identified needs will be considered from the Information Systems checklist. This will identify information needs that cannot be met by the existing systems and steps that should be taken to satisfy those needs. If system capabilities exceed the receiver's needs, consideration should be given to whether the configuration and size of the system should be altered to increase efficiency and control costs.

2. Verify Condition of Hardware and Adequacy/Integrity of Software

The condition of the hardware should be carefully examined to determine both its reliability and its capacity to handle anticipated growth. Suspect components should be repaired or replaced. In like manner, the existing software should be carefully reviewed to confirm adequacy, appropriate licensing and integrity. Software that is inadequate, outdated, corrupted or no longer supported by the vendor should undergo review to determine the best strategy for replacement.

3. Assure Adequate Security and Disaster Recovery

Given the likelihood of litigation and other legal proceedings that will depend upon data gathered and processed by the system, as well as the threat of a cyber-attack, immediate steps should be taken to ensure its continued security. Access should be limited to those with an absolute need and in whom the receiver has utmost confidence. Consideration should be given to purchasing cyber insurance for the liquidation estate, if the company does not already have an applicable policy. A review should also be made of the current system as it pertains to the documentation and quality of data, and as to a disaster recovery plan. Many data processing centers do not have a disaster recovery plan other than having the system back up information in an off-site location. A true disaster recovery plan provides for installation of system backup information in an off-site location so that, in the event of a disaster, the system can be running within a specified time frame. That time frame may vary from a few hours to a few days.

4. Devise Assessment Methodology

Methodology should be devised for assessing the adequacy of the staff, the system, the software, security procedures and disaster recovery procedures. Weaknesses identified through this assessment should be remedied. If necessary, a third-party contractor may be brought in to make this assessment.

B. Enhancement

If the receiver has control over the system, and it is determined that the existing system can be retained but should be enhanced in order to meet the receiver's needs, a plan should be devised for the implementation of those enhancements. After careful consideration, a list should be made of the hardware, software and applications that require enhancement. These may consist merely of the addition

of hardware components or may require restructuring of the operating system or supplementation of available software. In like manner, available staff may be inadequate for the anticipated needs.

Once the required enhancements are identified, availability should also be ascertained, and the availability of qualified personnel should be similarly confirmed. Once the needed enhancements have been identified and their availability confirmed, a schedule should be prepared for implementation in a manner that will not interfere with other aspects of the receivership proceeding and which will be consistent with the anticipated needs of the receiver. This may require the operation of shadow systems on a parallel track with the implementation of the enhancements. Testing methodology should be implemented to confirm that the enhancements were successful and sufficient

C. System Replacement

If the receiver determines that the existing system, even if enhanced, is inadequate and decides to replace it, a plan should be devised for system implementation. The first step is to select the replacement system, considering the future needs of the receiver, including how long the estate may have to remain open, and the available assets of the estate. A plan for migration from the existing system to the replacement system should be implemented. In many circumstances, the replacement or enhancement is handled by a third-party vendor.

To make use of a third-party vendor as a replacement for in-house systems, it is essential to prepare a comprehensive list of the receiver's anticipated needs. Because the receiver will have relatively little control of the actual operation of the system and therefore little flexibility in adjusting the ability of the system to meet its needs, it is essential that the initial list of needs provided to the third-party vendor be as comprehensive as possible.

Once the needs have been identified, a list of potential vendors should be compiled for evaluation. Each eligible vendor should be carefully evaluated with full consideration being given to at least the following factors:

- Cyber security expertise and data safety requirements;
- Short-term and long-term availability;
- Expertise and demonstrated ability;
- Price and method of charging;
- Support and maintenance resources;
- Available warranties;
- Capability to respond to emergencies;
- Ability to preserve confidentiality and comply with security procedures;
- Existence of potential conflicts of interest;
- Ability to respond to changing needs; and
- Familiarity with the type of business involved.

1. Contract with Vendor

Once the appropriate vendor has been selected, a contract that will meet the anticipated needs of the receiver should be negotiated in accordance with the receiver's contracting policy. It should be clear

that liability under the contract will be limited to estate assets and will not involve personal liability on the part of the receiver or the state. Once an agreement in principle has been reached with the vendor, protocols should be established for the operational relationship. A plan should be devised for assessing whether a third-party vendor satisfies the requirements of the contract.

2. Document and Back Up Old System

As a result of the decision to use a third-party vendor, the existing system will become unnecessary. Before it is shut down and disposed of, however, it should be fully backed up, including both the software and data, and documented for future reference.

3. Shut Down and Disposal of Old System

Once the old system has been completely backed up and documented, it should be taken out of operation and prepared for disposition. Disposal of any system, data or information related to the liquidation must meet the requirements set I the Liquidation Order and be pre-approved by the court before any action is taken. Before the system is shut down, any data must be erased. Once the existing system is shut down, it should be disposed of at maximum gain to the estate. Proprietary software developed solely by the insurer may also be marketable.

D. General Concerns

Be careful not to dispose of the system too soon. If the information is to be migrated either to the receiver's computer system or to a third-party vendor's system, steps should be taken to ensure that the integrity of the data from the insurer's old system is preserved and accessible. Controls should be in place to ensure that the same number of records leaving one system is received by the other system. This should be confirmed by the comparison of record counts and the cross-checking of financial data.

If any enhancements have been planned, then consideration should be given to whether the enhancements should be done by in-house staff or an outside consultant. Once again, it is usually best to get competitive bids as required by the receiver's purchasing policy.

E. Implementation of UDS

A plan to secure the information required for UDS should be developed as early as possible in the receivership proceedings when there is an indication that liquidation is a possibility. Data availability from company to company varies significantly. In some cases, all data for UDS is located on the system; in other situations, manual coding is necessary to capture the required data. The goal is to make the information available to the guaranty associations as soon after entry of the liquidation order as possible.

The guaranty associations must be notified as soon as possible when liquidation preparations have begun. The notice should include a copy of the company's Schedule T from its annual statement and the receiver's plans to supply UDS data. Data transfer preparations should begin immediately after the notice, to be put in place immediately following receipt of the Liquidation Order. This step is important, as it places the guaranty associations in a better position to respond to the inquiries that typically occur soon after the company is placed in liquidation.

It is likely that the initial UDS plan will be modified as the receiver completes its review of the company's systems. (See Section IV. M. above, which expounds on UDS production and record priority.)

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 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 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 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 objective is 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 to 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 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 that 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 of responsibilities 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 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 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 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 e-mailed 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 his 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, giving 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 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 ACH transactions. Review all accounts for recurring charges so they can be canceled as appropriate.

Some Companies will have gift cards or pre-paid debit cards (for example Visa or American Express branded pre-paid 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, who the counterparties are and 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 Centers for Medicare and Medicaid Services (CMS) for all approved plans.
- Review recent claims and loss adjustment expense 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 pre-existing 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 pre-existing 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 pre-existing accounting records that are typically maintained at various locations of the insurer and/or at affiliated and non-affiliated 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, managing general agent 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, Flow Chart 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 flow chart of the accounting process might describe what action is taken for the significant functions or accounting processes. The flow chart may summarize the route of the original accounting documentation. Most importantly, the flow chart 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 flow chart 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 flow chart 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 my 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 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; and

- 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 on Investments (Section IX) 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, check 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 letter of credit agreements. For health maintenance organizations, 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 letters of credit.

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.

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 which 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 certified public accountants’ 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 Securities and Exchange Commission (SEC) i.e., 10K and 10Q for US 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 daily upload data 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. Receiver should collect any check books 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 chief financial officer. Review the inventory and compare with any retention policies.

D. Records at Offices of Other Parties

1. Managing General Agent (MGA)

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, all related accounting records, as previously described, may be at the office of the MGA. If the MGA has limited authority, then only records that pertain to the specific function will be in the office of the MGA. 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 (TPA)

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 letters of credit, 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, flow-charts, 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 (CPA) 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 there 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 (IRS)

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

9. Securities and Exchange Commission (SEC)

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 Sarbanes-Oxley-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 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 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 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, letters of credit or other restricted cash. The initial procedures established with the financial institutions regarding wire transfers, and 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 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
- 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 entities
- Real estate
- Company owned automobiles
- Other Assets including healthcare 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, 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 IRMA section 612 and section 8(N) of the NAIC Life and Health Insurance Guaranty Association Model Act, as adopted in the states.

A receiver should, as part of his 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 letters of credit 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 healthcare related receiverships healthcare receivables can include items like provider risk sharing receivables, coordination of benefits, provider overpayments and/or subrogation recoverables among othe 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 and casualty 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 IBNR 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 third-party administrator 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 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 arms-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 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, and 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 very 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 ,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 Model 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 integral part of the insurers operations or are essential to the insurers 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 *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. Since 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, 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 he or she 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 arms-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 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 non-affiliated 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 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 which categorizes disbursements by type and which 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* (#440) and *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 Act #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; and

- 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.

[3] Although in 2021 the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#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.

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:

  - 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 Model #440 and #450 revisions also describes 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.
- Model Regulation #450, Section 19 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].

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 non-regulated 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 which 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

[4] The full text of Section 19 of the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) is available on the NAIC website at: https://content.naic.org/sites/default/files/MO450_0.pdf

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 forward 20 years by property and casualty insurers. Prior to 2018, life insurers were allowed to carry back ordinary losses for 3 years and carry forward losses for 15 years. No carryback is allowed for operating losses of insurers other than property and casualty insurers for taxable years after December 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 3 years and forward up to 5 years to offset capital gains and 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. An insurer may also 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 Internal Revenue Code, 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 December 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 which 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 he is 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 property and casualty 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 October 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's 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**
Property/Casualty	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	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 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 percent 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's

a change in qualification as a life insurance company as defined in Internal Revenue Code ("IRC") Section 816(a).

For taxable years ending before January 1, 2018, life insurers with less than $500 million in assets are entitled to a small life insurer deduction of 60 percent 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 December 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 which 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 utilizing 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 January 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. Since most companies in liquidation have virtually zero premium income after the first couple of years of the liquidation, and since 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 January 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 I.R.C. §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 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 (Internal Revenue Code 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 (Internal Revenue Code Section 172(b)(1)(A)). Operational losses of life insurers arising in 2017 and earlier are carried back three years and forward fifteen years. A non-life insurance company can use the full amount of its net operating losses to offset taxable income (Internal Revenue Code Section 172(f)). A life insurance company is limited to an 80% net operating loss deduction against taxable income (Internal Revenue Code 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 December 31, 2017. The net operating loss deduction is limited to 80 percent of taxable income (without regard to the deduction) for losses arising in taxable years beginning after December 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 which 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 W-2s, as well as Forms 940 and 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 Forms W-2 and/or1099 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 Forms 1099 and send the forms 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; "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 Insurers Association of America (PCI), the American Insurance Association (AIA) 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 his 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 a rehabilitation vs. 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 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 & preferred stock, SCA's, etc.); Schedule DA—Short-term Investments; Schedule DB—Financial Options and Futures; 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 of the NAIC documentation to support the market value of the securities. The Securities Valuation Office 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. Very often, derivative instruments are used by insurers 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* 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 *Accounting Practices and Procedures Manual* provides additional examples, for both life and property/casualty companies, of complex investment arrangements entered into by insurers. The receiver should consider engaging a 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 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 Investigation and Asset Recovery Chapter of 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, and 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 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. Since 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 United States and outside the United States may also present problems to the receiver. Many United States 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 he can divest himself of the responsibility for foreign claims.

3. Structured Settlements

In the in solvency 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 Ruling 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 differs, depending upon the insurer (e.g., direct billing of policyholders vs. billing of agents) and type of insurance (e.g., primary vs. 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 utilize 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 and 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 & Health Premiums

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

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 SSAP 6.) 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; or

- 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 non-payment 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 NAIC *Accounting Practices and Procedures 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 which are for amounts below the high deductible. The high deductible definition varies, but it 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, and 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 regulator in this review.

E. Reinsurance

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

1. Reinsurance Recoverables

For property/casualty insurers, reinsurance recoverables on unpaid losses are not reported in the cedent's financial statement as receivables, but are accounted for as a reduction of its gross liabilities for unpaid losses and loss adjustment expenses. Reinsurance recoverables on loss payments and loss adjustment expenses 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 property/casualty 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. Healthcare 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) 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 IRMA 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 very 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 property/casualty insolvencies only, loss and loss adjustment expense 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 utilized 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. 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 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

*Page numbers in TOC will be updated in final publication.

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 vs. 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, that 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 their intentions regarding:
    - Possible full ancillary receivership
    - Holding the deposit due to open claims within their state
    - Release the deposit to the receiver
    - Release or assign 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 and casualty 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: FHLB, Life/Health, and Large Deductible

In chapter 5 there is a section that discusses special issues regarding particular claims, namely: (a) claims of the Federal Home Loan Bank (FHLB), (b) life and health claims, and (c) 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"; and
- 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 IRMA. 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 IRMA is two years. Not all preferences can be avoided by the receiver. Subsection 604B 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; or
- 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; or
    - An affiliate.

Subsection 604C states which preferences may not be avoided even if they would otherwise be avoidable under Subsection 604B. 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: a specific state statute; the Uniform Fraudulent Conveyance Act to the extent adopted in the particular state; and/or the common law of fraud. Fraudulent transfers are covered by Section 605 of IRMA. 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 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 property and casualty 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, which has been adopted in most states.

Footnote suggestion – The NAIC's Insurer Receivership Model Act, Section 612, 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 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 letters of credit 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, 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 loss adjustment expenses 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; however, the long-term economics of the transaction 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.

IRMA Section 605 addresses the avoidance of reinsurance transactions incurred on or within two (2) years before the date of the initial filing of a petition commencing delinquency proceedings under certain conditions. IRMA 612 relates to the continuation of life, disability income and long-term care reinsurance in liquidation and the right of the GA to elect within 180 days of the liquation to continue that reinsurance subject to IRMA 612 requirements. 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 letters of credit. 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. Since 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 property and casualty 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. But 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 associations, guaranty association and insured). It must be quickly established with insured as to 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 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 impact 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 ALAE and deductible aggregates where available.
c. Copies of deductible policies should be made available if required.
d. Guaranty Association's will provide, through the establishment of UDS data feed, all financial information regarding deductible claims that they are handling.
e. Receiver will collate data from guaranty associations and review historical billing information to invoice the insureds on a monthly or quarterly basis.
f. 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 their deductible.
g. To assist in the collection process receiver and 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 ("PEOs")

a. Policies issued to 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 PEO may not have received notice of cancelation, 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 insurer and 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 (although generally admissible, such assets usually are 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) and common stock, as well as the relative percentages of certain investments. 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 crypto-currency and other assets) Other sources include internal and external audits, 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 managing general agents (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 retain 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

Insurer Receivership Model Act (#555, commonly known as IRMA) Section 711 – Qualified Financial Contracts (or Similar Provision) addresses stays termination or 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 qualified financial contracts (QFC) and netting agreements in the event of the insolvency of state regulated insurers.

A. Definition of Qualified Financial Contract

IRMA 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, 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 qualified financial contract because an insurance contract includes the indemnification against loss. Therefore, reinsurance agreements would not be considered a swap agreement.

B. Insolvency Treatment of QFCs under the IRMA Section 711 Provision[1]

IRMA 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 Federal Deposit Insurance Act (FDIA), as well as laws of other 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 or 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 IRMA. 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.

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[1] [1] 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 twenty-four-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 Dodd-Frank 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 (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the 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 Dodd Frank, the FDIA, as well as comparable foreign resolution regimes. Notwithstanding 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 QFCs. Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, FDIC and 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; *Mandatory Contractual Stay Requirements for Qualified Financial Contracts*, 82 FR 56630 (29 November 2017), available at https://www.federalregister.gov/d/2017-25529.

C. Considerations of QFCs held by an Insurer Receivership:

- Although the Investments of Insurers Model Act (either Defined Limits or Defined Standards) (#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 to quantify the effect of the loss of the contracts if possible. The receiver may wish to engage outside resources to assist in evaluating 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 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 central clearinghouses (CCH) 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 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 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 Dodd-Frank 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 collateral and counterparties to the contract. See 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 *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts* [#1556] and 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 qualified financial contracts (QFCs) are reported within the *Accounting Practices and Procedures Manual* and the statutory financial statements.

[2] See footnote 1 of this Chapter.
[3] See footnote 1 of this Chapter.

Derivative Instruments—AP&P 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*
- 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 provides 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; or
- 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; or
- 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; or
- 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; and
- 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 loss-adjustment expenses;
- 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; and
- 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, and 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, 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; and
- 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 that 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, 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, 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 directors and officers 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 directors and officers did or did not do. Accordingly, the receiver should begin the investigation by identifying the directors and officers 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 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 directors and officers 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 directors and officers.

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, and 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, and 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 (RICO)

The availability of the federal Racketeer Influenced Corrupt Organizations (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, and it is not necessary to prove a pattern of activity and 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 Officers and Directors 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 officers and directors 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 an officer or director 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 (letters of credit or 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 loss adjustment expenses 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 property and casualty 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. D&O 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. E&O and D&O 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 Insurer Receivership Model Act (#555, known as IRMA)

In litigation between the receiver and affiliates of the insolvent insurer, Section 113 of IRMA prohibits 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 (property and casualty); fidelity/surety; a health maintenance or preferred provider organization; 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; and
- 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. (SeeIRMA, Section 501 B.) 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 claimagainst 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 property and casualty 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 claims filing deadline?

A claim filing deadline is the deadline for filing proofs of claim against the estate. (See IRMA Section 701 A.) The purpose of the claim filing deadlineis 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 IRMA late-filed claims are assigned to Class 9, provided that the claim was late due to certain specified criteria (IRMA Sections 701 and 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 property/casualty 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 deadlinemay 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 IRMA Section 701, also 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 deadlinebar 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. 6. 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

[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.

- Government Agencies
- Wage Claimants
- General Creditors
    - Reinsurers and Reinsureds
    - Intermediaries
    - Managing General Agents and Third-Party Administrators
    - 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 alpha-numeric 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 which 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 (IRMA Section 702 C). 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, and also 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 IRMA Section 702.) 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 which 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 (IRMA Section 702 A); and,
- The name and address of the claimant and any attorney representing the claimant.

Additionally, IRMA 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 (IRMA Section 702 A).

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 IRMA Section 702 C.) 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 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 utilize the guidance provided in sub-section 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, managing general agents 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 by-laws. 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. IRMA Section 702 D 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 which 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 deadlinemay 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 & 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 property and casualty policyholders. Guaranty associations may request that the receiver to 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 CLAIM DISTRIBUTION LIST SHOULD BE MAINTAINED, 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 up front affords timely notice to claimants prior to the expiration of any claim filing deadlinesand permits the development of claim forms and procedures consistent with such decisions. Each of these topics are discussed below:

A. Filing Methods

State lawstypically 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,, acceptable forms of supporting documentation. whether actual receipt. postmark, or receipt of delivery to a courier by the claim filing deadline are required.

State law may provide the receiver with discretionto exempt pre-existing 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 ofinformation sharing requirements with other stakeholders such as state 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 impact 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 IRMA Sections 303 and 405.) 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 associationor claim handler. The receiver may alsoneed 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 pre-payment plan for hardship categories such as workers compensation claims, pharmacy benefits, or impounded automobiles. Such payments may be appropriate for subsequenttreatment as early access distributions to or direct reimbursement by affected guaranty associations. See IRMA Section 802 D. [Note: IRMA Section 802(D) relates specifically to Workers' compensation payments in P&C cases]. In the case of a life and health multi-state 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 IRMA Section 803. The referral of a claim to a guaranty association does not terminatethe 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 sharingso that the receiveris able to notify, cede and recover losses from reinsurers. Many state laws exempt guaranty associations from proof of claim requirements and claim filing deadlines. IRMA permits guaranty associations to file a single omnibus proof of claim for all claims of the association, See IRMA Section 702 D,which may be updated periodically without regard to the claim filing deadline.

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. IRMA 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 (IRMA Section 707 A).

Prompt and efficient resolution of claims should be management priorities for the receiver. IRMA provides that the liquidator shall review all duly filed claims and shall further investigate as the liquidator considers necessary, *except* 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 (IRMA Section 703 A). However, if there are insufficient assets to justify processing all claims for any class, the liquidator shall report the facts to the receivership court and make appropriate recommendations for handling the remainder of the claims (IRMA Section 703 K). 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 (IRMA Section 703 A).

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 resolutionwhen closure of the receivership estate is in view.

Completion of the claims evaluation process will enable the receiver toeffectuate distributions to policyholders and creditors, generatereinsurance recoverables, and resolvesubrogationand 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 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 instanceswhere pre-receivership payments were made by the insurer prior to guaranty association assumption of a claim, those payments typically constitutesubrogation 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 lawto determine whether a claim qualifies under the limited exception.. See IRMA Section 801.For example, in some states, a late-filed claim may be deemedtimely filed claim, if the claimant can show that he/she was 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 creditors who received transfers that were subsequently voided by the receiver or surrendered assets transferred to them, secured creditors whose security was valued below the amount of their claims (See IRMA Section 701 B), reinsurers whose reinsurance contract is terminated by the liquidationgiving rise to a termination claim under IRMA Section 701 C.

- Post-Deadline Maturity of Timely Filed Claims

Certain timely-filed claimsmay 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 detemination 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 IRMA 705. IRMA 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 (IRMA Section 706). In such instances, an insured may also file a contingent claim for the same occurrence raised by the third party.. IRMA Section 706 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. IRMA Section 706 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 IRMA 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.

IRMA Section 706 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

Amendmentand 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 property and casualty insurer, the liability for claims that a property and casualty 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) below.)

- Claims under Occurrence Policies under IRMA

IRMA 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 (IRMA Section 704).

Having concluded that a proof of claim was timely filed (or properly amended), the receiver should next review the claim to determine whether all required information has been provided and the form has been completed in accordance with the applicable instructions. IRMA 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) (IRMA Section 703 I).

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. IRMA provides that no claim shall be allowed in excess of the applicable policy limits or otherwise, beyond or contrary to the coverage provided (IRMA Section 703 A).

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 (IRMA Section 706 D). 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 accident and health claims, the receiver should be alert to pre-existing 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.

IRMA 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 (IRMA Section 703 E).

- Assumed Reinsurance Claims

Most states accord cedent claims the same priority as claims of general creditors (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 receivershould 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. IRMA 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 (IRMA Section 703 F). The receiver also should carefully review the terms of all leases. IRMA 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 (IRMA Section 703 L).

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

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, 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 property/casualty guaranty associations. Property and casualty 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 property and casualty 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 IRMA Section 703 A 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, co-payments, 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 reportingcan hinder the collection of reinsurance recoverables. Sinceguaranty

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. IRMA 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 (IRMA Section 709).

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.). IRMA 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 (IRMA Section 703 H).

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. IRMA allows the value of security to alternatively be determined by agreement or litigation between the creditor and the liquidator (IRMA Section 710 A). 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. IRMA 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 (IRMA Section 710 C, D).

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 property/casualty 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 policyholderexpectationsand 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 claimdeadline 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.

  - IRMA 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 (IRMA Section 703 D).

  - 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 MO statute, whereas NJ 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 (IRMA Section 611 I).

- . 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 around 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, since 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 his or her 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, since 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 which, 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, IRMA Section 703 B 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. IRMA provides 45 days (IRMA

Section 703 C). IRMA allows the liquidator to accelerate the allowance of claims by obtaining waivers of objections (IRMA Section 703 C). IRMA 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 (IRMA Section 703 B). 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. IRMA 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 (IRMA Section 707 B). 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. IRMA 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 (IRMA Section 708). 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. IRMA provides that disputed claim procedures are not applicable to disputes with respect to coverage determinations by guaranty associations as part of their statutory obligations (IRMA Section 707 C). 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 (i) the time and date of the hearing, (ii) the procedure to be followed at the hearing, (iii) the amount claimed, (iv) the relevant priority status of the disputed claim(s), (v) the reason for the denial or priority status assigned, and (vi) 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 (IRMA Section 707 D).

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.

IRMA Section 105 E recognizes the propriety of arbitration to resolve reinsurance disputes. (See Chapter 7 VII.)

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 property/casualty 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 or not 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 which 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 accident and health 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 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 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 IRMA Article VIII.

A. Priority of Distribution in Receiverships

All state receivership statutes and IRMA Section 801 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; for

example, 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 IRMA Section 801. Secured creditors and special deposit claimants are outside the scheme of priorities established by Section 801. Secured creditors are covered by IRMA Section 710, and special deposit claimants are covered by IRMA Section 1002C.

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. IRMA 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 IRMA Section 710 B.)

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 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 (*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, IRMA Section 801 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. IRMA 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 property/casualty guaranty association, in Class 2 (i.e., after administrative expenses of the receiver). The second alternative places the defense and cost containment expenses of property/casualty 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 IRMA 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 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 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 IRMA 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: IRMA Section 712, the *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) and, National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act (NCIGF Model). Individual state statutes based on the NCIGF Model or Guideline #1980 may differ from IRMA Section 712 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 usually 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 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 vs. 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 letters of credit against 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

IRMA 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 (IRMA Section 801). (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 IRMA, 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 IRMA Section 701 B and C). In some state receivership statutes, there may be some ambiguity on the treatment of late-filed claims.

12. Class 11 – Surplus Notes

IRMA 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. IRMA allows interest on claims in classes 1 through 11 if the liquidator proposes and the court approves a plan to pay interest (IRMA Section 801 K). 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 (*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 IRMA 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 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) 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, and 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 for example IRMA Section 802 A). IRMA, , 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 (IRMA Section 802 D). (See also 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. IRMA and most state laws also require the liquidator to make early access payments to guaranty associations from distributable assets of the liquidation estate (See for example IRMA Section 803). (See 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 pre-pay 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 for example IRMA Section 802 B). 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 for example IRMA Section 802 C – consult state law for specific requirements).

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. 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.

IRMA 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 (IRMA Section 804).

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 (*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: (a) claims of the Federal Home Loan Bank (FHLB), (b) life and health claims, and (c) 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 (FHLB) CLAIMS

1. Overview

Insurance companies are increasingly likely to be members of, and have a borrowing relationship with, one of the 12 Federal Home Loan Banks (each, an "FHLBank"). The FHLBanks are federally chartered cooperatives under the Federal Home Loan Bank Act (the "FHLBank Act"), regulated by the Federal Housing Finance Agency (the "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, he or she 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, and

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 maty be more accommodating. While prepayment may create hedging issues for the bank, avoiding prepayment is generally a secondary goal and the bank may 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, he or she 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

[2] For additional information regarding the mission and purpose of the FHLBanks, http://www.fhlbanks.com/overview_whyfhlb.htm

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.]

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B. LIFE/HEALTH CLAIMS

Overview

The processes for handling claims in life/health and property/casualty 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 NOLHGA

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 National Organization of Life and Health Guaranty Associations (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 none the less 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 & health guaranty acts provide for the continuations of certain policies covered by the guaranty association. The Liquidator should determine howany 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 which 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 impacted 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) *Insurer Receivership Model Act* (Model #555—IRMA) Section 712 Administration of Loss Reimbursement Policies;

(b) *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980); or,

(c) National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act (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. IRMA § 712 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, those that permit direct payment by the policyholder, and 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 or 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 incurred but not reported liability to ensure that collateral remains adequate throughout the administration of the program.

Iiii. Agreements between Liquidator and guaranty associations.

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 up-front 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 utilize a letter of credit 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 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.

viAnnual collateral review by 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 incurred but not reported, 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 non-performing 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 IRMA provides:

> The receiver is entitled to recover through billings to the insured or from large deductible 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 IRMA 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.

Guideline #1980 subsection (F) 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. he following definition is taken from Guideline #1980. The definitions in the other Model Acts are similar; however, the term used in IRMA 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; or
> (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 which 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 loss adjustment expenses, 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, letters of credit, 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.

IRMA 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 letters of credit 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] IRMA § 104(V)(1).

[5] For example, IRMA § 712(D) 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 a letter of credit (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 IRMA, 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.

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[6] *Compare* IRMA § 712(C)(3) *with* Guideline #1980 § (C) and NCIGF Model § 712(C).

[7] *See* Guideline #1980 § (E)(3) and NCIGF Model § 712(E)(3).

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[8] *See, e.g.,* Guideline #1980 § (E)(4) and NCIGF Model § 712(E)(5).

9 *See* Property and Casualty Insurance Guaranty Association Model Act, (# 540), § 8(A)(1)(a)(i). 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.

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 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 IRMA 712, 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] Model 540, § 13.
[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] Model 540, § 13(B)(2) Alternative 2.

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 property and casualty 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, IRMA 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 limits, can vary on the obligation for defense cost and expenses and, in some cases permit the insured to "self-

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[13] Model 540 § 8(A)(1)(b). *Compare Life and Health Insurance Guaranty Association Model Act* (#520), § 3(B)(2)(a), 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.

fund" its claims with an account in the possession of the TPA which 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 (FHLB) Claims Supplement

This supplement will provide additional details for receivers' involved in FHL Bank 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 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 member 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 (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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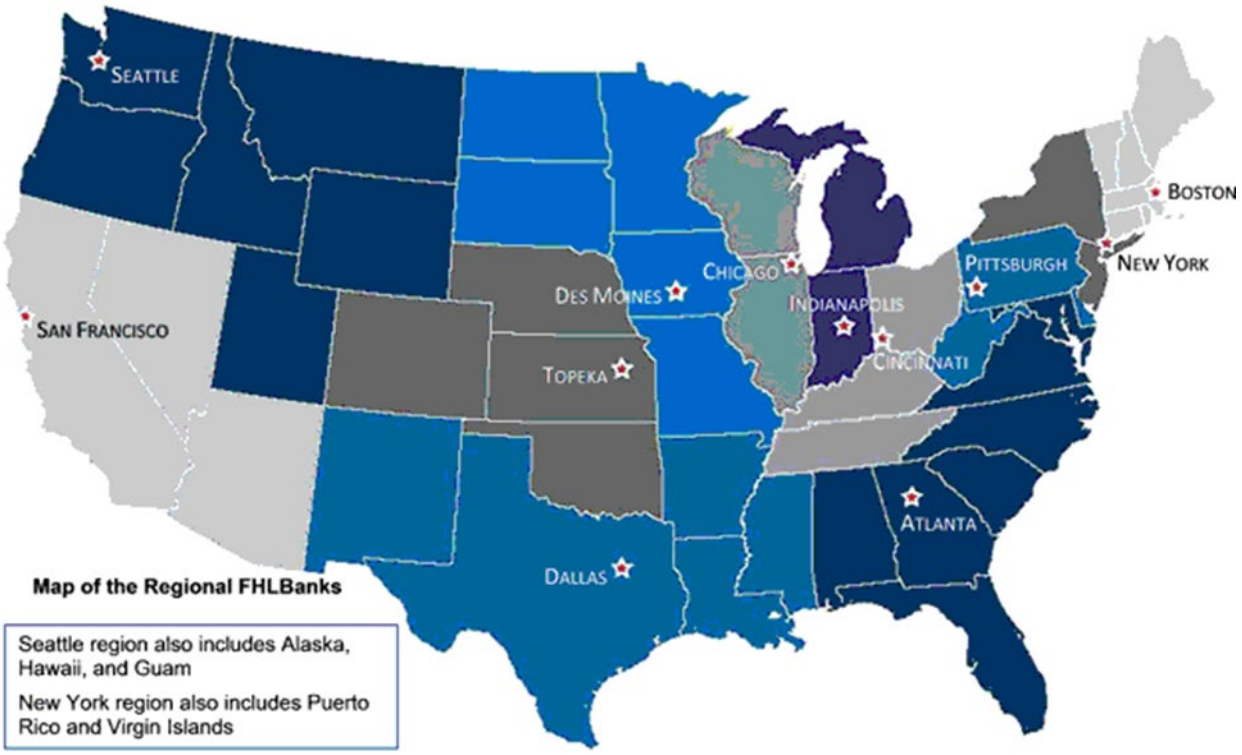

FHLBank	Title/Department	Phone
FHLBank Atlanta	Member Support Operations	mergers@fhlbatl.com
FHLBank Boston	Director of Credit	617-292-9705
FHLBank Chicago	General Counsel	312-565-5805
FHLBank Cincinnati	Vice President, Credit Risk Management	513-852-7525
FHLBank Dallas	Chief Banking Operations Officer	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 a 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 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 very 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 **form 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 imbalance between the duration of existing liabilities and newly acquired investments intended to fund them.

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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

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 himself or herself 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 (for example 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 hold a conference call meeting 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, letters of credit, 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, 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; or

- 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 Federal Home Loan Bank.

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)

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.

[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 US insurer, then the domiciliary insurance department would also have to approve the transaction.

[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.

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 letters of credit, 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 on-going 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

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 (for example 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"), for example because 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 Pre-Payment

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

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 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.

[23] See Footnote 3

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

National Association of Insurance Commissioners & The Center for Insurance Policy and Research

Assignment of Claims Issues Considerations and Guidelines

On a national level, there is an increase in the number of claim assignments that are presented to receivers. One of the many regulator consumer protection duties to be fulfilled on behalf of the policyholder is to make certain that claims assignments are being carried out. Some states have developed policies for managing the assignment of claims and the Receivership Technology and Administration Working Group provided a forum to draw upon the experience of those states as well as those of other state regulators and other interested parties to a receivership to develop guidance of how to address claims assignment issues. Keeping consumer protection in mind, each state should review its state statutes and regulations regarding the access to information that potential claim buyers have and whether there are any legal privacy issues at the state and federal levels.

1. Cost to Receivership of Claims Assignments

A. Explanation of the issue

Each state is going to have different issues addressing the specific cost of claims assignments contingent upon their specific state laws pertaining to claims assignments, and their own rules that apply to verify and process such assignments. Some specific costs are noted below.

B. Considerations

1. Developing and maintaining the proper infrastructure to record a claims assignment. The Liquidator must maintain the original claim, and record the claim assignee as the new proper claim beneficiary.

2. Processing the request. Some form of external notice must be generated to initiate a claim assignment. How is it received and recorded?

3. Due diligence. The liquidation must verify whether the assignor is the appropriate party to execute the assignment.

4. The disparity of knowledge between the claim seller and claim buyer regarding the claim assignment process can be significant. This results in increased communication demands from buyers on the Liquidator.

C. Recommendations

1. Provide additional court filings with required listings of all approved claims on a quarterly basis.

2. Establish a specified time frame to respond to a claims assignment request irrespective of the quality of information submitted in the request.

3. Revise the existing database to record whether the creditor was eligible to have the personal data of his claim published or not.

4. Research all open estates, provide listings of creditor information, and obtain consent from all creditors for the release of personal claims data.

5. Require the Liquidator to make a good faith effort to predict when distributions would occur and estimate pay-out percentages for the distribution.

2. Difficulty Associated With Verifying Claims

A. Explanation of the issue

1. Some companies placed in liquidation (hereinafter called "Estates") have poor records (e.g., accounting, policy, claim and reinsurance records). Records have to be reconstructed by Estate staff before basic policy information can be verified (e.g., in-force coverage at time of loss, policy terms, deductibles and exclusionary endorsements). This information is necessary for the Estate and guaranty funds to verify coverage and appropriately handle asserted claims against the Estate.

2. Some Estates have switched to a paperless environment (i.e., system only records). If these record only systems are not maintained properly or kept current, the Estate is unable to transition complete and accurate records or to access pertinent supporting documents. See 2.A.1. above for reconstructing Estate records.

3. Claimants do not keep Estate informed of changed information (e.g., corporate name change, merger of company into another entity, change of address, name change due to divorce and death of claimant). Lack of updated claimant information slows down the verification process.

B. Considerations

1. The Estate and guaranty funds require accurate information to verify coverage and to appropriately handle asserted claims against the Estate.

2. The issue of the Estate utilizing resources in order to handle inquiries concerning the claims assignment process. Additional pressures exerted on Estate staff to finish verification process quickly by third party vendors.

3. Possibility that the Estate may have to retain legal counsel to assist the Estate in complex claim assignment issues.

C. Recommendations

1. Establish standards, as well as a submission package, for use by all Estates for processing of claim assignments with third party vendors.

2. Permit Estates to bill third party vendors for work performed in processing claim assignments (e.g., telephone inquiries, production of reports; verification of assignment from claimant; detailed claims history information and updating Estate records).

3. Cut-Off Dates

A. Explanation of the issue

1. Establishing a date prior to the issuance of any Estate distribution monies where incomplete and/or unverified claim assignments will no longer be processed by the Estate. Some Estates bulk or batch process its distribution documents (e.g., letters, envelopes and distribution checks). Time

is needed to close the Estate records from any future updates so the distribution documents can be bulk or batch processed.

2. Many third party vendors are either on the Estate's service list or receive notification through other means of pending Estate distributions. The number of claim assignment requests increase significantly just prior to a pending Estate distribution.

3. Generally, once complete and verified claim assignments are received, Estate records can be updated quickly in 1 or 2 days.

B. Considerations

1. Sufficient time is needed to close the Estate records from any future updates so the distribution documents can be bulk or batch processed. Without establishing a cut-off date, last minute claim assignments could disrupt the Estate distribution process.

2. The concern that the third party vendor ("assignee") may have more information than is known by the claimant ("assignor"). The need to ensure that the assignor has full knowledge of all relevant facts before making the decision to assign the claim to a third party vendor.

3. Time needed to verify the accuracy of the claim assignment with the assignor prior to the pending Estate distribution.

C. Recommendations

1. Establish a date (1 day to 1 week) prior to any Estate distribution where incomplete and/or unverified claim assignments will not be further processed by the Estate before the pending Estate distribution.

4. Interpretation of Financial Information

A. Explanation of the issue

Explore options to facilitate the interpretation of financial information by entities and claimants that are interested in buying/selling claims.

B. Considerations

1. Publish financial statements and court information (in GRID and/or on receivership websites) with no additional interpretation. (This is currently available in GRID)

2. Develop a consumer guide that would help claimants make an informed decision regarding the potential value of their claim.

Concerns

1. Interpretation of financial information varies based on the type of financial information made available, which varies from state to state.

2. Development of a consumer guide to encompass all types of receiverships.

3. Publish in GRID and/or receivership websites a number to call to receive information on if/when a distribution may be made and possible percentage.

4. Publish a good faith estimate or other type of predictive information regarding the timing and amounts of potential distribution with no additional interpretation.

5. Any combination of the above.

C. Recommendations

To close the gap on asymmetric information concerns, it is recommended that receivers publish a consumer guide with a "Frequently Asked Question" document. However, further discussion is needed to finalize a long term recommendation regarding other available options.

5. Consumer Protection (Fairness)

A. Explanation of the issue

Basic question: What duty, if any, does the Insurance Commissioner in his capacity of statutory liquidator have to claimants who may wish to sell their claim?

Claims Assignment Vendors (the entities who purchase creditor claims) who purchase creditor claims in an insurance insolvency proceeding are not regulated. They do not have generally accepted practices applicable to purchasing claims. There is no definition of the due diligence required for identifying the party with the proper legal authority to sell a claim. They have no specific statutory prohibition on what advice they may give the seller of a claim, nor is there any guideline on what they are required to pay for the purchase. There is no statutory requirement that the Claims Assignment Vendor must get a claim purchase approved by the Court overseeing the liquidation process.

Conversely, there is statutory authority which requires a Liquidator to accept assignments, but there are no regulations what the Liquidator may require before it accepts a claim assignment.

Many estates cover several years before a first distribution occurs for the non-Guaranty Association claimants, generally the "little guys" who would be the most likely to benefit from selling a claim for a percentage of its ultimate value and receiving payment for their claim now. The Claims Assignment Vendor then bears whatever risk that unforeseen circumstances may reduce the ability of an Estate to make distributions, but the vendor does receive the entirety of the amount which would have been received by the seller whenever distributions are made.

Consumer protection considerations for the Commissioner include the attempt to make sure that all the claimants are treated equitably. This duty appears to be at least twofold, i.e. the claimant harmed by the insurance insolvency should get the fair value of their claim at any given time, and the Liquidator should not be burdened with a set of rules and regulations that are onerous which causes the Estate to incur expenses which diminish the value of claims of other creditors.

Each state must be conversant with their own, as well as the Federal, consumer protection statutes in terms of what information can go into the public domain. For example, do name, address and amount approved for the creditor claim submitted for a court filing constitute any kind of issue for the Liquidator? Does it make a difference if the creditor is a corporation versus an individual? Does it make a difference if you add a tax payer ID or a Social Security number? How about if you post the same information on the Liquidator's website instead of within a court filing?

B. Considerations

1. Should claim assignments require court approval whereby a Judge overseeing the liquidation specifically approves the assignment for "fairness"?

2. Should Claims Assignment Vendors be regulated to ensure scrupulous practices; or, should the Liquidator be allowed to create whatever rules deemed appropriate to control the assignment process?

3. What constitutes reasonable expense for the Liquidator to make the creditor information available for Claim Assignment Vendors whereby other creditors of the Estate are not harmed?

4. What mechanism allows creditors to find a Claims Assignment Vendor?

5. In general, individuals are perceived to have more acute needs for immediate money than corporate entities, but they also have more privacy protections afforded. Should the Claims Assignment process be limited to just businesses?

6. Should the liquidator allow all approved creditors the opportunity to opt-in, or to opt-out, of the publication of their name, address, approved claim amount, and Tax-ID or SS#?

7. Should the liquidator be responsible for having sufficiently simple financial data available on their website to allow relatively unsophisticated creditors to knowledgeably be able to discuss the value of their claim with a probably more sophisticated representative of the Claims Assignment Vendor?

C. Recommendations

Each state should review its current state statutes and requirements to make sure they are compliant.

6. Information Exchange

A. Explanation of the issue

Explore options to facilitate the exchange of information between entities and claimants that are interested in buying/selling claims.

B. Considerations

1. Provide information through a matchup of willing buyers and willing sellers.
   a. Identify willing sellers through an "opt in" process and a forum for willing buyers and sellers to communicate.

   b. Concerns:
      i. Limiting the exchange of information to a subset of claimants willing to sell their claims may not pass public records scrutiny.
      ii. Providing a forum for buyers and sellers to exchange information will add additional cost to the receivership.
      iii. The creation of a receiver-sponsored forum will create potential issues regarding the implied endorsement/recommendation of a particular buyer and may influence the consumer's ultimate decision to sell a claim.

2. Provide information by filing claim reports with the receivership court.
   - Address privacy concerns regarding protected personal information.

3. Provide non-protected information through claim report court filings.

4. Provide non-protected information through web postings.

5. Provide non-protected information in response to public records request.

C. Recommendations

To promote efficiency of receivership resources and transparency in providing non-protected information to the public, it is recommended that receiverships provide non-protected information through claims report filing with the receivership court and web posting of such information as it becomes available.

7. Availability of Receivership Information to the Public and Related Procedures

A. Explanation of the issue

Consumer privacy concerns (both legal and common sense) advocate identity protection for consumer claimants. However, certain state laws contain requirements regarding identifying information which must be included in receivership proceedings. To the extent permitted by state law, receivership pleadings should accordingly seek to protect specific identifying information of individual consumer claimants. For example, where permitted, receivership pleadings should not combine both names and addresses, or other specific identifying information, for individual consumer claimants.

B. Considerations

1. Privacy concerns aside the receiver has no fundamental objection to claim assignments.
   a. Property right
   b. A fair claim assignment can be a good result (time, uncertainty)
   c. Receiver has sold claims it holds in other receiverships

2. Nonetheless, assignments have consumer protection issues that are Commissioner/ Receiver's legitimate concern
   a. Fundamentally, consumer protection is a key aspect of insurance regulation
   b. Obligation to have a process that is designed to yield best results for creditors (not a duty to achieve a particular result, but for good process)

3. Reasonable measures to protect creditor interest in claims trading are warranted. Areas of concern that these measures address should include:
   a. Information symmetry/transparency
   b. Preventing abuse
   c. No undue administrative burden
   d. Fraud detection

C. Recommendations

1. Receiver should develop practical methods for distinguishing individual consumer claims from commercial/corporate creditors in receivership pleadings.

2. Contested claim pleadings, where specific identifying information may need to be plead, may require special procedures where appropriate (e.g. filing under seal).

3. Receiver believes it has identified a number of protections that, in combination, can give the Director confidence that claims trading on receiver Estate claim takes place in a fair environment.
   a. Convenient publication of better Estate information including publishing allowable corporate claim lists with identifiers.

b. Good Faith Estimates (forward looking statements of intent, typically regarding amount and time of distribution)
c. Requiring acknowledgement of information.
d. Tracking of assignment percentage (price),

4. With these protections in place, the receiver is not, as an initial matter, opposed to a carefully constructed process by which buyers and sellers find each other (whether an information exchange or a publication of claimant identifying information that avoids legal and common sense privacy concerns). The construction and ultimate acceptance and implementation of any such process would involve consideration of many complex issues such as: liability, unintended implicit receiver approval, and use of resources.

8. Federal / State Privacy of Claimants' Personal Information

A. Explanation of the issue

Information regarding claims is typically reported in a receivership proceeding in accordance with the state receivership act. Receivership acts vary regarding the information that must be included in a report. Some laws require that each individual claimant must be named. Under certain circumstances, information may be submitted to the court under seal.

Federal privacy laws, such as the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act (HIPAA), restrict the disclosure of personal information by insurance companies. In addition, states have adopted privacy statutes and regulations regarding the disclosure of information by insurance companies.

The disclosure requirements in these statutes are summarized in the attached **Addendum**. There are issues regarding the applicability of these laws in a receivership.

B. Considerations

GLBA

GLBA imposes restrictions on an insurer's disclosure of "non-public personal information" about a consumer. A list of names and addresses derived from personally identifiable financial information is non-public personal information. Subject to certain exceptions, an insurer is **prohibited** from disclosing to a nonaffiliated third party any non-public personal information, unless the consumer does not "opt out" after proper notice. This prohibition does not apply to disclosures to regulators, or to comply with laws, investigations, subpoenas or other judicial process. **GLBA's privacy requirements do not override state law**, except to the extent that a law is inconsistent with GLBA. A state law is not inconsistent with GLBA if the protection it affords is greater than the protection provided by GLBA.

HIPAA

HIPAA privacy standards apply to health plans, clearinghouses, and health care providers that transmit health information as defined in the act. HIPAA protects "individually identifiable health information", which includes names and geographic subdivisions smaller than a state. HIPAA restricts the disclosure of protected health information without the consent of the individual.

State Privacy Laws

GLBA requires insurance regulators to adopt privacy standards for insurers. The NAIC has adopted the Privacy of Consumer Financial and Health Information Regulation. The NAIC Model rule applies to licensed insurers, producers and others required to be licensed. It does not specify whether it

applies to an insurer in receivership. However, a drafting note to the Model suggests that a rule could provide an exception for insurers in receivership.

C. Recommendations

A Receiver should consider the following:

1. If a receivership act requires the disclosure of a claimant's name and/or address:
   a. Is the information regarding the claimant considered publicly available under GLBA because disclosure is required by state law, or
   b. Is the requirement to disclose information regarding the claimant pre-empted because it is inconsistent with GLBA?
2. If GLBA governs the content of a claim report:
   a. What information may a claim report include if a claimant has opted out? What information may a claim report include if a claimant has not opted out?
   b. To avoid the administrative costs involved in identifying those claims who have opted out, should all claimants be treated as if they opted out?
3. Under HIPAA, what information may a claim report include regarding a health insurance claim filed by an individual?
4. Is an insurer in receivership a "licensee" under the state privacy law? If there is a conflict between a state's receivership act and privacy act, which law prevails?
5. If the disclosure of information regarding individuals with insurance claims is prohibited, should a claim report identify other claimants (*e.g.*, corporations or general creditors)? If these claims are reported differently, will this impose an administrative burden on the receivership Estate?
6. Under what circumstances should a claim report be submitted to the court under seal for *in camera* inspection?
7. If a receivership act only requires that a claim report disclose the amount and class of each claim, what information should be provided to identify claims?

Addendum
Summary of Disclosure Provisions

Federal Privacy Laws

Gramm-Leach-Bliley Act (GLBA)

GLBA imposes requirements on financial institutions to protect the privacy of their customers. *See* 15 U.S.C. Subchapter I, §§ 6801-6809.

Applicability
GLBA applies to a "financial institution", which is defined by 15 U.S.C. § **§ 6809** (3) (A) to mean an institution engaging in financial activities as described in 12 USC § 1843 (k). Section 1843(k) provides that activities that are considered to be financial in nature include insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death, or providing and issuing annuities.
15 U.S.C. § 6809(4) defines **"**non-public personal information" to mean personally identifiable financial information resulting from any transaction with the consumer or any service performed for the consumer, or otherwise obtained by the financial institution. The term specifically includes "any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived using any nonpublic personal information other than publicly available information", but excludes "any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any nonpublic personal information." **N**onpublic personal information does not include "publicly available information", as defined by regulations prescribed under 15 U.S.C. § 6804.

Non-public personal information is further described by regulations. 16 C.F.R. 313.3 (n) provides examples of nonpublic personal information, including "any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information (that is not publicly available), such as account numbers." Nonpublic personal information does not include "any list of individuals' names and addresses that contains only publicly available information, is not derived, in whole or in part, using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution."

16 C.F.R. 313.3 (o)(1) defines personally identifiable financial information to mean any information a consumer provides to a financial institution: (i) to obtain a financial product or service; (ii) about a consumer resulting from any transaction involving a financial product or service; or (iii) that a financial institution otherwise obtains about a consumer in connection with providing a financial product or service. Examples of such information include the fact that an individual is or has been a customer, or has obtained a financial product or service from a financial institution, and any information about a consumer that is disclosed in a manner that indicates that the individual is or has been a consumer of a financial institution.

16 C.F.R. 313.3 (p)(1) provides that "publicly available information" means any information that a financial institution has a reasonable basis to believe is lawfully made available to the general public from federal, State, or local government records; widely distributed media; or "disclosures to the general public that are required to be made by Federal, State, or local law."

Restrictions on Disclosure

GLBA imposes restrictions on a financial institution's disclosure of non-public personal information provided by a consumer. Subject to certain exceptions, 15 U.S.C. § **6802 prohibits** a financial institution from disclosing to a nonaffiliated third party any nonpublic personal information, unless the financial institution provides the consumer with an "opt out" notice, gives the consumer a reasonable opportunity to opt out, and the consumer does not opt out. Section **6802** (e) (8) provides that this prohibition does not apply to "the disclosure of nonpublic personal information to comply with Federal, State, or local laws, rules, and other applicable legal requirements;

to comply with a properly authorized civil, criminal, or regulatory investigation or subpoena or summons by Federal, State, or local authorities; or to respond to judicial process or government regulatory authorities having jurisdiction over the financial institution for examination, compliance, or other purposes as authorized by law."

Relation to State laws

15 U.S.C. § **6807 provides that GLBA's privacy requirements "**shall not be construed as superseding, altering, or affecting any statute, regulation, order, or interpretation in effect in any State, except to the extent that such statute, regulation, order, or interpretation is inconsistent with the provisions of this subchapter, and then only to the extent of the inconsistency." A state statute, regulation, order, or interpretation is not inconsistent with GLBA if the protection it affords is greater than the protection provided by GLBA.

Health Insurance Portability and Accountability Act (HIPAA)

Applicability
The HIPAA Standards for Privacy of Individually Identifiable Health Information apply to health plans, health care clearinghouses, and to any health care provider that transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA.

Restrictions on Disclosure

HIPAA protects all "individually identifiable health information" held or transmitted by a covered entity. Under 45 C.F.R. § 164.514 (b), a name and any geographic subdivision smaller than a state, including street address, city, county, precinct, zip code or geocode, is considered an "identifier" of an individual.

45 CFR 164.512 describes the conditions under which protected health information can be disclosed without the consent of the individual. 45 CFR 164.512 (a) provides that a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. A covered entity must meet the requirements described in § 164.512 (c) [relating to disclosures about victims of abuse, neglect or domestic violence]; (e) [relating to disclosures for judicial and administrative proceedings]; or (f) [relating to disclosures for law enforcement purposes].

2. State Privacy Laws

Title V of GLBA requires state insurance regulators to adopt standards relating to the privacy and disclosure of nonpublic personal financial information applicable to the insurance industry. States have adopted statutes or regulations based on the NAIC Privacy of Consumer Financial and Health Information Regulation (the "NAIC Model").

Applicability

The NAIC Model applies to "licensees", which is defined as "all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the Insurance Law of this state, [and health maintenance organizations]." It does not specify whether it applies to an insurer in receivership. However, a drafting note to the Model states: "Because the notice requirements of this regulation could be a financial burden on a company in liquidation or receivership and negatively impact the ability of the liquidator or receiver to pay claims, regulators may want to consider adding an additional exception providing that licensees in liquidation or receivership are not subject to the notice provisions of this regulation."

Restrictions on Disclosure

The NAIC Model defines "nonpublic personal financial information" to include personally identifiable financial information, and any list, description or other grouping of consumers (and publicly available information

pertaining to them) derived using personally identifiable financial information that is not publicly available. "Personally identifiable financial information" as defined in the NAIC Model includes "[t]he fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee".

An example of nonpublic personal financial information given in the Model is a list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers. In contrast, a list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution, is not considered to be nonpublic personal financial information.

The NAIC Model defines "publicly available information" to mean any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law.

3. State Receivership Laws

The contents of a claim report are typically described in the state receivership act. The act may also specify notice requirements for matters submitted to the court (*See* IRMA § 107). Under IRMA § 107 B (1), if the Receiver determines that any documents supporting the application are confidential, they may be submitted to the court under seal for *in camera* inspection.