2019 Fall National Meeting
Austin, Texas

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE
Sunday, December 8, 2019
11:00 a.m. – 12:00 p.m.
JW Marriott Austin— Lone Star Ballroom D-E—Level 3

ROLL CALL

Kent Sullivan, Chair
Texas
Chlor Lindley-Myers
Missouri

Stephen C. Taylor, Vice Chair
District of Columbia
Matthew Rosendale
Montana

Lori K. Wing-Heier
Alaska
Bruce R. Ramge
Nebraska

Peter Fuimaono
American Samoa
Marlene Caride
New Jersey

Allen W. Kerr
Arkansas
John G. Franchini
New Mexico

Ricardo Lara
California
Mike Causey
North Carolina

Michael Conway
Colorado
Glen Mulready
Oklahoma

Andrew N. Mais
Connecticut
Jessica Altman
Pennsylvania

David Altmaier
Florida
Elizabeth Kelleher Dwyer
Rhode Island

Robert H. Muriel
Illinois
Raymond G. Farmer
South Carolina

Doug Ommen
Iowa
Hodgen Mainda
Tennessee

Vicki Schmidt
Kansas
Todd E. Kiser
Utah

Nancy G. Atkins
Kentucky
Scott A. White
Virginia

James J. Donelon
Louisiana
Mike Kreidler
Washington

Gary Anderson
Massachusetts

NAIC Support Staff: Jane Koenigsman

AGENDA

1. Consider Adoption of its Summer National Meeting Minutes—*James Kennedy (TX)*

2. Consider Adoption of its Working Group Reports
   a. Receivership Financial Analysis (E) Working Group—*Kevin Baldwin (IL)*
   b. Receivership Large Deductible Workers’ Compensation (E) Working Group
      — *Donna Wilson (OK)*

3. Consider Adoption of Revisions to the *Receiver’s Handbook for Insurance Company Insolvencies* for Large Deductible Workers’ Compensation—*Donna Wilson (OK)*

4. Discuss Macroprudential Initiative (MPI) Report Recommendations—*James Kennedy (TX)*
   b. Discuss Methods for Addressing Continuity of Essential Services and Functions in Receivership
   c. Discuss Methods for Addressing Variances in the States’ Receivership Laws

5. Hear a Presentation on the International Association of Insurance Receivers (IAIR) Designation Program—*Wayne Johnson (Risk & Regulatory Consulting, LLC)*

6. Hear an Update on International Resolution Activity—*James Kennedy (TX) and Robert Wake (ME)*

7. Discuss Any Other Matters Brought Before the Task Force—*James Kennedy (TX)*

8. Adjournment
The Receivership and Insolvency (E) Task Force met in New York, NY, Aug. 4, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by James Kennedy (TX); Stephen C. Taylor, Vice Chair, represented by N. Kevin Brown (DC); Lori K. Wing-Heier represented by David Phifer (AK); Allen W. Kerr represented by Mel Heaps (AR); Ricardo Lara represented by David Wilson (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jon Arsenault (CT); David Altmaier represented by Toma Wilkerson (FL); Doug Ommen represented by Kim Cross (IA); Robert H. Muriel represented by Patrick Hyde and Douglas Harrell (IL); Vicki Schmidt represented by Justin McFarland (KS); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelon represented by Liz Butler (LA); Gary Anderson represented by Christopher Joyce (MA); Chlora Lindley-Myers represented by Debbie Doggett (MO); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Matt Holman (NE); Marlene Caride, represented by John Sirotetz (NJ); John G. Franchini represented by Victoria Baca (NM); Glen Mulready represented by Donna Wilson (OK); Jessica Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Raymond G. Farmer represented by Lee Hill (SC); Carter Lawrence represented by Patrick Merkel (TN); Todd E. Kiser represented by Reed Stringham (UT); Scott A. White represented by Dan Bumpus (VA); and Mike Kreidler represented by Doug Hartz (WA).

1. **Adopted its 2019 Spring National Meeting Minutes**

Mr. Holman made a motion, seconded by Mr. Hartz, to adopt the Task Force’s April 7 minutes (see NAIC Proceedings – Spring 2019, Receivership and Insolvency (E) Task Force). The motion passed unanimously.

2. **Adopted revisions to Guideline #1556**

Mr. Kennedy stated that the drafting group discussed receivership stays on qualified financial contracts (QFCs) as part of the Macroprudential Initiative (MPI). The Insurer Receivership Model Act (#555) Section 711 exempts QFCs from receivership stays. The Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556) was adopted to impose a 24-hour stay to align with federal stays. States have not enacted Guideline #1556 because it conflicts with the federal rules on master netting agreements that do not recognize stays in state receiverships. The Task Force exposed for public comment edits to the drafting note for Guideline #1556 that describes the conflict with the federal rules. Only one comment was received supporting the need for a federal rule change. No comments were received on the revisions to Guideline #1556.

Mr. Kaumann made a motion, seconded by Mr. Phifer, to adopt the revisions to Guideline #1556 (Attachment One). The motion passed unanimously.


Mr. Wilson said the Receivership Financial Analysis (E) Working Group met Aug. 4 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. The Working Group discussed the status of individual receiverships and related issues.

Mr. Wilson made a motion, seconded by Ms. Hartz, to adopt the Working Group’s report. The motion passed unanimously.

4. **Adopted the Report of the Receivership Large Deductible Workers’ Compensation (E) Working Group**

Ms. Wilson said the Receivership Large Deductible Workers’ Compensation (E) Working Group met July 18 and took the following action: 1) adopted its May 8 minutes; 2) received a presentation from Robin Marcotte (NAIC) on the high deductible annual statement notes to the financial statement; and 3) discussed the draft revisions to the Receiver’s Handbook for Insurance Company Insolvencies (Receiver’s Handbook) and the comments from Maine and the National Conference of Insurance Guaranty Funds (NCIGF). Comments were incorporated into the draft and further revisions were provided. The revised draft will be redistributed and considered for adoption on a future conference call. The Working Group is anticipating completing its charge to have the revisions to the Receiver’s Handbook by the Fall National Meeting.
Ms. Wilson made a motion, seconded by Ms. Slaymaker, to adopt the Working Group’s report, including its July 18 minutes (Attachment Two). The motion passed unanimously.

5. **Adopted a Report on the MPI Referral from the Financial Stability (EX) Task Force**

Mr. Kennedy summarized the recommendations of the drafting group. In 2018 the Financial Stability (EX) Task Force made a referral to the Task Force as part of the MPI. The Task Force’s drafting group met this year in March, May and July to continue discussions on the issues it identified last year. The drafting group completed its work and issued a report of its recommendations.

Mr. Kennedy said the drafting group agreed that the powers under U.S.’s current state laws, regulations and guidance generally provide the powers described in the Financial Stability Board’s (FSB) Key Attributes of Effective Resolution Regimes for Financial Institutions, as well as the International Association of Insurance Supervisors’ (IAIS) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and its Insurance Core Principles (ICPs). In some cases, however, the powers under state laws are implicit rather than explicit. He said the report outlines issues within the three topics from the referral that the drafting group identified needed further consideration and made recommendations.

Mr. Kennedy said that the first topic of the referral was to evaluate recovery and resolution laws, guidance and tools, and determine whether they incorporate best practices with respect to financial stability. In addressing the first topic, the drafting group had recommendations related to three issues.

- **a. The first issue involves bridge institutions, which are used in the banking context but typically are not needed in insurance receiverships. The drafting group considered the benefit of bridges in the transfer of QFCs at the inception of receivership. However, this process requires a temporary stay, which is not permitted in states that have adopted Model #555 Section 711 prohibits stays and would be in conflict with the federal rules on the termination of QFCs. Therefore, it recommends a charge to the Receivership Model Law (E) Working Group to explore if bridge institutions could be implemented under regulatory oversight, such as during administrative supervision or conservation, to address the early termination of QFCs.**

- **b. The second issue is the need for best practices and legal remedies to provide continuity of essential services by requiring other entities within a group to continue services. The drafting group recommends charging the Receivership Model Law (E) Working Group to further the discussion on this topic and to consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.**

- **c. The third issue involves an evaluation of current models laws for recovery and resolution. The drafting group noted that while Model #555 generally comports with international standards, some of the relevant sections of the model are not in all states’ laws. Efforts in the past to encourage states to adopt key receivership provisions have not been very successful. The drafting group recommends that the Task Force discuss other methods to encourage states to adopt key areas of receivership law, including to consider recommending amendments to the Financial Regulation Standards and Accreditation Program Part A standards for receivership and guaranty fund laws. The current Part A standard is that states have a receivership scheme. The drafting group is not yet recommending a change in accreditation standards, but a discussion of these standards.**

Mr. Kennedy said the second topic of the referral asked the Task Force to evaluate recovery and resolution planning tools for systemically important cross-border U.S. groups. He said the drafting group agrees that many topics for recovery and resolution planning are already covered in the Receiver’s Handbook and other regulatory guidance, as well as in the federal Dodd Frank Wall Street Reform and Consumer Protection Act provisions for resolution of systemically important financial institutions (SIFI). Additionally, some topics are captured elsewhere in the U.S. solvency framework. Mr. Kennedy said that the drafting group agrees that consideration of imposing recovery planning reporting requirements on insurers that are not in financial distress is outside the scope of the Task Force and may require the Financial Stability (EX) Task Force to consider discussions with other group(s) within Financial Condition (E) Committee. As the IAIS will develop an application paper on resolution planning next year, the drafting group recommends that the Task Force review and provide input to the application paper. Providing input into international work falls within the Task Force’s existing charges.

Mr. Kennedy stated that the third topic of the referral involved an evaluation of whether there are misalignments between federal and state laws that could be an obstacle to recovery and resolutions for U.S. insurance groups. He noted that the Task Force had adopted revisions to the Guideline #1556. Also, the drafting group received comments and feedback on the guidance
Draft Pending Adoption

in the Receiver’s Handbook for federal taxes and federal releases and determined that the handbook is outdated and needs to be revised. Drafting for both issues is recommended as a charge for Receivership Model Law (E) Working Group.

Mr. Hartz made a motion, seconded by Mr. Kaumann, to adopt the drafting group’s report (Attachment Three). The motion passed unanimously.

6. Heard an Update on International Resolution Activities

Mr. Kennedy reported that the IAIS Resolution Working Group has been working on the resolution portions of the ICPs and ComFrame and the Application Paper on Recovery Planning. The comment period for the Application Paper on Recovery Planning closed in January. The Resolution Working Group met to review the comments, and will continue work on this project. The next project is an application paper on resolution powers and planning, which will begin next year.


Mr. Kennedy summarized the proposed 2020 charges for the Task Force and its working groups.

a. The Task Force charge to monitor “state adoption of receivership related model acts” is broadened to reflect that the Task Force should monitor legislation related to receiverships and guaranty associations. This will ensure that the Task Force may consider laws that are not based on an NAIC model. Since this charge is broadened, the separate charge to monitor Federal Home Loan Bank legislation is deleted.

b. The charges for the Receivership Financial Analysis (E) Working Group are changed to refer to “potential or pending receiverships” to allow feedback to the Financial Analysis (E) Working Group on insurers that are not yet in receivership.

c. The charges for the Receivership Large Deductible Workers’ Compensation (E) Working Group allow the Working Group additional time to complete the discussions on work that has already begun, should those discussions extend beyond year-end.

d. The charges for the Receivership Model Law (E) Working Group delete “Model” from the name of the Working Group to reflect that its work is not restricted to model laws. The new charges include discussion of significant cases that may affect the administration of receivership. The new charges also reflect the recommendations from the report on the Financial Stability (EX) Task Force referral that the Task Force has adopted. The prior charge to monitor and recommend enhancements based on international standards is deleted, as it is incorporated in the new charges.

Mr. Wilson made a motion, seconded by Ms. Wilson, to adopt the 2020 proposed charges for the Task Force and its working groups (Attachment Four). The motion passed unanimously.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call Dec. 2, 2019. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynnowycz (AR); Toma Wilkerson (FL); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Tom Green (NE); and James Kennedy (TX).

1. **Adopted its Minutes**

Ms. Wilson presented the minutes from the Working Group’s Oct. 24 conference call (Attachment Two-A). Mr. Baldwin made a motion, seconded by Ms. Wilkerson, to adopt the Working Group’s Oct. 24 minutes. The motion passed unanimously.

2. **Exposed a Model Guideline for #555**

Ms. Slaymaker presented the NAIC staff memorandum to the Working Group (Attachment Two-B). The Working Group focused their discussion on the variations from the National Conference of Insurance Guaranty Funds (NCIGF) model adopted by some states. The Working Group directed NAIC staff to amend the draft guideline for the *Insurer Receivership Model Act* (#555) as an alternative approach to Section 712 based on the NCIGF model (Attachment Two-C) to reflect administrative fees, a state specific citation for the definition of large deductible, and the guaranty association entitlement to the net amount of the reimbursement. The Working Group exposed the model guideline for a 60-day comment period ending Jan. 31, 2020. Comments are to be submitted to Sherry Flippo (NAIC).

Having no further business, the Receivership Large Deductible Workers’ Compensation (E) Working Group adjourned.

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Receivership Large Deductible Workers’ Compensation (E) Working Group
Conference Call
October 24, 2019

The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call Oct 24, 2019. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Tom Green (NE); Christopher Brennan (NJ); and James Kennedy (TX).

1. **Adopted Revisions to the Receiver’s Handbook for Insurance Company Insolvencies**

Ms. Slaymaker presented the revisions to the *Receiver’s Handbook for Insurance Company Insolvencies* (Handbook) from the minutes of the Working Group’s May 8 conference call, which were discussed during its July 18 call. Ms. Wilson made a motion, seconded by Mr. Brennan, to adopt the Handbook revisions (Attachment Three). The motion passed unanimously.

2. **Heard a Presentation on Distributive Variation Between Model #555 Section 712 and the NCIGF Model**

Sherry Flippo (NAIC) presented the PowerPoint presentation (Attachment Two-A1). The Working Group directed NAIC staff to draft a model guideline for the *Insurer Receivership Model Act (#555)* as an alternative approach to Section 712 based on the National Conference of Insurance Guaranty Funds (NCIGF) model.

Having no further business, the Receivership Large Deductible Workers’ Compensation (E) Working Group adjourned.
Adopted by Receivership Large Deductible Worker’s Compensation (E) Working Group on 10/14/19.

Proposed Changes to Receivers Handbook for Insurance Company Insolvencies

**RE: Large Deductible Worker’s Compensation**

Inserts into Existing Handbook shown in “tracked” change.
Text between sections/pages eliminated to conserve space.

**Chapter 1 – Takeover & Administration (Page 30)**

**VIII. CLAIMS**

**A. Control the Claim Department’s Records**

Obtain copies of the insurer’s claim policies and procedures manuals. Review them to determine if the insurer has formal procedures that address the following areas:

- Actual claim processing flow;
- The level of claim file documentation required;
- The coverage confirmation process;
- Claims reserving and settlement philosophy;
- Claims settlement authority;
- Litigated claims;
- Aggregate policy procedures;
- **Large Deductible Policy Procedures including collection, collateral and aggregates**;
- Reinsurance recovery procedures;
- Theories relevant to property/casualty insurers, such as trigger theories for asbestos and environmental claims; and
- The insurer’s relationships with and responsibilities to managing general agents, TPAs, outside claim adjusters, reinsurance intermediaries and other outside parties.

**Chapter 1 – Takeover & Administration (Page 79)**

<table>
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<tr>
<th>Checklist 6—Underwriting</th>
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<td><strong>Insurance</strong></td>
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<td>Locate, obtain copies and review all insurance policies and contracts:</td>
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<td>- Professional Liability</td>
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Chapter 1 – Takeover & Administration (Page 84)

Checklist 6—Underwriting

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**Large Deductible Policies**

Review underwriting, billing and collateral records to determine which policies have large deductible endorsements and the status of collateral held, billings, and reserve calculations.

Chapter 1 – Takeover & Administration (Page 102)

Checklist 8—Accounting

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**Securities**

Identify letters of credit, trust agreements and other collateral held to secure obligations of policyholders under large deductible endorsements, and review and/or establish procedures for reviewing the adequacy of such collateral.

Chapter 1 – Takeover & Administration (Page 105)

Checklist 8—Accounting

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**Receivables**

Review large deductible billing procedures to determine that all amounts are billed timely. Determine that there are no outstanding items for billing and obtain an aging of outstanding receivables.

[Insert After Checklist 10 and Renumber]

Checklist 10—Large Deductible Policies

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**Overview**

- Meet with Manager of Large Deductible Collections (and/or other appropriate personnel) to discuss large deductible policies.
Collection procedures, personnel and responsibilities, staffing and what will be required from staff as a result of the order

- Conduct interviews of appropriate large deductible collection department personnel to determine policies and procedures. Document same.
- Establish a large deductible recoverable balance as of the receivership date

### Gathering Documentation

- Determine location of large deductible records – secure and inventory. This should include:
  - All policies containing large deductible endorsements
  - Claims files arising under such policies
  - Correspondence files
  - Billing records
    - Letters of credit, trust agreements, deductible reimbursement policies or other collateral
- For all LOCs, trust accounts, funds withheld:
  - Secure all originals
  - Notify all banks and trustees of the order

### Documenting Large Deductible Collection Procedures

- Review recent billings for all large deductible policies
- Obtain a list of large deductible payment history and determine whether insured payments have been ongoing or if payment from collateral has been required.
- Obtain a list of paid and unpaid bills updated after liquidation
- Obtain claim documentation for claims arising under large deductible policies
  - By paid loss and loss reserves and ALAE paid and reserves
  - List of claims in litigation/arbitration
- Review large deductible billing system; determine that all paid losses arising under large deductible policies have been billed.
- Determine whether large deductible endorsements provide that losses within the deductible are limited in the aggregate
- Evaluate recovery processes and determine if new procedures are appropriate
- Determine whether collateral is held by affiliated/unaffiliated third party via large deductible reimbursement policy, trust
agreement or other vehicle, and evaluate whether collateral can be transferred to the receivership
• Document insured collection disputes
• Determine which functional group handles disputes
• Interview members of each group responsible for coordinating, monitoring and controlling large deductible collection disputes
• Audit large deductible collection-specific systems. Track data from source to final product to verify billings are correct and inclusive and internal controls are adequate

Chapter 2- Information System (Page 139)

H. Common Systems Applications

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.

9. 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

109. Other

Chapter 2- Information System (Page 141)

C. Types of Business Written

Initially, it will be necessary to identify general characteristics of the insurer’s business practices. This analysis 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 included 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.

Chapter 2- Information System (Page 142)
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 manual processing. If it is the latter, the receiver should then determine whether the level of supplemental manual 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

Chapter 3 – Accounting and Financial Analysis (Page 194)

D. Salvage and Subrogation (Property/Casualty Only)

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

a. Large 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 certain losses and LAE incurred. While these policies share some characteristics with retrospectively rated policies, the accounting treatment of recoveries under the two types of policies is different.

b. Accounting Practices

Under statutory accounting practices, recoveries under large deductible policies are not treated as premium. Unpaid losses are booked net of the deductible, except where the deductible is deemed not to be collectible, in which case the losses are booked on a gross basis. Because losses within the large deductible limit are not booked, 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. Because these recoverables do not appear on the balance sheet...
unless uncollectible, but may be a significant recoverable amount, 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 should aid the regulator in this review.

Chapter 4 – Investigation and Asset Recovery (Page 225)

VI. OTHER SIGNIFICANT TRANSACTIONS

B. Large Deductible Policies

Large deductible recoveries can represent a significant source of recoveries for insolvent companies, especially those property and casualty companies that wrote workers’ compensation insurance. Because these recoverables do not appear on the balance sheet unless uncollectible, but may be a significant recoverable amount, the receiver should examine the scope of the large deductible business written, and the collection and collateral procedures employed by the company

1. 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 as it is unlikely to be collected after liquidation.
       • 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. Guaranty funds may opt for telephonic communication with insureds. 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.

Chapter 5 – Claims (Page 288)

V. PAYMENT OF APPROVED CLAIMS

A. Priority of Distribution in Receiverships

5. Class 3 and 4 – Claims for Policy Benefits

a. Deductible and Limits

The policyholder’s claim is for the amount that the insurer should have paid. For some policies (e.g., 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. With other policies, the insurer’s liability attaches after the deductible has been paid by the insured (“Non Advancement Policies”). IRMA Section 712 provides for the disposition of Large Deductible Policy or Loss Reimbursement Policy recoveries between receivers and guaranty associations. Individual state statutes (see, for example, 40 PA §221.43a) differ from IRMA Section 712 in certain respects.”

Chapter 9 – Legal Considerations (Page 518)

G. Assets that are not General Assets, Special Deposits and Letters of Credit

3. Letters of Credit

There has been some controversy surrounding the rights and obligations of receivers regarding letters of credit (LOCs). LOCs are typically used to support reinsurance and large deductible obligations. Letters of credit issued in connection with reinsurance transactions are discussed in detail in Chapter 7, Section VIII and in connection with large deductible transactions in Chapter 4, Section A.
I. Large Deductibles

Many liability policies for large commercial insureds are being written with deductible limits that may exceed $100,000. The purpose of these large deductible amounts is to reduce premiums for the insured while permitting the insured to meet statutory or regulatory insurance requirements. Large deductible policies are most common in the workers’ compensation area but may be found in other types of liability insurance.

Typically, a large deductible policy provides that the insurer will pay claims in full and then collect the deductible amount from the insured (first dollar coverage). Conversely, first party claims against an auto policy with a deductible are paid minus the amount of the deductible. To ensure that the deductible will be paid, most insurers that write this type of policy will require the insured to post some form of security. This can be a letter of credit or securities placed in a trust or escrow account for the benefit of the insurer, or some other form of a third-party commitment to reimburse for claims within the large deductible, such as a bond or large deductible reimbursement insurance policy. When the insurer pays a claim, depending on the agreement with the insured, the insurer may either submit a bill to the insured for the amount of the claim paid within the deductible or collect directly from the collateral.

As long as the insurer and the insured remain solvent, there are seldom any difficulties with large deductible arrangements. If the insured becomes insolvent and stops paying the deductible billings and if the collateral held is insufficient to pay current and future billings, the insurer’s ability to collect the amounts due will be adversely affected. Or funding the collateral account, the insurer remains liable for injuries sustained prior to the termination of the policy.
Proposed Changes to Receiver’s Handbook for Insurance Company Insolvencies

RE: Large Deductibles

(NEW SECTION IN EXISTING HANDBOOK)

Chapter 5 – Claims (Page 304)

VIII. BEST PRACTICES FOR SUCCESSFUL BILLING AND COLLECTION OF LARGE DEDUCTIBLE PROGRAMS IN LIQUIDATION

A. Overview of Large Deductible Worker’s Compensation

A large deductible worker’s compensation policy or program is a method of insuring workers’ compensation risk with the employer assuming some of that risk in a deductible of $100,00, $250,000, or even higher per claim (varies by state) and an insurer taking on the remaining risk. In states that permit professional employer organizations (PEOs), PEO’s often operate large deductible programs. A PEO is an outsourcing firm which provides services to small and medium sized businesses. The PEO enters into a contractual co-employment agreement with its clientele. If the employer or PEO fails to pay for any reason, the insurer incurs an unexpected liability, and the failure of the claim reimbursement mechanism has been a significant factor in a number of insurer insolvencies.

B. 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 two options available regarding statutory authority concerning Large Deductible Worker’s Compensation, namely:

1) Insurer Receivership Model Act (Model #555—IRMA) Section 712 Administration of Loss Reimbursement Policies; or
2) National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act.

Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which would greatly enhance the ability to manage complex large deductible programs post-liquidation. Generally, both approaches provide for the collection of large deductible reimbursements from policyholders, clarify entitlement to reimbursement, and ensure that the claimants are paid. The provisions in each of the two options generally complement each other except for conflicting provisions regarding the issue of the ultimate ownership of and entitlement to the deductible recoveries and collateral as between the estate and the guaranty fund.

C. Communication and Reporting Between the Liquidator, Policyholders and Guaranty Associations, Including Administration of Self-Funded Policyholder Programs

1. 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 the both Model Acts, 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”) as amended by the provisions of the Model Act. Both Model Acts make provision for two types of LDAs, those that permit self-funding 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-funding 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. Both Model Acts require the Liquidator to form an independent opinion on outstanding claim reserves reported by policyholders and guaranty associations, including a safety factor and incurred but not reported liability to ensure that collateral remains adequate throughout the administration of the program.

2. Agreements between Liquidator and guaranty associations.

For states that have enacted the either of the two Model Acts or similar statutory framework for the Liquidator’s administration of large deductible programs an agreement between the Liquidator and the guaranty associations is not necessary. The Models provide a comprehensive framework for administration of the program. For states that have not enacted either Model, an agreement between the Liquidator and guaranty associations may be advisable. The Models can serve as an outline for the issues that should be addressed in such an agreement. Among other things, an agreement should address: 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, claim reporting protocols, frequency of collateral review and reimbursement activity, and administration of collateral for under collateralized non-performing policyholder accounts.

3. Converting policyholder accounts from an incurred to paid basis under the Model Act.

The NCIGF Model Act provides for the conversion of a policyholder’s LDA at liquidation from an “incurred” to a “paid” basis. Conversion 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 NCIGF Model Act recognizes these important policyholder rights and provides incentive to policyholders to cooperate with the Liquidator’s administration of large deductible programs and guaranty association reimbursement. 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 in accordance with the NCIGF Model Act, memorializing any elections with an endorsement that otherwise follows and requires the policyholder to adhere to the provisions of the NCIGF Model Act.

4. 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, that meets Liquidator and policyholder expectations for claim payments made by the estate prior to liquidation and by guaranty associations after liquidation. 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 self-funded 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.

3.5. Annual collateral review by Liquidator.

The NCIGF Model Act, consistent with the typical LDA, requires the Liquidator to perform an annual collateral review for each policyholder account 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, 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. The NCIGF Model Act 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.

D. 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.

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.

E. 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. For purposes of this handbook, “Large deductible policy” means any combination of one or more workers compensation policies and endorsements issued to an insured, 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 under the policy up to a specified dollar amount, 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 in addition to a per claim deductible limit. 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. 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 for large deductible policy. The policy should provide acceptable financial instruments that can be held for 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.

**F. Whether receiver or guaranty fund should Responsible Party For Collection of Large Deductible Reimbursements**

It is critical to immediately establish the party responsible for billing and collecting large deductibles. 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 as well as the disposition of any collateral being held by the receiver.

**G. 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.

The Insurance Receivership Model Act, NAIC Model Law # 555 (“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.” In states without an explicit statutory definition, the common-law definition is substantially similar.

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1 IRMA § 104(V)(1).
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, and will specify what the receiver may do when the documents are silent, incomplete, or missing.

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, 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 laws substantially similar to the NCIGF Model treat them as the ultimate source of funding for the underlying claims, so that they belong unconditionally to the guaranty association. Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral, 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, 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.

H. 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

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2 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.”
3 Compare IRMA § 712(C)(3) with NCIGFMA § 712(C).
4 See NCIGFMA § 712(E)(3).
5 See, e.g., NCIGFMA § 712(E)(5).
in full. However individual states may have adopted caps on guaranty association coverage.\(^6\) States have created this exception to honor their state’s promise that injured workers will be paid the full benefits to which they are entitled. The general purpose of these exclusions is to avoid any obligation for the guaranty association to pay losses that can and should be borne by the policyholder. Net worth exclusions make guaranty association protection unavailable to policyholders with net worth above a specified threshold, while deductible exclusions expressly prohibit guaranty association coverage for amounts within a policy deductible.

Unless these exclusions are drafted and implemented carefully, there is a risk that they could result in delays in claims payments or even a complete loss of coverage. In some states, claimants might be protected by an 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.

1. Net Worth Exclusions:

The PC GA Act 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.\(^7\) 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 PC GA Act, 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.\(^8\) 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 the NCIGF Model, this is the same reimbursement right the guaranty association would have in the absence of the exclusion as the insurer’s successor.

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 PC GA Act’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.\(^9\) Otherwise, the claimant’s

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\(^6\) See Property and Casualty Insurance Guaranty Association Model Act, NAIC Model Law # 540 (“PC GA Act”), § 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.

\(^7\) PC GA Act, § 13.

\(^8\) 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.

\(^9\) PC GA Act, § 13(B)(2) Alternative 2.
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 both IRMA 712 and the NCIGF large deductible model statute, 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.

2. Deductible Exclusions:

The PC GA Act 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 the policy or coverage from which the claim arises.”10 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.11 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.12 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.13 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).14 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.15

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10 PC GA Act, § 8(A)(1)(b). Compare LH GA Act, § 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.”

11 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.

12 Minn. Stat. § 60C.09(2)(4).


14 Minn. Stat. § 60C.09(3).

15 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
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. 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-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.

16. 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.
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, alternative minimum tax, Phase III tax triggering for life companies, 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, and taxation of life insurers differs to some extent from taxation of property and casualty insurers. To further confuse the issue, mutual life insurers are subject to tax adjustments not applicable to stock life insurers.
Even though an insurer may have substantial statutory losses, it is possible that based on its taxable income, federal income taxes will be due. See discussion in this chapter of deferred income that may be taxed when a company loses its status as a life insurance company for federal tax purposes. There also exists the possibility that the insurer is entitled to recover prior years' taxes because of the existence of capital losses, operating losses or tax credits. Operating losses, which 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 a net operating losses to the preceding tax years, the deadline will be three years from the due date of the return which generated the net operating 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 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 March-April 15) of the following 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 March-April 15 deadline. This extension, however, is only for the filing of the return and not for the payment of tax liabilities. The March-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 by the IRS and may not be likely.

Following is a list of various insurance or insurance-related entities and the Federal Income Tax Form that should be filed:

<table>
<thead>
<tr>
<th>Type of Insurer (Based on Business Written)</th>
<th>Federal Income Tax Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property/Casualty</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Life</td>
<td>1120-L</td>
</tr>
<tr>
<td>HMO</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Staff Model HMO</td>
<td>1120-PC</td>
</tr>
<tr>
<td>501(c)(15)(A) - tax exempt</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Title</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Blue Cross/Blue Shield</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Health</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Health w/ noncancellable and/or Guaranteed renewable contracts</td>
<td>1120-L</td>
</tr>
</tbody>
</table>

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). This happens when, under prior federal law, a portion of the income earned by a life insurer was considered to belong to the policyholders and was excluded from income. It was segregated and carried on the tax return in an account called “policyholder surplus.” Upon loss of life insurance company tax status, or certain other events, all or a portion of the “policyholder surplus” account may be taxed. This is referred to as “Phase III tax liability” and can be a material amount for some life insurers. Phase III tax liability also can result from losses exceeding prior years’ accumulated taxable income and reduction of premium volume or reserves or loss of insurance company status.

Phase III tax may be a liability which arises prior to the receivership or during the administration of the estate. This may have a significant impact on the statute of limitations for assessment of the tax as well as the priority of the claim for payment of the tax relative to creditors and policyholders. The existence of net operating losses may be unavailable in reducing or avoiding a Phase III tax liability.

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. Alternative minimum tax should be considered in calculating the benefit of the small company deduction. 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 $42.2 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...
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of this provision to exempt liquidation estates from federal income taxation. In 2004, IRC Code 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 2006-2476-23 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. Net operating losses can be carried back for two years, and capital losses can be carried back for three years.

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, which may trigger alternative minimum tax liabilities. A company could have alternative minimum tax, even if there are net operating losses available to offset the income, because of the 90% limitation for alternative minimum tax net operating losses. 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.

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.
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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 periodically assess insurers to cover their administrative and claim costs. If the insurer is operating under supervision or rehabilitation, it may still be liable for guaranty fund assessments. If the insurer is in liquidation, the funds will typically waive payment of the assessment upon notice of the insolvency.

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/or 1099 for all commissions and other payments to an individual or partnership in excess of $600 during the year. In addition, the receiver is required to prepare Form 1099 and send the forms to policyholders of life companies while business is still being serviced by the insolvent insurer. 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

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 the 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 the 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 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.

3. Structured Settlements

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

These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS Tax Codes (primarily 104(a)(2)) and various Revenue 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.
Example: Restructuring Transaction

When placed into liquidation, Reliance was part of a three-tiered holding company structure, whereby 100% of the stock of Reliance was owned by Reliance Financial Services Corp (“RFS”). RFS, in turn, was wholly-owned by Reliance Group Holdings, Inc. (“RGH”).[1] In 2003, a settlement agreement was entered into between Reliance, RFS, and RGH whereby, among other things, the parties created a new consolidated tax group for federal income tax purposes with RFS as the common parent and with Reliance as a member.

In 2015, after collection of certain assets, RFS desired to terminate its existence and dissolve. Because Reliance is part of the consolidated tax group, the dissolution of RFS could have led to a change in ownership of Reliance which, under §382 of the Internal Revenue Code of 1986, as amended (“Code”), could have adversely affected the significant net operating loss carryovers (“NOLs”) held by Reliance which may be used to offset future net income, thereby reducing tax liabilities. Therefore, Reliance and its advisors developed a restructuring plan and a transaction which was approved by this Court and executed as of December 31, 2016.

The transaction resulted in an ownership change of Reliance which qualified for the bankruptcy exception under §382(l)(5) of the Code. Pursuant to the plan, all of the issued Reliance common shares are now owned by 4 GAs (“Participating GAs”) who paid Reliance policyholder claims and who received Reliance stock in exchange for the partial cancellation of such indebtedness. Each Participating GA has entered into a shareholder’s agreement which restricts the sale, transfer, pledge or assignment of the shares, and each shareholder executed a revocable proxy granting the right to vote all the shares to the Pennsylvania Insurance Commissioner as Liquidator. The Participating GAs will receive no preference as to their claims against Reliance due to their new ownership status. Furthermore, the Reliance stock issued to the Participating GAs provides them with no additional viable claim against Reliance as assets will be insufficient for distributions to any creditors below priority class (b), much less priority class (i) shareholders.

The transaction received a favorable private letter ruling on August 24, 2016 from the Internal Revenue Service holding that the Participating GAs would be treated as receiving the Reliance stock in their capacity as creditors of Reliance for purposes of the Code. The plan preserved the substantial NOLs for the benefit of the Reliance estate and allows Reliance to control its own future regarding tax positions and negotiations with the Internal Revenue Service. As a result of the restructuring, Reliance will become its own tax filer and will no longer be part of a consolidated tax group.[2]

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[1] RGH and RFS jointly filed for bankruptcy in 2001 and the RGH and RFS reorganization plan was approved in 2005 with RGH converting into a liquidating trust and RFS converting into Reorganized RFS Corporation.

[2] As a result of the large losses suffered by Reliance during the final years of its independent operations and during its liquidation, in excess of $4 billion of NOLs were accumulated through 2014. Approximately $1.5 billion of that $4 billion was utilized in the 2015 consolidated tax return.

[3] For additional details, see the Liquidator’s Application for Approval of Restructuring Proposal filed with the Court on October 7, 2016, which is document # 3745 on the www.reliancedocuments website.
CHAPTER 10 – CLOSING ESTATES

III. CONSIDERATIONS PRIOR TO CLOSURE OF A LIQUIDATION

B. Tax Issues to be Considered Prior to Closure

1. General

Generally, federal and state tax returns should be filed by the liquidator throughout the liquidation. The final returns will be filed as of December 31 of the year during which final distributions are paid. As set forth above, the expenses that will be incurred to prepare the returns should be prepaid, as the actual filings will occur in the year subsequent to closure.

With each of the federal tax returns filed during the liquidation, the liquidator may consider the submission of a written application requesting a Prompt Audit and Determination under Revenue Procedure 76-232006-24 to the IRS. Generally, this will expedite the entire process and end the statute of limitations for the returns. Technically, this procedure only applies to companies in a bankruptcy proceeding (Title 11), but in the past the IRS has extended it to insurers in receivership. If this procedure is not extended to an insurer in receivership, however, the IRS has taken the position that Revenue Procedures 76-23 and 81-17 do not apply to insurance companies in receivership. This position requires insurance company receivers are required to file federal income tax returns in the normal course of business as if the insolvent insurer were a perpetual concern, with no mechanism to sever the statute of limitations period. As it stands, this is an impediment to closure of an estate that must be dealt with by receivers on a case by case basis through closing agreements with the IRS.

For more information regarding tax issues, refer to Chapter 3—Accounting and Financial Analysis. It is strongly recommended that the receiver consult and retain a tax expert for all tax related issues.

2. Phase III Tax of Life Insurance Companies

Any life insurance company that was a stock life insurance company before 1984 potentially has a balance in a Policyholder Surplus Account (as defined in Section 815 of the Internal Revenue Code). The balance represents previously deferred income, which is potentially subject to recapture at some point prior to closure of the estate, producing a tax liability without an increase in the ability to pay.

Some estates have recently filed returns taking the position that the recapture event does not occur in the course of an insolvency proceeding. One theory is based on an assertion that the legislative history of Section 815 provides ample evidence of a Congressional intent not to impose the Phase III tax when a Policyholder Surplus Account is eliminated due to events occurring in a liquidation. This theory seems enhanced by the obvious statutory reliance on regulatory accounting principles, under which the real surplus of the company has been obliterated by losses.

Another theory that has been advanced is that, as a result of the changes made by the Tax Reform Act of 1984, a literal interpretation of the statute allows the recapture to be offset by operating losses, clearly a benefit not previously allowable.
3. Internal Revenue Codes Relative to Insurance Contracts and Distributions

Tax implications and/or consequences of assumption transactions, 1035 exchanges or other such transfer of policyholder liabilities or payout of policyholder benefits is also an area of concern and consideration by the receiver. In response to insurer insolvencies, the IRS has addressed several issues affecting such taxation and tax implications. Such rulings have addressed issues such as funding in “steps,” tax free exchanges, multiple contract issues and contract dates and testing for compliance, to name a few, and specifically relate to Internal Revenue Codes 72 and 7702.

Section 72 of the IRC, “Annuities; Certain Proceeds of endowment and life insurance contracts,” specifically subsection (s), references required distributions where the holder of an annuity dies before the entire interest is distributed. The rules in Section 72 govern the income taxation of all amounts received under annuity contracts and living proceeds from life insurance policies and endowment contracts. Section 72 also covers the tax treatment of policy dividends and forms of premium returns.

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1 (Rev. Rul.) 92-43, 1992-1 CB 288. The IRS will allow a valid exchange where funds come into the contract or policy in a series of transactions if the insurer issuing the contract or policy to be exchanged is subject to a “rehabilitation, conservatorship or similar state proceeding.” Funds may be transferred in this “serial” manner if: (1) the new policy or contract is issued by an insurer subject to a “rehabilitation, conservatorship, insolvency or similar state proceeding” at the time of the cash distribution; (2) the policy owner transfers the full amount of the cash distribution to which he is entitled under the terms of the state proceeding; (3) the exchange would otherwise qualify for Section 1035 treatment; and (4) the policy owner transfers the funds received from the old contract to a single new contract issued by another insurer not later than 60 days after receipt or, if later, September 13, 1992. If the amount transferred is not the full amount to which the policy owner is ultimately entitled, the policy owner must assign his right to any subsequent distributions to the issuer of the new contract for investment in that contract. Revenue Proc. (Rev. Proc.) 92-44, 1992-1 CB 875, as modified by Rev. Proc. 92-44A, 1992-1 CB 876; (Let. Rul.) 9335054.

2 If a non-qualified annuity contract is exchanged under Section 1035 within the scope of Rev. Rul. 92-43 (i.e., as part of a rehabilitation proceeding), the annuity received will retain the attributes of the annuity for which it was exchanged for purposes of determining when amounts are to be considered invested and for computing the taxability of any withdrawals.

3 An annuity that is received as part of a Section 1035 exchange that was undertaken as part of a troubled insurer’s rehabilitation process under Rev. Rul. 92-43 is considered to have been entered into for purposes of the multiple contract rule on the date that the new contract is issued. The newly-received contract is not “grandfathered” back to the issue date of the original annuity for this purpose. Let. Rul. 9442030.

4 The IRS, in response to insurer insolvency proceedings, stated that modification of an annuity, life insurance, or endowment contract after Dec. 31, 1990, that is necessitated by the insurer’s insolvency will not affect the date on which such contract was issued, entered into or purchased for purposes of IRC Section 72, 101(f) 264, 7702 and 7702A and also as not resulting in retesting or the start of a new test period under §§7702(1)(7)(B)-(E) and 7702A(c). Rev. Proc. 92-57, 1992-2 CB 410; Let. Rul. 9239026. See also Let. Rul. 9305013. The date is not affected by assumption reinsurance transactions entered into by the insurer provided that the terms and conditions of the policies, other than the insurer, do not change. Let. Ruls. 9323022, 9305013. The IRS also concluded that where a nonqualified annuity is exchanged for another via Section 1035 as part of a troubled insurer’s rehabilitation process under Rev. Rul. 92-43, the annuity received in the exchange will be treated as issued, entered into, or purchased as of the date of the exchange except as provided in IRC Sections 72(e)(5) and 72(q)(2)(F). Let. Rul. 9442030.
Chapter 10 – Closing Estates

IRC Section 7702 relates to the definition of a life insurance contract. For purposes of this section, the term “life insurance contract” means any contract that is a life insurance contract under the applicable law, but only if such contract meets the cash value accumulation test as defined in Section 7702(b), or meets the guideline premium requirements of Section 7702(c) and falls within the cash value corridor of Section 7702(d).

a. Cash Value Accumulation Test

Generally, a contract meets the cash value accumulation test if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract.

b. Guideline Premium Requirement and Cash Value Corridor

With respect to the guideline premium, a contract generally meets this requirement if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of such time. Guideline premium limitation means, as of any date, the greater of the guideline single premium or the sum of the guideline level premiums to such date. Guideline single premium means the premium at issue with respect to future benefits under the contract. Guideline level premium means the level annual amount, payable over a period not ending before the insured attains age 95, computed on the same basis as the guideline single premium.

A contract generally falls within the cash value corridor if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value.

As with any tax issue, the implications of all Internal Revenue Codes to a particular liquidation proceeding and that proceeding’s specific transactions should be explored with tax counsel.

4. Collection of Tax

Under Section 801 of IRMA, claims of the federal government are assigned a Class 5 priority and claims of state or local government are assigned a Class 8 priority, unless the claims represent losses incurred under policies of insurance (Class 3 or 4 claims). Thus, tax liabilities not properly characterized as an expense of receivership administration (Class 1) rank behind any claims for guaranty fund administrative expenses (Class 2) and all claims of policyholders (Class 3 or 4), including guaranty funds. Conversely, under the federal “super-priority” statute, 31 U.S.C. § 3713, claims of the federal government (in cases not covered by the bankruptcy code) are given first priority. The Supreme Court of the United States has resolved this conflict in United States Department of the Treasury, et al v. Fabe, 508 U.S., 491, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993). The Court held that the Ohio priority of distribution statute was not pre-empted by the federal statute to the extent that the Ohio law protects policyholders, because to that extent it constitutes a law enacted “for the purpose of regulating the business of insurance.” Since the court also viewed administrative expenses as incurred in the process of protecting policyholders, administrative expenses also were ranked ahead of federal claims.

More recently, the 1st U.S. Circuit Court of Appeals has ruled that the federal government does not automatically have priority over other creditors, including state guaranty funds, in insurer liquidations. The 1st Circuit panel’s ruling in Ruthardt vs. United States of America (see Chapter 9—Legal Considerations, section on Federal Government Claims) affirmed a Massachusetts district court’s decision. In this litigation, the federal government challenged two aspects of the Massachusetts liquidation statute. First, the government argued that the liquidation priority provision
in the statute is preempted by federal law to the extent it provides for payment of guaranty association claims ahead of claims of the federal government. The federal government also argued that the state’s statutory bar date for filing claims against the insolvent insurer’s estate does not apply to claims of the federal government. The federal district court ruled that the provision affording priority to guaranty association claims under the Massachusetts statute is a provision enacted for the purpose of regulating the business of insurance and is therefore shielded from federal pre-emption in accordance with the McCarran-Ferguson Act. With respect to the claims bar date, the district court concluded that it was bound by a controlling 1993 First Circuit decision finding that the benefits provided to policyholders by a state’s claim bar date were too tenuous for that provision to constitute the regulation of the business of insurance subject to the McCarran-Ferguson protections. The Court of Appeals affirmed on both issues.

Generally, taxes are, at most, an expense of administration if the taxes arise during the period of administration (as distinguished from unpaid taxes for periods ending before commencement of liquidation) and are incurred by the estate, i.e., imposed on income from which the estate derived some benefit. While the matter has not yet been tested in court, it is likely that the Phase III tax would not be treated as an expense of administration, since the income upon which it was imposed was obviously earned, collected and dissipated before the liquidation commenced. Decisions regarding the payment of computed taxes should only be made after consultation with legal counsel.

5. Filing of Tax Returns

The entry of an order of liquidation does not terminate the existence of the insurer for tax purposes, regardless of the impact the order may have under state law. The taxable entity remains in existence until the liquidation is complete, i.e., all the assets have been distributed. Accordingly, the liquidator must attend to the continued filing of tax returns during the liquidation proceeding, which may include several taxable years. Therefore, the liquidator should recognize the need to undertake tax planning.

As set forth above, it is possible that over the period of administration, an insolvent insurer may lose its status as an insurance company or become exempt from taxation altogether. Since these classifications are based on a testing of the company’s activities and reserve characteristics, as activities cease, premium diminishes and insurance obligations are ceded under assumption reinsurance arrangements, the company will begin to fail these tests. The liquidator should anticipate the occurrence of this, and plan for the attendant consequences (reserve restoration, Phase III tax, etc.).

If the insurance company placed in liquidation is the common parent of a group that has been filing consolidated returns, the receiver may have to continue filing on that basis. If the company was a subsidiary in a consolidated group, it is arguable that an order of liquidation should cause a termination of membership in the group. It should be noted that the only apparent pronouncement in this area is a 1985 private ruling (LTR 8544018) in which the IRS held that continued inclusion in a consolidated group is required of an insurer throughout the period of administration. However, among the consequences of entering an order of liquidation are the facts that the liquidator is given the power to exercise all shareholder rights (Section 504A(16) of IRMA), the receiver may contemporaneously dissolve the corporate existence under state law (Section 503) and the shareholders, in their capacity as owners, become creditors of the estate (Section 501). Any one of these conditions, and certainly all of them in combination, would seem to indicate that the parent company no longer has any stock ownership interest in the insurer, much less any voting rights. Furthermore, considering that this is a permanent stockholder displacement rather than a mere suspension of rights, the ruling seems rather questionable. In this situation, tax counsel should be consulted. When dealing with tax sharing agreements and consolidated tax returns, the need for termination of any prior agreements should
quickly be assessed. Termination of these agreements could prevent a parent of a subsidiary insurance company from taking away tax benefits that rightfully belong to the estate.

The liquidator needs to also be aware of the tax consequences for a member of a consolidated group upon its ceasing to be a member. It will have two short-period years, one ending on the day it leaves the group that will be included in the group’s consolidated return, and one beginning on the next day and ending at the insurer’s normal year-end that will require a separate return. Even though the insurer might be included in the group’s consolidated return for a small portion of the year, it will be jointly and severally exposed to the group’s consolidated tax for the entire year, which tax could be increased by the recognition of an excess loss account (i.e., negative basis) that the group might have in the stock of the insurer. If gains of the insurer on prior transactions with other members were deferred, the gains must be recognized in the consolidated return upon the member’s departure. The tax thereon can come back to the insurer, either through joint and several liability or under a tax allocation agreement of the group. Any estimated tax payments made by the group during the year must be allocated. Operating losses sustained by the insurer in subsequent periods that can be carried back to prior consolidated returns will produce refunds that will be made to the common parent of the group.

Affiliates’ use of losses within a consolidated return presents a difficult issue regarding the estate’s ability to recover any portion of the benefit. If the group had entered into a tax allocation agreement, the estate’s benefit would be determined pursuant to that agreement. However, absent a written agreement, as a matter of equity, courts seem to allocate tax benefits according to which entities paid the tax being recovered, or whose income is being offset (thus giving value to the loss). Note that the rules contained in the Department of the Treasury’s regulations regarding allocations of consolidated tax are effective only for determining income tax consequences and do not, in and of themselves, create a contractual right of any member to receive any tax payments from another member.

Accordingly, a loss of the insurer, which can only be used against income of other members in the current year or another year and producing a refund of consolidated tax paid in by other members, is not likely to provide a material benefit for the insurer. If a refund potential exists, the liquidator might consider taking the position that inclusion in a consolidated return by a subsidiary insurer is no longer permitted or required (pursuant to the discussion above), thereby perhaps developing some leverage in negotiating a tax allocation agreement.

6. Net Operating Losses

An insurer placed under a liquidation order will ordinarily have incurred large operating losses, some of which may have been realized prior to the receivership and remain eligible for carryover to periods ending after the receivership began, and some of which may be realized during the receivership and may be carried back to earlier periods. Operating losses incurred by life insurers may no longer be carried back for taxable years beginning after December 31, 2017. Net operating loss deductions (“NOLs”) are limited to 80 percent of taxable income (without regard to the deduction) for losses arising in taxable years beginning after December 31, 2017. Carryovers to other years are adjusted to take accounting of this limitation and may be carried forward indefinitely. Property and casualty insurers may carry back losses 2 years and forward 20 years. The 80 percent limitation on use of NOLs does not apply to a property and casualty insurance company.

Under general rules, loss carryovers expire if not used within a certain period of time. It may be, therefore, necessary for the liquidator to project the probable timing of income realization, particularly for property and casualty insurers where loss carryovers expire if not used within a...
certain period of time. The major item of income realization which may be debt cancellation income when advances from guaranty funds, for example, are forgiven at closing.

The general rules for carryback and carryover of losses are modified if there is a change in the status of the insurer before January 1, 2018. A loss of a life insurance company may only be carried back to a year in which it qualified as a life insurance company if the loss occurs prior to January 1, 2018. For years beginning after December 31, 2017, life insurance companies are allowed the NOL deduction under section 172. A similar rule exists for property and casualty companies. As to loss carryovers, a change in character does not result in denial of the carryover, but the amount of loss from the earlier year may not exceed the amount it would have been if the insurer had the same character in all relevant years as it has in the year to which the loss is carried.

Loss carryforwards generally become severely restricted upon a substantial change in the ownership of the stock of a corporation. However, the rules requiring this result should not apply in these cases. If the IRS takes the position that the entry of an order of liquidation does not affect stock ownership (as, for example, in LTR 8544018), then the rules are not invoked. Conversely, if the entry of the order, in fact, does represent a complete change in ownership, then the exception for “Title 11 or similar case,” e.g., bankruptcy or receivership, should be available (see 26 U.S.C. § 382(l)(5)).

The liquidator should consider techniques having the effect of accelerating income, such as the sale of appreciated property, reserve adjustments or reinsurance transactions. If the insurer can remain in a profitable consolidated group with which it has a tax allocation agreement, benefits can be realized without regard to extraordinary transactions.

7. Federal Claims and Releases

a. Communicating with the Department of Justice.

Contact with the Department of Justice (“DOJ”) at the inception of a receivership estate is critical to obtaining a prompt release of personal liability of the Receiver under 31. U.S.C. 3713(b) (the “3713 Release”) to facilitate estate distributions to policyholders, claimants against policyholders, guaranty associations and other creditors. DOJ has historically identified a single Assistant U.S. Attorney as gatekeeper between the receiver and all federal agencies, except for the Internal Revenue Service, that may have claims against the receivership estate. Receivers may want to limit the number of people communicating with the DOJ to reduce the possibility of mixed messages, or messages going to the wrong person. Additionally it is recommended that Receivers follow the checklist provided by the DOJ when submitting documents. Contact the NAIC’s office in DC if you need assistance to identify the current DOJ receivership contact.

b. Identifying potential federal claims, particularly long tail claims.

The Receiver’s initial goal should be to identify potential federal claims from the insurer’s claim and corporate files. Federal claims that are classified at the policyholder priority level as claims under an insurance policy or against an insured under an insurance policy should be reviewed and adjusted as soon as possible and their resolution and adjudication should be summarized for the DOJ in connection with the 3713 Release request. In addition to potential federal claims identified by the receiver, DOJ will typically request the receiver to identify all former policyholders of the insurer, including policy periods and limits of coverage so that federal agencies can perform their own search of potential claims against the insurer. An example of claims with a federal agency as a claimant are claims identified as having an environmental exposure.
c. Classification and handling of federal claims.

Pursuant to United States Dept. of Treas. v. Fabe, 508 U.S. 491 (1993), state law may prioritize payment of administrative expenses and policyholder claims, including claims by third parties against policyholders and claims by guaranty associations, ahead of claims of all other general unsecured creditors, provided that the priority of federal claims immediately follows that of policyholders and precedes all other creditor classes. Claims of federal agencies under a policy of insurance or against a policyholder, however, are entitled to policyholder priority treatment.

d. Facilitating the process of obtaining a federal release.

All federal claims that are prioritized at the policyholder priority level should be identified and resolved before applying to the DOJ for a 3713 Release. The process of interacting with the DOJ, including the DOJ’s survey of federal agencies for potential federal claims can take several years. Long-tail claims, such as claims involving environmental liability and coverage, as well as the number of policy years that the insurer provided coverage for long-tail exposures, is likely to increase the amount of time needed to resolve the potential federal claims and obtain the 3713 Release.

A best practice is to provide the DOJ with very detailed information on policies and claim information in order to avoid prolonging the process unnecessarily and lead to a long series of back-and-forth requests and production of additional data. For example, include a list of all policyholders unless the lines of business were limited to medical insurance. It may be helpful to segregate the various lines of business as the Environmental Protection Agency (EPA) is more interested in general liability lines as opposed to workers compensation exposures. If the company uses specific policy prefixes for different lines of business, a listing of the policy prefix definitions should be submitted with the list of policies. DOJ resource are usually limited, so key to successfully receiving the Release, it is helpful to keep the lines of communication open, not press for immediate results, consider routine follow-ups with the DOJ such as scheduled monthly status calls.

e. Impact of federal release on receivership closure.

Obtaining the 3713 Release is essential to protecting the receiver against the personal liability imposed under 31 U.S.C. s.3713, and accordingly impacts the receiver’s ability to make final distributions of estate assets and close the estate. The foregoing practices should be commenced at the outset of the receivership and pursued with diligence throughout the life of the estate to ensure that the ultimate discharge of the estate is not prolonged.

7. Closing Agreement

The liquidator may want to consider utilizing a closing agreement pursuant to Revenue Procedure 2019-98-1, IRS Procedures for providing advice to taxpayers in the form of letter rulings, closing agreements, determination letters and information letters, and orally on issues Issuing Rulings, Determination Letters, and Information Letters, and for Entering Into Closing Agreements on Specific Issues Under the Jurisdiction of the Associate Chief Counsels (DomesticCorporate), (Employee Benefits and Exempt Organizations), (Financial Institutions & Products), (Income Tax & Accounting), (International), (Passthroughs & Special Industries), (Procedure and Administration) and (Enforcement & Litigation) Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). The closing agreement is a final agreement between the IRS and the taxpayer on a specific issue or liability and is entered into under the authority in §7121. The closing agreement would provide for a final determination to be made by the IRS with respect to tax returns filed on
behalf of the insolvent company for specific years and would be final and conclusive except in the event of fraud, malfeasance or misrepresentation of material fact.

Additionally, retaining a Taxpayer Advocate’s opinion is a possible best practice to address potential tax liability after receivership closure. Because the Taxpayer Advocate is associated with the IRS, this type of opinion could create an obstacle for tax authorities if they decide to revisit a tax return.

***************TEXT NOT SHOWN TO CONSERVE SPACE***************
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• Broader Expertise in Insurance Resolutions
• Promoting Consistent Standards for Administration of Insurance Resolutions
• Rigorous Program and Objective Designation Testing
• Deepening of the Pool of Qualified Individuals to Assist Commissioners with Troubled Companies
Professional Designation Program
Effective January 1, 2020

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  • Verification of Continuing Education
  • Background Certification
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- iair.org
- Designation Programs Selection on Home Page
- Overview of the IAIR Professional Designation Program
- Specific Listing of AIRD and CIRD Designation Requirements
- Updated and Streamlined Professional Designation Application and Instructions
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  • Reporting Period Concludes December 31 of the Following Even Numbered Year
I’m lost, can you go over that again?