

Statutory Issue Paper No. 35

Accounting for Guaranty Fund and Other Assessments

STATUS

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This issue paper may not be directly related to the current authoritative statement.

Type of Issue:

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SUMMARY OF ISSUE

1. Guaranty fund assessments represent a funding mechanism employed by state insurance departments to provide funds to cover policyholder obligations of insolvent reporting entities. Most states have enacted legislation establishing guaranty funds for both life and health insurance and for property and casualty insurance to provide for covered claims or to meet other insurance obligations of insolvent insurers in the state. Guaranty funds generally make assessments after an insolvency based upon retrospective premium writings for Life and Accident and Health Insurance Companies or prospective premium writings for Property and Casualty Insurance Companies. However, a small number of states have guaranty funds that prefund, that is they assess members before an insolvency occurs. Reporting entities are subject to a variety of other assessments, such as workers' compensation second-injury funds and funds that pay operating costs of the insurance department, health related assessments, or the workers' compensation board.

2. State laws often allow for recoveries of guaranty fund assessments through refunds from the guaranty fund, premium tax credits, policy surcharges, and future premium rate structures.

3. Current statutory accounting provides only limited guidance on accounting for guaranty fund and other assessments; requiring that assessments be charged to taxes, licenses and fees, but not addressing when to recognize liabilities for assessments. *SOP 97-3, Accounting by Insurance and Other Enterprises for Insurance-Related Assessments* (SOP 97-3) dictates GAAP guidance. This issue paper establishes statutory accounting principles for guaranty fund and other assessments that are consistent with the Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy (Statement of Concepts).

SUMMARY CONCLUSION

4. *Issue Paper No. 5—Definition of Liabilities, Loss Contingencies and Impairments of Assets* (Issue Paper No. 5), requires accrual of a liability when both of the following conditions are met:

- a. Information available prior to issuance of the statutory financial statements indicates that it is probable that an asset has been impaired or a liability has been incurred at the date of the statutory financial statements. It is implicit in this condition that it is probable that one or more future events will occur confirming the fact of the loss or incurrence of a liability, and
- b. The amount of loss can be reasonably estimated.

For purposes of subparagraph 4 b., loss generally means assessment or assessment rate. Guaranty fund and other assessments shall be charged to expense (Taxes, Licenses and Fees) and a liability shall be accrued when those criteria are met except for certain health related assessments which shall be reported as a part of claims. Health related assessments that are reported as a part of claims instead of taxes,

licenses and fees are those assessments that are designed for the purpose of spreading the risk of severe claims or adverse enrollment selection among all participating entities, and where the funds collected via the assessment are re-distributed back to the participating entities based upon the cost of specific claims, enrollment demographics, or other criteria affecting health care expenses.

5. For refunded guaranty fund assessments and assessments used to fund state operating expenses, reporting entities shall credit the refund or charge the assessment to expense when notification of the refund or assessment is made.

6. For guaranty fund assessments, subparagraph 4a is met when the insolvency has occurred, regardless of whether the assessments are based on premiums written before or after the insolvency. For purposes of applying this guidance, the insolvency shall be considered to have occurred when a reporting entity meets a state's (ordinarily the state of domicile of the insolvent reporting entity) statutory definition of an insolvent reporting entity. In most states, the reporting entity must be declared to be financially insolvent by a court of competent jurisdiction. In some states, there must also be a final order of liquidation. Loss-based administrative-type and second injury fund assessments are presumed probable when the losses on which the assessments are expected to be based are incurred.

7. Subparagraph 4b requires that the amounts can be reasonably estimated. For guaranty fund or other assessments, a reporting entity's estimate of the liability shall reflect an estimate of its share of the ultimate loss expected from the insolvency. The reporting entity shall also estimate any applicable premium tax credits and policy surcharges. An entity need not be able to compute the exact amounts of the assessments or be formally notified of such assessments by a guaranty fund to make a reasonable estimate of its liability. Entities subject to assessments may have to make assumptions about future events, such as when the fund making the assessment will incur costs and pay claims to determine the amounts and the timing of assessments. The best available information about market share or premiums by state and premiums by line of business generally should be used to estimate the amount of future assessments. Estimates of loss-based assessments should be consistent with estimates of the underlying incurred losses and should be developed based upon enacted laws or regulations and expected assessment rates. Premium tax credits or policy surcharges may only be considered in the estimate if it is probable they will be realized. Changes in the amount of the liability (or asset) as a result of the passage of time and revisions to estimates in the amount or timing of the payments shall be recorded in taxes, licenses and fees.

8. In accordance with Issue Paper No. 5, when the reasonable estimate of the loss is a range, the amount in the range that is considered the best estimate shall be accrued. When, in management's opinion, no amount within management's estimate of the range is a better estimate than any other amount, however, the midpoint (mean) of within management's estimate in the range shall be accrued. For purposes of this issue paper, it is assumed that management can quantify the high end of the range. If management determines that the high end of the range cannot be quantified, then a range does not exist, and management's best estimate shall be accrued.

9. The liability for assessments shall be established gross of any probable and estimable recoveries from premium tax credits and premium surcharges. Because assessments are generally paid before premium tax credits are realized or policy surcharges are collected, an asset may result, which represents a receivable for premium tax credits that will be taken and policy surcharges which will be collected in the future. These amounts, to the extent it is probable they will be realized, meet the definition of assets, as specified in *Issue Paper No. 4—Definition of Assets and Nonadmitted Assets* (Issue Paper No. 4), and are admitted assets to the extent they conform to the requirements of this issue paper. The asset shall be established and reported independent from the liability (not reported net).

10. In certain circumstances, a reporting entity acts as an agent for certain state agencies in the collection and remittance of fees or assessments. In these circumstances, the liability for the fees and

assessments rests with the policyholder rather than with the reporting entity. The reporting entity's obligation is to collect and subsequently remit the fee or assessment. When both the following conditions are met, an assessment should not be reported in the statement of operations of a reporting entity:

- a. The assessment is reflected as a separately identifiable item on the billing to the policyholder; and
- b. Remittance of the assessment by the reporting entity to the state is contingent upon collection from the insured.

Disclosure

11. In the event that the criteria in paragraph 4 are not met, the notes to the financial statements shall include the disclosure required by Issue Paper No. 5 which, indicates the nature of the assessments and states that an estimate of the liability cannot be made.

DISCUSSION

12. This issue paper applies Issue Paper No. 5 to guaranty fund and other assessments.

13. Current statutory practice is that assessments for life guaranty fund obligations (which are based on premiums written prior to the insolvency) are accrued at the time of the insolvency. Current statutory practice for property and casualty guaranty fund assessments varies. Not all property and casualty guaranty fund obligations are accrued at the time of the insolvency. Those that have not accrued the obligation believe that guaranty fund assessments that are based on premiums written after an insolvency should be accrued when the premiums are written, because the event that obligates the company is the writing of the premiums. This issue paper rejects that point of view, because it is inconsistent with the concepts of conservatism and recognition outlined in the Statement of Concepts. It is also inconsistent with the accounting principles set forth in Issue Paper No. 5. With respect to conservatism, the Statement of Concepts states that:

Financial reporting by insurance enterprises requires the use of substantial judgments and estimates by management ... In order to provide a margin of protection for policyholders, the concept of conservatism should be followed when developing estimates as well as establishing accounting principles for statutory reporting.

With respect to recognition, the Statement of Concepts states that:

Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies... Accounting treatments which tend to defer expense recognition do not generally represent acceptable SAP treatment.

Drafting Notes/Comments

- Voluntary Guaranty Funds should be accounted for in accordance with *Issue Paper No. 5—Definition of Liabilities, Loss Contingencies and Impairments of Assets*.

RELEVANT STATUTORY ACCOUNTING AND GAAP GUIDANCE

Statutory Accounting

14. The Accounting Practices and Procedures Manuals for Life and Accident and Health and for Property and Casualty Insurance Companies mention guaranty fund surplus in their respective chapters on surplus. Both state that "Guaranty fund surplus for mutual companies" should be considered as part of surplus, for purposes of meeting the minimum surplus requirements.

15. The NAIC Annual Statement Instructions indicate that Taxes, Licenses & Fees should include guaranty fund assessments.

16. Emerging Accounting Issues Working Group of the Accounting Practices and Procedures (EX4) Task Force discussed the accounting for guaranty fund and other assessments in Issues 91-1 through 91-4 and 92-1. The discussion focused around whether guaranty fund assessments could be reported as loss payments. The consensus reached was that guaranty fund assessments should be reported as expense items through Taxes, Licenses and Fees.

17. The Life and Health Insurance Guaranty Association Model Act provides the following guidance:

Section 9. Assessments

- A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at [insert amount] percent per annum on and after the due date.
- B. There shall be two (2) assessments, as follows:
- (1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of Section 12E. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.
 - (2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section 8 with regard to an impaired or an insolvent insurer.
- C.
- (1) The amount of any Class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. A non-pro rata assessment shall not exceed \$150 per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.
 - (2) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer or policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.
 - (3) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this Act. Classification of assessments under Subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.
- D. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the

ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

- E. (1) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent (2%) and for the health account shall not in any one calendar year exceed two percent (2%) of the insurer's average premiums received in this state on the policies and contracts covered by the account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.
- (2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.
- (3) If a one percent (1%) assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to Subsection C(2), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in Subsection E(1) above.

Editor's Note: For interpretation of this section, see Guaranty Fund (EX4) Task Force minutes in 1988 Proceedings of the NAIC, Volume II, page 335.

- F. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses.
- G. It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this Act, to consider the amount reasonably necessary to meet its assessment obligations under this Act.
- H. The Association shall issue to each insurer paying an assessment under this Act, other than Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

Comment: When an insurer is impaired or insolvent the member insurers will be assessed on the basis of the premiums they write in the state. This corresponds to the Association's liability which, in most cases, is limited to covered policies of residents. This assessment system provides a base broad enough to meet fairly large demands on the Association. Equally important, since it reflects the market share of each member in the state considered, it is an equitable method of apportioning the burden of the assessments.

The maximum assessment per year may be varied from state to state depending on the size of the base and the concentration of the business. The two percent maximum assessment per year should produce an adequate amount while at the same time not impose an undue strain in any given year on the assessed companies and their policyholders.

In order to prevent further financial difficulties caused by an assessment, Subsection D permits abatement of assessments when such financial difficulties might result. Subsections D and E provide some limitation on the amounts which can be assessed in any given year. If these limits are reached, to fulfill its responsibilities the Association is empowered to borrow funds which later can be repaid out of future assessments.

Subsection G provides that a member insurer may consider in its premium rates and dividend scale an amount reasonably necessary to meet its assessment obligations. This makes it clear that the cost can be ultimately passed on to the policyowners - i.e., to persons who enjoy the protection provided by the Act.

Subsection H provides that the Association shall issue to assessed insurers certificates of contribution in the amount levied. The certificates may be carried by an insurer in its annual statement as an asset in such form, amount and period as may be approved by the Commissioner. By permitting the companies to carry these certificates as an asset, to the extent of their estimated value, the impact on member insurers will be lessened.

18. The Post-Assessment Property and Liability Insurance Guaranty Association Model Act provides the following guidance:

Section 8. Powers and Duties of the Association

A. The Association shall:

- (1) Be obligated to pay covered claims existing prior to the determination of the insolvency arising within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if he does so within thirty (30) days of the determination. The obligation shall be satisfied by paying to the claimant an amount as follows:
 - (a) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;
 - (b) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (c) An amount not exceeding \$300,000 per claimant for all other covered claims.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include any claim filed with the Guaranty Fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. The Association shall pay only that amount of each unearned premium which is in excess of \$100.

Comment: The obligation of the Association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the Association should

become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to \$10,000, against the Association. The deductible amount (\$100) and the maximums (\$10,000 for the return of unearned premium; \$300,000 for all other covered claims) represent the subcommittee's concept of practical limitations, but each state will wish to evaluate these figures.

[Alternate Section 8A(1)]

A. The Association shall:

- (1) Be obligated to pay covered claims existing prior to the determination of the insolvency arising within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if he does so within thirty (30) days of the determination. The obligation shall extend to covered claims reported pursuant to an optional extended period to report claims sold to the insured by the liquidator. The obligation as to covered claims shall be satisfied by paying to the claimant an amount as follows:
 - (a) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;
 - (b) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (c) An amount not exceeding \$300,000 per claimant for all other covered claims.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provision of this Act, a covered claim shall not include any claim filed with the Guaranty Fund after the earlier of the final date for the filing of claims against the liquidator or receiver of an insolvent insurer or eighteen (18) months after the order of liquidation. The Association shall pay only that amount of each unearned premium which is in excess of \$100.]

Comment: The Alternate Section 8A(1) should be used if the state includes a provision in its liquidation law giving the liquidator authority to sell a limited extended reporting period for claims-made policies.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.
- (3) Assess insurers amounts necessary to pay the obligations of the Association under Section 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due.

No member insurer may be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the Association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order which it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurers financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments.

[Alternate Section 8A(3)

- (3) Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the Association under Section 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurer's for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order which it deems reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

Comment: The maximum assessment per year may be varied from state to state depending on the size of the base. The figure used should produce sufficient funds to handle any possible insolvency, keeping in mind that the total amount may not be needed in one year. The two percent maximum used here would have produced in 1968 on a nationwide basis, from the kinds of insurance to which this Act applies, approximately \$500,000,000.

- (4) Investigate claims brought against the Association and adjust, compromise, settle and pay covered claims to the extent of the Association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested.
- (5) Notify such persons as the Commissioner directs under Section 10B(1).

Comment: The liquidation statutes of the state may describe the persons to be notified by the liquidator, but since this Association provides a distinctive service, the Commissioner may wish to require a separate notification by it.

- (6) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but the designation may be declined by a member insurer.
- (7) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association and shall pay the other expenses of the Association authorized by this Act.

B. The Association may:

- (1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;
- (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
- (3) Sue or be sued;
- (4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this Act;
- (5) Perform such other acts as are necessary or proper to effectuate the purpose of this Act;
- (6) Refund to the member insurers in proportion to the contribution of each member insurer to the Association that amount by which the assets of the Association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association exceed the liabilities of the Association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)]

- (6) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]

Comment: The subcommittee feels that the board of directors should determine the amount of the refunds to members when the assets of the Association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

19. The 24-Hour Coverage Pilot Project Model Act provides the following discussion of guaranty fund assessments:

Section 15. Guaranty Fund Participation

The twenty-four hour medical insurance policy shall be classified as property and casualty coverage regardless of the carrier approved to provide the coverage. As such, the carrier shall be obligated to participate in the property and casualty guaranty association specified in [insert applicable section providing for participation in the property and casualty insurance guaranty association]. All premiums collected for the twenty-four hour medical insurance policy shall be considered assessable premiums for purposes of participation in the guaranty association. In the event of insolvency of the carrier, the guaranty association shall honor the full extent of the contractual obligation assumed by the carrier under the twenty-four hour medical insurance policy.

Section 16. Special Assessments

A carrier providing coverage to an employer through the twenty-four hour medical insurance policy is obligated to participate in the [insert reference to residual market mechanism, second injury fund or other fund that relies on assessments from workers' compensation insurance premiums]. For purposes of calculation of this special assessment, the commissioner shall establish by rule, or order, the amount of premium generated under the twenty-four hour medical insurance policy which shall be considered assessable premium.

Drafting Note: A state should consider the ratio of the workers' compensation standard premium to the total premium for both workers' compensation and the health insurance plan used by the employer in choosing an appropriate amount. States with relatively small residual market shares for workers' compensation may choose to exclude this section. States should consider loss based assessments, if applicable.

20. The Health Maintenance Organization Model Act contains the following:

Section 33. Insolvency Protection; Assessment

- A. When a health maintenance organization in this state is declared insolvent by a court of competent jurisdiction, the [commissioner] may levy an assessment on health maintenance organizations doing business in this state to pay claims for uncovered expenditures for enrollees who are residents of this state and to provide continuation of coverage for subscribers or enrollees not covered under Section 15. The [commissioner] may not assess in any one calendar year more than two percent (2%) of the aggregate premium written by each health maintenance organization in this state the prior calendar year.
- B. The [commissioner] may use funds obtained under Subsection A to pay claims for uncovered expenditures for subscribers or enrollees of an insolvent health maintenance organization who are residents of this state, provide for continuation of coverage for subscribers or enrollees who are residents of this state and are not covered under Section 15, and administrative costs. The [commissioner] may by regulation prescribe the time, manner and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

- C. (1) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.
- (2) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the [commissioner] to the extent of the benefits received. The [commissioner] may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon that person. The [commissioner] is subrogated to these rights against the assets of an insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.
- (3) The assignment of subrogation rights of the [commissioner] and allowed claim under this subsection have the same priority against the assets of the insolvent health maintenance organization as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.
- D. When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the [commissioner] will distribute on a pro rata basis any amounts received under Subsection A which are not *de minimis* to the health maintenance organizations that have been assessed under this section.
- E. The aggregate coverage of uncovered expenditures under this section shall not exceed \$300,000 with respect to one individual. Continuation of coverage shall not continue for more than the lesser of one year after the health maintenance organization coverage is terminated by insolvency or the remaining term of the contract. The [commissioner] may provide continuation of coverage on any reasonable basis; including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the [commissioner].
- F. The [commissioner] may waive an assessment of a health maintenance organization if it would be or is impaired or placed in financially hazardous condition. A health maintenance organization which fails to pay an assessment within thirty (30) days after notice is subject to a civil forfeiture of not more than \$1,000 per day and suspension or revocation of its certificate of authority. An action taken by the [commissioner] in enforcing the provisions of this section may be appealed by the health maintenance organization in accordance with [the administrative procedures act].

Drafting Comment: Section 33 is not recommended for all states. A state should carefully review its health maintenance organization market to determine whether the assessment procedure under this section is feasible. If health maintenance organization premium volume is small or dominated by a few organizations, a state may wish to rely solely on the protections provided under Section 14 and 15.

For those states where an assessment is feasible, this section provides assurance that funds will be available to pay uncovered expenditures even if those liabilities have been underestimated by the organization or have significantly escalated as the financial condition of the organization deteriorated. In addition, an assessment provides a means for continued coverage for those subscribers or enrollees who are not protected under Section 15.

Generally Accepted Accounting Principles

21. The *AICPA Audit and Accounting Guide: Stock Life Insurance Companies* contains the following in Chapter 7, *Capital and Surplus*:

In lieu of capital stock, mutual companies are organized with prescribed minimum surplus which varies among states. Such surplus may take the form of guaranty funds, guaranty capital, or

other permanently designated funds subject to the payment of interest and subject to repayment under conditions prescribed by the respective state laws.

22. *AICPA Statement of Position 97-3, Accounting by Insurance and Other Enterprises for Insurance-Related Assessments* contains the following guidance (only pertinent sections included):

Reporting Liabilities

10. Entities subject to assessments should recognize liabilities for insurance-related assessments when all of the following conditions are met:

- a. An assessment has been imposed or information available prior to the issuance of the financial statements indicates it is probable that an assessment will be imposed.
- b. The event obligating an entity to pay (underlying cause of) an imposed or probable assessment has occurred on or before the date of the financial statements.
- c. The amount of the assessment can be reasonably estimated.

Probability of Assessment

11. Premium-based guaranty-fund assessments, except those that are prefunded, are presumed probable when a formal determination of insolvency occurs, and presumed not probable prior to formal determination of insolvency. Prefunded guaranty-fund assessments and premium-based administrative-type assessments (as defined in paragraph 4), are presumed probable when the premiums on which the assessments are expected to be based are written. Loss-based administrative-type and second-injury fund assessments are presumed probable when the loss on which the assessments are expected to be based are incurred.

Obligating Event

12. Because of the fundamental differences in how assessment mechanisms operate, the event that makes an assessment probable (for example, an insolvency) may not be the event that obligates the entity. The following defines the event that obligates an entity to pay an assessment for each kind of assessment defined in this SOP.

13. For premium-based assessments, the event that obligates the entity is generally writing the premium or becoming obligated to write or renew (such as multiple-year, noncancelable policies) the premiums on which the assessments are expected to be based. Some states, through law or regulatory practice, provide that an insurance enterprise cannot avoid paying a particular assessment even if that insurance enterprise reduces its premium writing in the future. In such circumstances, the event that obligates the entity is a formal determination of insolvency or similar triggering event. Regulatory practice would be determined based on the stated intentions or prior history of the insurance regulators.

14. For loss-based assessments, the event that obligates an entity is an entity's incurring the losses on which the assessments are expected to be based.

The SOP defines the condition of obligation differently than the issue paper. This issue paper indicates that the conditions of probability and obligation have been satisfied when insolvency has occurred, regardless of whether the assessment is based upon premiums or losses written, incurred or paid before or after the insolvency. This issue paper rejects SOP 97-3 because it is inconsistent with the concepts of conservatism and recognition outlined in the Statement of Concepts. It is also inconsistent with the accounting principles set forth in Issue Paper No. 5. This issue paper has incorporated language from the Ability to Reasonably Estimate the Liability section of the SOP in paragraph 7.

OTHER SOURCES OF INFORMATION

23. The draft discussion material from previous Property/Casualty codification projects provides the following guidance:

CHAPTER X
GUARANTEE FUND AND OTHER ASSESSMENTS

The expense for guarantee fund and other assessments should be reported as taxes, licenses and fees in the annual statement (and not as loss payments) when incurred. Specific assessment practices differ from state to state. In general, however, when an assessment is made, in addition to the amount requested, an estimate of the ultimate range of assessment may be indicated. Experience has shown that these ranges may change dramatically within a short time frame. The expense is incurred when an insolvency has occurred, an assessment is probable, and the amount can be reasonably estimated.

Accounting for Guarantee Fund and Other Assessments

Guarantee fund and other assessments are incurred, must be expensed, and a liability established when the following criteria are met:

- a. An insolvency has occurred which creates an obligation for a state guarantee fund. This obligation will usually be evident when a company receives a court order for liquidation.
- b. Information available indicates that it is probable that a liability has been incurred.
- c. The amount of the liability can be reasonable estimated.

The amount accrued must reflect the ultimate liability expected from the insolvency. The accrual will be determined net of anticipated premium tax offsets.

If it is probable that a liability has been incurred from an insolvency, but it can not be reasonable estimate, a footnote should disclose the nature of the contingent liability and shall express the potential range of the anticipated loss exposure, when the potential liability is deemed material.

Reporting for Guarantee Fund and Other Assessments

The expense for guarantee fund and other assessments should be reported as taxes, licenses and fees in the annual statement (and not as loss payments) when incurred.

Assessment for which the Insurance company acts as Agent for the State

In certain circumstances, an insurance company acts as an agent for certain state agencies in the collection and remittance of fees or assessments. In these circumstances, the liability for the fees and assessments rests with the policyholder rather than with the insurance company. The insurance company's obligation is to collect and subsequently remit the fee or assessment. These situations differ from a premium tax liability whereby the insurance company is required to remit the premium tax whether or not the premium has been collected.

When both the following conditions are met, an assessment should not be reported in the statement of operations of an insurance company:

- The assessment is reflected as a separately identifiable item on the billing to the policyholder; and

- Remittance of the assessment by the insurance company to the state is contingent upon collection from the insured.

24. NAIC Technical Resource Group Proposed Draft Life Codification provides the following guidance in Chapter 22, *General Expenses and Taxes, Licenses and Fees*:

6. All other taxes will include guaranty fund assessments and taxes of Canada or of any other foreign country not specifically provided for elsewhere. Guaranty fund and other assessments must be expended and a liability established when the following criteria are met:

- An insolvency has occurred which creates an obligation for a state guaranty fund; this obligation will usually be evident when a company receives a court order for liquidation;
- Information available indicates it is probable that a liability has been incurred; and
- The amount of the loss can be reasonably estimated using the risk free investment rate of a bond having a duration equivalent to the duration of the liability.

The amount accrued must reflect the ultimate loss exposure expected from the insolvency. The accrual will be determined net of estimated premium tax offsets and will reflect the present value of the anticipated payments.

If it is probable a liability has been incurred from an insolvency, but it cannot be reasonably estimated, the nature of the contingent liability and the potential range of the anticipated loss exposure must be disclosed in the notes to the financial statements, when the potential liability is deemed material.

RELEVANT LITERATURE

Statutory Accounting

- Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy
- *Issue Paper No. 5—Definition of Liabilities, Loss Contingencies, and Impairments of Assets*
- Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies, Chapter 27, *Paid-In or Contributed Surplus and Organizational Surplus*
- Accounting Practices and Procedures Manual for Property and Casualty Insurance Companies, Chapter 24, *Paid-In or Contributed Surplus and Organizational Surplus*
- NAIC Annual Statement Instructions
- Emerging Accounting Issues Working Group of the Accounting Practices and Procedures (EX4) Task Force, 92-1, Minutes, Meeting of February 21, 1992
- Life and Health Insurance Guaranty Association Model Act, Section 9 - Assessments
- Post-Assessment Property & Liability Insurance Guaranty Association Model Act, Section 8 - Assessments
- 24 Hour Coverage Pilot Project Model Act, Sections 15 and 16
- Health Maintenance Organization Model Act, Section 33
- Issue Paper No. 4—Definition of Assets and Nonadmitted Assets

Generally Accepted Accounting Principles

- *AICPA Audit and Accounting Guide: Stock Life Insurance Companies*, Chapter 7, *Capital and Surplus*, section 7.03
- *AICPA Statement of Position 97-3, Accounting by Insurance and Other Enterprises for Insurance-Related Assessments*

State Regulations

- No further guidance obtained from state statutes or regulations.

Other Sources of Information

- Draft discussion material from previous Property/Casualty Codification Projects, Chapter X, Guarantee Fund and Other Assessments
- NAIC Technical Resource Group Proposed Draft Life Codification, Chapter 22, *General Expenses and Taxes, Licenses and Fees*

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