RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force Aug. 7, 2020, Minutes
  Receivership and Insolvency (E) Task Force’s March 4 & Jan. 8, 2020 Conference Call Minutes (Attachment One)
  Combined Comments (Attachment One-A)
  Referral to the Financial Condition (E) Committee (Attachment One-B)
Receivership and Insolvency (E) Task Force’s March 4 & Jan. 8, 2020 Conference Call Minutes (Attachment Two)
Receivership and Insolvency (E) Task Force’s March 4 & Jan. 8, 2020 Conference Call Minutes (Attachment Three)
  712 Guideline Staff Memorandum (Attachment Three-A)
  Draft Guideline Alternative to Section 712 (Attachment Three-B)
  NCIGF Comment Letter (Attachment Three-C)
  Summary of Proposed Maine Revisions to Section 712 Guideline (Attachment Three-D)
RITF 8-4-20 Laws (Attachment Four)
The Receivership and Insolvency (E) Task Force met via conference call Aug. 7, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by James Kennedy (TX); Karima M. Woods, Vice Chair (DC); Alan McClain represented by Steve Uhrynowycz (AR); Ricardo Lara represented by Joe Holloway (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Doug Ommen represented by Kim Cross (IA); Robert H. Muriel represented by Kevin Baldwin (IL); Vicki Schmidt represented by Chut Tee (KS); Sharon P. Clark represented by Rodney Hugle (KY); Gary Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by James Gerber (MI); Chlora Lindley-Myers represented by Debbie Doggett and Shelley Forrest (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Glen Mulready represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer and Matt Gendron (RI); Raymond G. Farmer represented by Ryan Basnett (SC); Hodgen Mainda represented by Patrick Merkel (TN); and Todd E. Kiser represented by Jake Garn (UT).

1. **Adopted its March 4, Jan. 8, and 2019 Fall National Meeting Minutes**

Ms. Cross made a motion, seconded by Ms. Wilson, to adopt the Task Force’s March 4, Jan. 8 (Attachment One), and 2019 Fall National Meeting (see NAIC Proceedings – Fall 2019, Receivership and Insolvency (E) Task Force) minutes. The motion passed unanimously.

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

Ms. Slaymaker made a motion, seconded by Mr. Baldwin, to adopt the Receiver’s Handbook for Insurance Company Insolvencies for federal taxes and federal releases (Attachment Two). The motion passed unanimously.


Ms. 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 to discuss the status of individual receiverships and related issues. Ms. Wilson made a motion, seconded by Ms. Wilkerson, 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. Slaymaker said the Receivership Large Deductible Workers’ Compensation (E) Working Group met March 2 and took the following action: 1) received comments on a draft model guideline that provides alternative language for the **Insurer Receivership Model Act** (#555) Section 712—Administration of Loss Reimbursement Policies; and 2) formed a drafting group to address comments received. The drafting group and the Working Group will reconvene after the national meeting. Ms. Slaymaker made a motion, seconded by Mr. Wake, to adopt the Working Group’s report, including its March 2 minutes (Attachment Three). The motion passed unanimously.

5. **Exposed Key Provisions of Receivership and Guaranty Fund Laws**

Mr. Kennedy discussed the Task Force’s response to the Macroprudential Initiative (MPI). The Task Force received comments on key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receiverships of insurers operating in multiple states. The Task Force discussed the comments on its March 4 conference call. He said the key provisions identified in comments will be exposed for a 30-day public comment period ending Sept. 8 for state insurance regulators and interested parties to provide additional feedback for each provision (Attachment Four). The Task Force requests comments on each key provision as follows: 1) if it is critical for all states to have in receivership and guaranty fund law in a receivership affecting multiple states; 2) if it should be considered for a limited scope accreditation standard; 3) if other methods should be used to encourage its adoption; and 4) if there are impediments to its adoption.
6. **Heard a Presentation on Cyber Claims in Receivership**

Roger H. Schmelzer (National Conference of Insurance Guaranty Funds—NCIGF), Chad Anderson (Western Guaranty Fund Services—WGFS), and Tim Schotke (Illinois Insurance Guaranty Fund—IIGF) gave a presentation on the NCIGF’s white paper, *Insurance Resolution: Preparing for Cyber Claims*, which is located on the NCIGF’s webpage.

Mr. Schotke said there is more risk in cyberinsurance due to lack of pricing and loss experience. He said cyberinsurance is operationally very different from any other business that guaranty funds deal with, such as indemnity provisions and in-kind services; therefore, receivers need to be prepared. There may be tasks that receivers are not prepared to provide, such as restoring system and forensic work. Mr. Anderson said these policies are complicated and inconsistent and there is little standardization. He said guaranty associations are aiming to be prepared for potential issues in the future. He said guaranty associations are looking for state insurance regulators and receivers to acknowledge potential issues with cyber claims in a receivership and engage in early communication with guaranty funds when an insurer that writes cyber policies becomes troubled. Guaranty associations are looking to put together a group of experts as contacts, if needed, such as forensic experts. Guaranty associations will also be internally evaluating potential claims or other issues. Mr. Schmelzer said guaranty associations are open and eager to work in advance with state insurance regulators and receivers on potential issues with a receivership of cyberinsurance.

7. **Heard an Update on International Resolution Activities**

Mr. Kennedy reported that the International Association of Insurance Supervisors (IAIS) Resolution Working Group (ReWG) met via conference call in April 2020 to continue development of the *Application Paper on Resolution Planning*. The ReWG expects to finalize the draft of the application paper at a conference call in September 2020. The draft paper is expected to be exposed for consultation in November 2020.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
The Receivership and Insolvency (E) Task Force met via conference call March 4, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by James Kennedy (TX); Karima M. Woods, Vice Chair, represented by N. Kevin Brown (DC); Lori K. Wing-Heier represented by David Phifer (AK); Allen W. Kerr represented by Steve Uhrynowycz (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 Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); Gary Anderson represented by Christopher Joyce (MA); Chlora Lindley-Myers (MO); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Lindsay Crawford (NE); Glen Mulready represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Raymond G. Farmer represented by Geoffrey Bonham (SC); Hodgen Mainda represented by Nikita Hampton (TN); and Todd E. Kiser represented by Jake Garn (UT).

1. **Discussed Comments on Key Provisions of Receivership and Guaranty Fund Laws**

Mr. Kennedy said that as part of the Task Force’s response to the Macroprudential Initiative (MPI), during its conference call on Jan. 8, the Task Force requested comments on key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receiverships of insurers operating in multiple states.

Mr. Kennedy summarized the comments received from Missouri, Pennsylvania, Texas, the American Council of Life Insurers (ACLI), the National Conference of Insurance Guaranty Funds (NCIGF), and the National Organization of Life and Health Guaranty Associations (NOLHGA) (Attachment One-A).

Barbara Cox (NCIGF) said she disagrees with the comment from Pennsylvania that all states should have uniform property/casualty (P/C) guaranty fund limits as there may be local variation between states—for example, home values. The claim cap in one state may not be appropriate in another state, so some difference in claim caps is probably appropriate for P/C business. Ms. McDonald said the Pennsylvania comment was regarding medical malpractice insurance.

Bill O’Sullivan (NOLHGA) said on the life side, there has been good success in states updating their laws to adopt the provisions of *Life and Health Insurance Guaranty Association Model Act* (#520). He said 28 states have adopted the 2017 revisions to the Model #520, and another nine states are expected to propose revisions in 2020. He said NOLHGA would have concerns if Model #520 were further revised as it may create delays in states adopting the 2017 revisions. He said NOLHGA has not identified any significant issues that would require amendments to Model #520. He said NOLHGA has not discussed consideration of changes to accreditation standards. He said it would be complicated to identify the standards and to compare them to states’ laws.

Wayne Mehlman (ACLI) said an ad hoc committee of the ACLI has had these comments under consideration. He said the comments address holistic improvements to the system rather than specific provisions. Ms. Wilkerson asked for clarification on ACLI’s comment related to timing of orders of liquidation. Mr. Mehlman said the intent was to address the length of time a rehabilitation order can continue as the administrative expenses of receivership consume resources before liquidation. Mr. Kennedy said Texas had a provision that imposed a deadline for closing a rehabilitation, but it created many legal problems, was unworkable and was repealed. He said there may be other ways to address the issue other than time limits in state statutes.

Mr. Kennedy said NAIC staff would circulate a list of the items identified in the comment letters to all members, interested state insurance regulators and interested parties and request feedback on each item: 1) agree or disagree to include the item in a response to the Financial Stability (EX) Task Force that this provision(s) is critical for states to have in law for a multi-jurisdiction receivership as it addresses financial stability concerns in resolution; and 2) agree or disagree that this provision(s) is critical for states to have in law for a multi-jurisdiction receivership and should be considered in further discussions regarding a possible update to accreditation standards. He requested responses by March 13.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
The Receivership and Insolvency (E) Task Force met via conference call Jan. 8, 2020. 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); Allen W. Kerr represented by Steve Uhrynowycz (AR); Ricardo Lara represented by Joe Holloway and 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 Carrie Mears and Kim Cross (IA); Robert H. Muriel represented by Kevin Baldwin (IL); Vicki Schmidt represented by Paige Blevins (KS); Gary Anderson represented by Christopher Joyce (MA); Chlora Lindley-Myers represented by John Rehagen (MO); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Justin Schrader and Lindsay Crawford (NE); Glen Mulready represented by Donna Wilson (OK); Jessica Altman represented by Laura Lyon Slaymaker (PA); Raymond G. Farmer represented by Lee Hill (SC); Hodgen Mainda represented by Bill Huddleston (TN); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); and Mike Kreidler represented by Ron Pastuch (WA).

1. **Adopted a Referral to the Financial Condition (E) Committee**

Mr. Kennedy said at the 2019 Fall National Meeting, the Task Force discussed requesting that the Financial Condition (E) Committee consider opening the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to consider revisions to address issues with the continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company, specifically agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

Iain Nasatir (Pachulski Stang Ziehl & Jones) asked if the Task Force had considered if such changes to Model #440 would conflict with federal laws, such as the McCarran-Ferguson Act or the federal bankruptcy law. Mr. Kennedy said that future discussions will include potential conflicts with other laws.

Mr. Kaumann made a motion, seconded by Mr. Hill, to adopt the referral to the Financial Condition (E) Committee (Attachment One-B). The motion passed unanimously.

2. **Requested Comments on Key Provisions of Receivership and Guaranty Fund Laws**

Mr. Kennedy said that as part of the Macroprudential Initiative (MPI), a recommendation was adopted by the Task Force to consider methods to encourage states to adopt provisions in receivership and guaranty fund laws that promote effectiveness and consistency, particularly with respect to receiverships of insurers operating in multiple states.

Mr. Kennedy requested that Task Force members, interested state insurance regulators, and interested parties submit suggestions for a list of key provisions that states should have in their laws to promote effectiveness and consistency in receiverships affecting multiple states. Comments should be submitted to Jane Koenigsman (NAIC) by Feb. 7, 2020.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

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You requested suggestions for a list of key provisions that states should have in its laws to promote effectiveness and consistency in receiverships impacting multiple states. I suggest that states consider adding provisions relating to the following:

1. **Conflicts of Law.** Please see the Insurer Receivership Model Act (MDL-555), Section 102. Conflicts of Law. “This Act, Title [XXX], and the state insurance guaranty association acts constitute this state’s insurer receivership laws, and these laws shall be construed together in a manner that is consistent. In the event of a conflict between the insurer receivership laws and the provisions of any other law, the insurer receivership laws shall prevail.”

2. **Police and Regulatory Exception to Stay.** The Bankruptcy Code includes certain exceptions to the automatic stay, including an exception for a governmental unit to enforce such governmental unit’s police or regulatory power. See 11 U.S.C. §362(b)(4). States should consider including such an exception to receivership statutes relating to injunctions and orders. Section 108 of the MDL-555 relates to Injunctions and Orders. Including an exception to the stay provision would confirm for states that an action by an insurance department, while exercising its regulatory powers against a license of an insurance company in a receivership case pending in a different state, is not stayed by the commencement of a receivership proceeding.

Please let me know if you would like additional information about the foregoing.

Best regards,

Shelley L. Forrest
Receivership Counsel
Missouri Department of Commerce and Insurance
PENNSYLVANIA COMMENTS

Sent: Friday, February 7, 2020 3:11 PM
Subject: RITF: Request for Comment on Key Provisions of Receivership/GA Laws

Suggestions from Pennsylvania focus on three different areas where we feel there is a lack of effectiveness and consistency in receiverships that impact multiple states. The biggest inconsistency is the recognition of stays and the failure to give full faith and credit when lawsuits are pending in states that are not the domestic state. Obviously in Pennsylvania we view the Warrantech issue and over the cap payments to claimants to be a large issue. Lastly the Model Act 520 did a lot to change inconstancies on the life and health side but we view the varying property and casualty GA limits across the country as an issue and something to possibly be addressed.

If there is anything else you need from me do not hesitate to reach out.

Best,

Crystal McDonald

Crystal D. McDonald, Esquire | Project Director
Insurence Department | Office of Liquidations, Rehabilitations and Special Funds
Insurer Receivership Model Act Key Provisions

Article X. Interstate Relations

Article X was drafted to resolve issues that arise in receiverships impacting multiple states. The enactment of these provisions would enhance the efficiency and effectiveness of receiverships.

Section 1001 provides for an ancillary conservation of foreign insurers. The adoption of this section would avoid unnecessary ancillary receiverships. In some cases, ancillary receiverships can increase the costs of administration while providing little or no benefit to policyholders.

Section 1002 deals with domiciliary receivers in other states, and addresses two important issues:

- It ensures that other states’ receivership statutes and court orders are given full faith and credit. This promotes a uniform application of laws and orders in receivership proceedings. It also avoids any criteria for determining whether another state qualifies as a “reciprocal state”, which is inconsistent in existing statutes. In 2017, the NAIC Financial Condition Committee encouraged states to enact laws according full faith and credit to stays and injunctions entered in other states’ receivership proceedings. This recommendation also suggested that states consider adopting the stay provisions of the more recent NAIC models (See IRMA §108).

- It provides for the disposition of deposits held for an insurer placed in receivership, and ensures that they are available to the receivership estate or guaranty associations, as applicable. This can avoid a situation where deposits languish due to statutory ambiguities or inconsistencies.

Section 102. Conflicts of Law

This section provides that the Insurer Receivership Act and state insurance guaranty association acts shall prevail in the event of a conflict with other laws. This is an important principle, as these laws must control over general laws governing insurers.

Section 502. Continuance of Coverage

This section governs the continuation of coverage under policies when a liquidation order is entered. Section 502 D specifies that insurance policies or annuities covered by a life and health insurance guaranty association continue in force after the entry of a liquidation order. This provision is critical in a liquidation of a life or health insurer, as it ensures that such policies are not automatically terminated as a result of a liquidation order. Section 502 B also permits the Liquidator, with court approval, to set the date on which policies not covered by a life and health insurance guaranty association are canceled. This gives the Liquidator flexibility to deal with situations where the default 30-day period might not be appropriate.

Section 801. Priority of Distribution

The priority scheme governing the distribution of assets must comport with the Supreme Court’s decision in United States Department of Treasury v. Fabe.

Guideline for Implementation of State Orderly Liquidation Authority

The NAIC Receiver’s Handbook for Insurance Company Insolvencies addresses the implementation of a receivership in the event of a proceeding under Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Title II). It includes a guideline for initiating a receivership in connection with a proceeding under Title II. A receivership act should include
TEXAS COMMENTS

authority similar to the guideline to ensure that expeditious action can be taken if there is a proceeding under Title II.
Wayne Mehlman  
Senior Counsel

February 7, 2020

James Kennedy, Chair  
Receivership and Insolvency (E) Task Force  
National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, MO 64108

RE: List of Key Provisions to Promote Effectiveness and Consistency in State Receivership and Guaranty Association Laws

Dear Chairman Kennedy:

The American Council of Life Insurers ("ACLI")\(^1\) appreciates this opportunity to respond to the Task Force’s request for a list of key provisions that states should adopt in its receivership and guaranty association laws in order to promote effectiveness and consistency, particularly with regard to multi-state receiverships.

The ACLI believes that both the state receivership and guaranty association systems have operated very efficiently and effectively since their inception and that there is a high degree of consistency among the states, particularly with regard to state guaranty association laws.

That being said, there is always room for improvement, which is why we are recommending a list of potential improvements. We are not, however, seeking to “open up” either the receivership or guaranty association models to revisions or additional provisions, though we are suggesting some amendments to the *Insurance Holding Company System Regulatory Act* which the Task Force is currently looking to revise.

Instead, we are seeking more holistic ways of improving the overall receivership and guaranty association systems and related state laws, including those pertaining to the timing, administration and costs of rehabilitations and liquidations, as well as to the judiciary and the NAIC.

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\(^1\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
Below is a list of our suggested improvements:

- Encourage all states to adopt the NAIC’s recently-revised *Life and Health Insurance Guaranty Association Model Act*

- Create a NAIC accreditation standard that would require states to adopt, in a “functionally consistent” manner, the *Life and Health Insurance Guaranty Association Model Act*

- Align our receivership and guaranty association laws as they relate to life and health reinsurance

- Promote least-cost resolution at the administrative level and in the early stages of judicial proceedings

- Limit how long a receivership proceeding can be left open (since administration expenses can consume considerable resources)

- Address the timing of orders of liquidations

- Limit judicial discretion regarding a regulator’s petition for rehabilitation or liquidation

- Create a designated receivership court in every state

- Provide standardized judicial education on the receivership process

- Strengthen the NAIC’s Financial Analysis Working Group (FAWG) and Receivership Financial Analysis Working Group (R-FAWG)

- Create a NAIC “SWAT” team of receivership experts

- Continue to address modifications to Section 7 of the *Insurance Holding Company System Regulatory Act* that would assure the continuation of inter-affiliate services where receiverships impact multiple states

- Create crisis management groups for supervisory colleges within Section 7 of the *Insurance Holding Company System Regulatory Act* and/or guidance such as the Receivers’ Handbook

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

Sincerely,

Wayne A. Mehlman
Senior Counsel, Insurance Regulation
February 7, 2020

James Kennedy  
Chairman, Receivership and Insolvency Task Force  
National Association of Insurance Commissioners  
1100 Walnut Street  
Kansas City, MO 64106-2197

Subject: Response to Request for Comment on Key Provisions for Insolvency Laws

Dear James:

Thank you for inviting comments on Key Provisions for Insolvency Laws. In response NCIGF offers the following:

The NCIGF is undertaking a multi-year effort to implement various revisions to property and casualty guaranty fund acts. This effort will focus on the following areas:

1) Modernization as needed of state laws. A small minority of states need updates to provisions in their laws such as the base for calculation of member assessments, claim bar dates and other matters. We plan to identify areas where an update may be needed and offer suggestions to fund managers and their boards in this regard.

2) Statutory changes to accommodate transactions under Insurance Business Transfer and corporate division statutes. We have advised the Restructuring Mechanisms Working Group that we have concerns that under current state guaranty fund laws certain claimants involved in these transactions may not be covered in the event of the insolvency of a new entity. NCIGF recently adopted a policy stating that coverage should remain in place for those claimants who would have had guaranty fund coverage before the transaction. Conversely, the policy states that guaranty fund coverage should not be created for such claims that would not have been covered claims before the transaction. We are in the process of developing statutory language to achieve this result and will suggest to local managers that the changes be implemented as needed and assist them in tailoring our template language to their local statutes.

3) Specific statutory changes if needed to permit guaranty funds to assess for administrative costs that are not tied to the volume of insolvency activity. As you are aware the guaranty funds are often called upon to “ramp up” very quickly to address new liquidations. To achieve this “always ready” status it is important that a minimal cadre of experienced staff be available to handle short-notice influx of claims and that physical guaranty fund facilities be maintained.

Sincerely,

James Kennedy
Chairman, Receivership and Insolvency Task Force
National Association of Insurance Commissioners
states may need specific statutory changes to address this need and we will be assisting our members in this regard.

4) Statutory changes as needed to prevent “orphan claims” scenarios. In a minority of states non-standard language, usually related to residency requirements, is on the books. This could create a claim denial of a claim the system is intended to cover. We plan to work with those states, again a minority, in which such problem could arise.

With regard to liquidation acts, as you know, the NCIGF for some time has promoted specific liquidation act language to address large deductibles. The NAIC’s IRMA model has such a provision and recently the large deductible working group has exposed an alternative approach as a “guideline” for states to consider. This alternative approach calls for the asset to be remitted in full to the guaranty funds and not be treated as a general asset of the estate. The NCIGF supports the alternative approach proposed by the Large Deductible Working Group with some technical tweaks that will be offered in our comments. The Large Deductible Working Group has concluded, and we agree, that large deductible business, in an insurance liquidation, is best managed when there is a statute in place.

Thank you for considering our comments. We would be happy to answer any questions the RITF may have.

Very truly yours,

Barbara F. Cox
Attorney at Law
Barbara F. Cox, LLC
February 7, 2020

James Kennedy, Chair
Receivership and Insolvency Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Jane M. Koenigsman, Life/Health Financial Analysis Manager
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197


Dear Mr. Kennedy and Ms. Koenigsman:

We understand that the NAIC’s Receivership and Insolvency Task Force is requesting comments from Interested Regulators and Interested Parties concerning efforts to encourage state adoption of provisions in receivership and guaranty association laws that promote effectiveness and consistency in multi-state insurer insolvencies, in furtherance of recommendations made related to the NAIC’s Macro Prudential Initiative. We understand further that the Task Force intends to develop a list of “key” receivership and guaranty fund provisions to recommend for adoption in the states. We appreciate the opportunity to have input in this process.

The Life and Health Insurance Guaranty Association system has already achieved a high degree of statutory consistency with the NAIC’s Life and Health Insurance Guaranty Association Model Act (“Model Act”). To date, there are 46 states that are substantially consistent with the key provisions of the Model Act, as it existed prior to the recently adopted 2017 amendments.¹

As you know, the process for amending the Model Act in 2017 was very thorough and resulted in extensive changes to reflect the Guaranty System’s most recent insolvency experience dealing with long term care insurance. Since the NAIC’s adoption of the 2017 amendments, there has been a successful effort to seek enactment of those amendments across the country. To date, 27

¹ The key provisions deal with coverage limits, triggering, the definitions of insolvent and impaired insurer, non-resident coverage, coverage of citizens living abroad, payee coverage for structured settlement annuities, non-guaranteed products, interest rate adjustments, equity indexed products, Medicare Part C and D products and reinsurance.
states have substantially adopted the 2017 amendments,² and there are continuing efforts to update the guaranty association laws in the balance of the states, including bills introduced or soon to be introduced for 2020 legislative sessions.

Given that the Model Act was recently updated in 2017, and given that there already is a high level of conformity between state law and the Model Act, we believe that the focus of current efforts should be on supporting the adoption of the 2017 amendments in the remaining states rather than reopening discussions about the Model Act. We would be concerned that such discussions, in particular if they resulted in additional changes to the Model Act, could distract and disrupt efforts to adopt the 2017 amendments in the remaining states.

Again, we thank you for this opportunity to comment, and we would be happy to answer any questions that you may have concerning our comments.

Sincerely,

Peter G. Gallanis
President

² Of these 27 states, one state, Utah, has adopted a 75/25 split between life and health insurers for purposes of allocating the costs of long-term care assessments.
To:   Financial Condition (E) Committee  
From:  Receivership and Insolvency (E) Task Force  
Date:  January 8, 2020  
RE:    Model Law Request for Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

The Receivership and Insolvency (E) Task Force requests the Committee consider opening the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to consider revisions to address issues with continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company, specifically agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

The Task Force is cognizant of other unrelated revisions being considered for Models 440 and 450 under an existing open Model Law Request and understands the sensitivity of the timing of that work. Work related to the continuation of essential services is not intended to delay or impede any other revisions; however, the Task Force feels it may be efficient to conduct its review and drafting concurrently with that work.

Background and Rationale

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

- The Insurance Holding Company System Model Act (#440) requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership.
Holding Company System Model Regulation (#450), Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.

- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.

The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450

The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed draft Models 440 and 450 revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450. Consistency with any revisions to Model 440

Any questions about this memorandum may be directed to NAIC staff, Jane Koenigsman (jkoenigsman@naic.org, 816-783-8145).
CHAPTER 3 – ACCOUNTING AND FINANCIAL ANALYSIS

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 accorded 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 may be due. See discussion in this chapter of deferred income that may be taxed when a company loses its status as a life insurance company for federal tax purposes. There also exists the possibility that the insurer is entitled to recover prior years’ taxes because of the existence of capital losses, operating losses or tax credits. Operating losses, 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 December 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

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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 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 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</td>
</tr>
<tr>
<td>501(c)(15)(A) - tax exempt</td>
<td>990</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
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 Forms 1099 and send the forms to policyholders of life companies while business is still being serviced by the insolvent insurer. In addition, if the insurer has received interest from mortgages, the receiver is required to prepare and provide Form 1098 to the payer. If more than 250 1099 forms are to be issued, the filing is required to be done electronically. However, relief from this electronic filing may be secured upon request to the IRS. The receiver should be able to demonstrate that an electronic filing would place an undue hardship on the insolvent insurer. The IRS can assess penalties for both the failure to issue the forms to agents and the failure to file the forms with the IRS. If the receiver has not already sought relief and the estate is assessed, the IRS may waive the assessment upon request. Additionally, most states and some localities have filing requirements.

5. Franchise Taxes

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

6. Other State Taxes and Licenses

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

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

IX. INVESTMENTS

***************TEXT NOT SHOWN TO CONSERVE SPACE**************

F. Other Considerations

The insurer may be the owner of various tangible and intangible assets that may not be apparent on its
insurer's 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 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 his 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
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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.

*************TEXT NOT SHOWN TO CONSERVE SPACE**************

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 of periodic or lump sum payments
in personal injury settlements, commonly known as “structured settlement annuities.”

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

*************TEXT NOT SHOWN TO CONSERVE SPACE**************
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”)[2] 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. 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 class (i) creditors (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.[3]

[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.

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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 76-23 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 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 old 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 withdraws 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.

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(f)(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 may 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 beis, 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
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. §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 2019-8-1, 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 (Domestic Corporate), (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**************************
The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call March 2, 2020. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Toma Wilkerson (FL); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Tom Green (NE); Mark Jordan (NM); and James Kennedy (TX).

1. Reviewed the Exposure of a Memorandum Regarding Model #555

Ms. Wilson presented an overview of the memorandum (Attachment Three-A) from NAIC staff regarding a guideline for an alternative to Section 712 of the *Insurer Receivership Model Act* (#555) (Attachment Three-B) that was exposed until Jan. 31, 2020.

2. Considered Comment Letters from the Exposure of a Model #555 Guideline

Ms. Slaymaker informed the Working Group that two comment letters had been received during the comment period from Mr. Wake and Barbara F. Cox (National Conference on Insurance Guaranty Funds—NCIGF) (Attachment Three-C). Mr. Wake presented a summary (Attachment Three-D) of the original comment letter (Attachment Three-E) submitted to the Working Group. Based on Mr. Wake’s comments, the Working Group agreed to form an ad hoc drafting group consisting of Mr. Wake, Mr. Kennedy, Ms. Wilkerson, Ms. Wilson, Ms. Cox and Rowe W. Snider (Locke Lord LLP) to develop revisions based on the comments received from Maine and NCIGF.

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

TO: Receivership Large Deductible Workers’ Compensation (E) Working Group

FROM: NAIC Staff

DATE: December 2, 2019

RE: Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies

Executive Summary

Having the necessary statutory authority specific to large deductible workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation.

NAIC staff has been asked to draft the attached Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies as alternative language to Section 712 of Model #555.

Guideline v. Model Law

The NAIC model law development process helps provide uniformity while balancing the needs of insurers operating in multiple jurisdictions with the unique nature of state judicial, legislative and regulatory frameworks. In 2007, the NAIC changed the way model laws and model regulations were developed. The criteria for development of a model law or regulation now involve a two-pronged test. First, the subject matter of the model law or regulation must call for a minimum national standard or require uniformity among the states. The second part of the test is the NAIC members must be committed to dedicating significant regulator and NAIC staff resources to educating, communicating and supporting the adoption of the model law or regulation.

When issues arise where a proposed model law does not meet the two-pronged test, a group can proceed to develop a guideline to address the regulatory issue. Guidelines are not considered to be equivalent to model laws of the NAIC. They are considered regulatory best practices. While Section 712 of Model #555 is a model law, it is the opinion of NAIC staff that the alternative language to Section 712 should be drafted as a guideline, because it does not meet the two-pronged test to be a model law.

2016 Workers’ Compensation Large Deductible Study

Section 712 of Model #555 was originally adopted in 2007 separately from the other provisions of Model #555. After discussion and consideration of recent workers’ compensation insurer insolvencies, the growth of the large
deductible market and the increased number of workers affected by large deductibles, the NAIC/IAAABC Joint (C) Working Group was charged in 2015 to provide an update to the 2006 Workers’ Compensation Large Deductible Study. The 2016 Workers’ Compensation Large Deductible Study provides the following discussion on the use, business practices and potential risks of large deductible policies in workers’ compensation:

Current State of the Law

In most states, there is little guidance governing the rights and obligations of the parties when an insurance company with a large deductible portfolio becomes insolvent. One approach to the problem could be called the “secured claim” approach, which places the highest importance on the principle that claims within the deductible are primarily the obligation of the policyholder. Under this approach, deductible reimbursements are earmarked to pay those claims, and any collateral posted by or on behalf of the policyholder is held to ensure that those claims are paid. Accordingly, when the guaranty association takes on the responsibility of paying a claim within the deductible, it earns the benefit of the reimbursement due from the policyholder, and the right to draw on the collateral if necessary, or to initiate a draw by the receiver, for the benefit of the guaranty fund. [Note: this is the approach of the NCIGF Model].

Another approach could be called the “reinsurance” approach, which places the highest importance on the principle that the insurer’s obligation to pay all covered claims and the policyholder’s obligation to reimburse the insurer are unconditional and that each is independent of the other. Under this approach, deductible reimbursements are a general asset of the estate so that large deductible policies and guaranteed cost policies are essentially identical from the guaranty fund’s perspective, and the guaranty fund only benefits from the deductible reimbursements in proportion to its share as a creditor of the estate. The NAIC has largely taken the second approach. Under the Insurer Receivership Model Act (Model #555), Section 712—Administration of Loss Reimbursement Policies, the receiver has the right to collect all deductible reimbursements, drawing on collateral as necessary. All such payments are general assets of the estate. Any reimbursements paid to the guaranty association are treated as early access distributions and offset from future recoveries from the estate. However, the receiver also has the option to enter into an agreement under which the policyholder takes on responsibility for claims within the deductible, directly or through a TPA, and any such claims remain off the books of both the estate and the guaranty fund. It should be noted that no state has enacted the reinsurance approach embodied in Model #555. The NCIGF approach, on the other hand, has had some success in state legislatures, as the paragraph below demonstrates. Further, some states may have concerns about the impact of the Model #555 approach on statutory deposit requirements in California.

[Update: Eleven states currently have statutes in place: California, Florida, Illinois, Indiana, Michigan, Missouri, New Jersey, Pennsylvania, Texas, West Virginia and Utah.] Most of these states follow the NCIGF approach and have amended their insurance liquidation acts to clarify the following when to secure competing claims such as deductible amounts owed the insurer and retroactive premium balances: 1) the ownership of the deductible reimbursements or collateral drawdowns; 2) claims-handling matters; 3) collection responsibility; and 4) allocation of collateral.

Variations on NCIGF Model

Some states have adopted variations from the NCIGF model that may be considered by states when they are considering adding such language. For example, Illinois, Michigan, and Pennsylvania adopted laws that provide for a three percent administrative fee for the receiver. The following is example language the Working Group included in the Guideline in section F:

The Commissioner as receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements as provided pursuant to [insert state priority of claim statute].
Another variation noted by the Working Group was that California law includes a variation in the threshold amount for the deductible. The Working Group edited section A(1)(b) to reflect a reference to each states’ definition of large deductible.

See ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555) “ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES”
GUIDELINE: ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555)
“ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES”

Drafting Note: Having the necessary statutory authority specific to large deductible workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation. Generally, both approaches provide for the collection of reimbursements, resolve disputes over who gets the reimbursements 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. The issue is whether the guaranty funds, on behalf of the claimants, are entitled to any deductible reimbursements or whether they are a general estate asset that is shared pro rata by the guaranty funds and the uncovered claimants.

Alternative Model Section 712. Administration of Large Deductible Policies and Insured Collateral

This section shall apply to workers’ compensation large deductible policies issued by an insurer subject to delinquency proceedings under this chapter; however, this section shall not apply to first party claims, or to claims funded by a guaranty association net of the deductible unless paragraph B. of this section applies. Large deductible policies shall be administered in accordance with their terms, except to the extent such terms conflict with this section.

A. Definitions. For purposes of this section:

1. “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. A large deductible shall include [any policy with a deductible of fifty thousand dollars or greater] [Alternative: inset state specific citation for the definition of large deductible].

Large deductible policies do not include policies, endorsements or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insurer shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder’s large deductible obligations.

2. “Deductible claim” means any claim, including a claim for loss and defense and cost containment expense (unless such expenses are excluded), under a large deductible policy that is within the deductible.

3. “Collateral” means any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured’s obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured’s obligation to reimburse or pay to the insurer as may be required for other secured obligations.

4. “Commercially Reasonable” means, to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter.
(5) “Other secured obligations” means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations the performance of which is secured by collateral that also secures an insured’s obligations under a large deductible policy.

B. Handling of Large Deductible Claims.

Unless otherwise agreed by the responsible guaranty association, all large deductible claims, which are also “covered claims” as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim, pursuant to an agreement by the guaranty fund or otherwise, the insured’s funding or payment of a deductible claim will extinguish the obligations, if any, of the receiver and/or any guaranty association to pay such claim. No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.

C. Deductible claims paid by a guaranty association.

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the net amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under [cite to early access statute].

To the extent that a guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, or incurred expenses in connection with large deductible policies that are not reimbursed under this section, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding.

Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses, such as those provided for pursuant to [insert cite to guaranty association net worth provision], or existing under similar laws of other states.

D. Collections

(1) The receiver shall have the obligation to collect reimbursements owed for deductible claims as provided for herein and shall take all commercially reasonable actions to collect such reimbursements. The receiver shall promptly bill insureds for reimbursement of deductible claims:

(a) Paid by the insurer prior to the commencement of delinquency proceedings;

(b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or

(c) Paid or allowed by the receiver.

(2) If the insured does not make payment within the time specified in the large deductible policy, or within sixty (60) days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.

(3) Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured’s reimbursement obligation under the large deductible policy.

(4) Except for gross negligence, an allegation of improper handling or payment of a deductible claim by the insurer, the receiver and/or any guaranty association shall not be a defense to the insured’s reimbursement obligations under the large deductible policy.
E. Collateral.

(1) Subject to the provisions of this subsection, the receiver shall utilize collateral, when available, to secure the insured’s obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any distributions made to a guaranty association pursuant to this subsection shall not be treated as distributions under [Insert state insurance liquidation priority distribution statute] or as early access payments under [Insert state early access statute].

(2) All claims against the collateral shall be paid in the order received and no claim of the receiver, including those described in this Subsection, shall supersede any other claim against the collateral as described in Subsection (4) of this Section.

(3) The receiver shall draw down collateral to the extent necessary in the event that the insured fails to:

(a) Perform its funding or payment obligations under any large deductible policy;
(b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty (60) days after the date of the billing if no time is specified;
(c) Pay amounts due the estate for pre-liquidation obligations;
(d) Timely fund any other secured obligation; or
(e) Timely pay expenses.

(4) Claims that are validly asserted against the collateral shall be satisfied in the order in which such claims are received by the receiver.

(5) Excess collateral may be returned to the insured as determined by the receiver after a periodic review of claims paid, outstanding case reserves and a factor for incurred but not reported claims.

E. Administrative Fees.

(1) The Commissioner as receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements as provided pursuant to [insert state priority of claim statute].
Laura Slaymaker, Co-Chairman, Large Deductible Working Group
Donna Wilson, Co-Chairman, Large Deductible Working Group
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Dear Ms. Slaymaker and Ms. Wilson:

Thank you for the opportunity to comment on the proposed draft guideline regarding large deductible treatment in liquidation. We applaud your efforts to make this process more efficient and cost effective in liquidation by proposing this draft guideline. As does the Working Group, NCIGF believes that clear statutory guidance is the best way for a state to manage large deductible claims in liquidation.

As you know, the NCIGF supports the alternative approach, GUIDELINE: ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555) “ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES” as attached to the memo forwarded for comment. The memo notes that some variation of this approach, which calls for the deductible collections and collateral draw downs to be remitted in full to the guaranty associations to the extent of their claim payments, has been adopted in eleven states. At this point, there are actually twelve states that have adopted this approach – Louisiana now has a provision which is effective January 1, 2020.

Regarding the specific language of the alternative we suggest the following revision to make the guideline more clearly reflect its intent.

The alternative is very close in language to the NCIGF Model Deductible statute. This statute reads in paragraph C:

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement, and available collateral as provided for under this section to the extent necessary, to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under[cite to early access statute].
The proposed NAIC Guideline Paragraph C reads as follows:

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the net amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under [cite to early access statute].

We believe the rephrased portion of this paragraph was meant to reference the second paragraph E in the draft guideline. (It is likely meant to be paragraph F.) This paragraph allows the receiver to deduct reasonable expenses from collected or drawn down amounts. We would suggest the following modification to paragraph C of the draft guideline to better reflect the intent:

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association less any expenses reasonably incurred by the receiver in accordance with paragraph F of this section. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under [cite to early access statute].

Thank you for considering our comments. We look forward to discussing them with you and we are available to answer any questions the Working Group may have.

Very truly yours,

Barbara F. Cox
Attorney at Law
Barbara F. Cox, LLC
Summary of Proposed Maine Revisions to Section 712 Guideline

General Structure: The NCIGF Model is a stand-alone Model Act, which makes sense from NCIGF’s perspective, since they don’t have a comprehensive model receivership law. However, once our work product is ultimately enacted in the states that choose to adopt it, it ought to go in the state’s comprehensive receivership law. Where this issue fits in the NAIC Model Law scheme is IRMA § 712. Furthermore, we aren’t changing the existing Section 712 at all, except to prepare a parallel version for states that choose to grant injured workers (and through them the guaranty funds) a property interest in the employer payment stream. Because we need to address the same issues either way, and the Alternative Section 712 can be drafted as a set of discrete amendments to the existing Model, I think we should go that route, which preserves the structure of the existing Model Law and makes clearer what is different under the Guideline and what is the same.

The D-Word: One big difference between the exposure draft and the existing IRMA language is editorial rather than substantive. The exposure draft refers to “large deductible” policies, while IRMA calls them “loss reimbursement” policies. “Large deductible” has one obvious advantage—that’s what everyone calls them in real life. If we were writing from a clean slate, that might sway me, but there are three reasons I prefer “loss reimbursement,” even though it’s a made-up term that nobody uses outside IRMA. The first is that we’re not proposing to use it outside IRMA—all other things being equal, if we’re drafting an alternate version of IRMA § 712, I think we should avoid unnecessary deviations. The second is that even though it’s supposed to be entirely a stylistic difference, it can have unintended legal consequences in practice—we’ve already seen that some courts have looked at the word “deductible” in a policy and applied laws that were clearly intended to apply only to true deductibles where the insurer has no obligation to pay below the deductible, even to the point of overriding the state’s strong public policy that injured workers should always have guaranty fund coverage. Finally, if we use the term “large deductible,” we either have to say “not only didn’t we really mean ‘deductible,’ we didn’t really mean ‘large’ either!” or (as in the exposure draft), we have to make an arbitrary decision how large is “large” enough? That would only make sense if there’s a reason for treating employer reimbursements (and the collateral that secures them) differently depending on the claim attachment point, and I haven’t heard anyone suggest such a reason. I did add a drafting note discussing this issue, which includes some language from the exposure draft that makes more sense as an explanatory note than as a defining criterion. (If it’s a “distinguishing characteristic” as a matter of law, does that mean people will have the right to dispute the law’s applicability to a particular case by litigating the “primary purpose” of the specific policy that’s at issue in that case?)

Decision Point – do we limit the Guideline to Workers’ Comp? I think this might have been a discussion worth having if we were reopening IRMA itself, but if we’re going to have two versions of Section 712 for states to choose from, does it make sense to limit one of them to workers’ compensation but not the other?

Net Reimbursement: As the NCIGF observed, the exposure draft refers to the “net amount of the reimbursement” but doesn’t say net of what. NCIGF and I both concluded that this refers to the provision allowing “reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements” to be deducted “from the collateral or from the deductible reimbursements.” This is a place where I prefer the existing IRMA language. Subsection 712(G) expressly authorizes the receiver to recover these costs “through billings to the insured or from loss reimbursement collateral” – deducting these amounts from the guaranty fund.
reimbursements should be a last resort, only if the collateral is insufficient to cover both the guaranty fund reimbursements and the collection costs, and the deficiency cannot be recovered from the insured.

**Other Secured Obligations:** They exist, so the law needs to address them – and even to honor them when that doesn’t come at more deserving parties’ expense – but commingled collateral should be disfavored, and I don’t think we should take the exposure draft’s approach of giving workers’ compensation claims and collateral-diluting side deals equal priority when there isn’t enough collateral to go around.

**Claims of the Receiver:** The exposure draft says “no claim of the receiver, including those described in this Subsection, shall supersede any other claim against the collateral as described in Subsection (4) of this Section.” My proposal says, instead, that the priority (regardless of who is making the claim) should be (1) uncovered policy claims (if any) secured by the same collateral; (2) reimbursements for covered claims, whether paid by the guaranty fund or by the receiver; (3) other secured obligations; and (4) return of excess collateral with strict guardrails.

**Gross negligence:** Both the exposure draft and existing Section 712 include language barring allegations of improper handling or payment of a claim as a defense against the employer’s obligation to reimburse the claim. The exposure draft makes an exception for gross negligence. This is worth discussing, but it has nothing to do with the issues that motivated the Guideline, so my comments suggest that if we did agree to propose a gross negligence exception, it ought to be done in a drafting note that makes clear that this is an optional provision states could consider whether they follow the Guideline approach or the existing IRMA approach.

“**No Charge of Any Kind**: In addition to the language providing that any claim payment made by the insurer extinguishes both the estate’s and the guaranty fund’s liability for that claim or the relevant portion of that claim, the exposure draft includes the sentence “No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.” What is the problem this additional language is trying to solve? What kind of charge might be made, in what circumstances, in the absence of this sentence?

**Miscellaneous Issues If We Stay with the Exposure Draft’s Format:** All the issues below are moot if we go with my draft, but if we revert to the exposure draft, I think we should make changes to address the following additional issues flagged in my balloon comments (numbered as in the handout): (2) Why are “claims funded by a guaranty association net of the deductible” exempt from this section? (6) The exposure draft exempts policies with aggregate-only deductibles – was this intended? (10) The exposure draft makes an exception to the reinsurance exception for reinsurance “arrangements or agreements [that] assume, secure, or pay the policyholder’s large deductible obligations”- does this encourage sham coverage with side agreements saying it will only be used as security even though the contract by its terms is absolute? (14) The right to opt out of the entire section by agreement with the guaranty association seems overbroad, especially if it purports to delegate powers that ought to be exercised only by the receiver; (16) I think self-pay agreements with employers should be under the ultimate control of the receiver, not the guaranty fund; (19 & 39) Especially since “the policy” is defined to include side agreements, the exposure draft’s deference to the policy terms seems overbroad and should be subject to the receiver’s usual powers to abrogate or modify executory contracts – this is a particularly serious problem where the exposure draft requires the receiver to honor any self-pay agreements the...
insurer entered into before it was taken down (even if they’re a contributing cause of the insololvency); (34) the exposure draft defines “commercially reasonable” for purposes of Section 712, but the term is used multiple times elsewhere in IRMA – is it intended to have a different meaning there? (35) The exposure draft provides that “the insurer’s” inability to perform its contractual obligations isn’t a defense to the employer’s reimbursement obligations (and therefore must be pursued, if at all, in some collateral action) – should we clarify that this is the insurer’s “or receiver’s” inability to perform? (46) The exposure draft gives the receiver the obligation to make all commercially reasonable efforts to obtain reimbursement, but doesn’t give the guaranty fund any remedy if the receiver fails to do it – I think we should include the existing Model’s language allowing the guaranty fund to go after the employer “on the same basis as the receiver, and with the same rights and remedies including without limitation the right to recover reasonable costs of collection from the insured”; (52) The exposure draft has language clarifying that the guaranty fund’s reimbursement rights under this section don’t limit any rights that might exist under other applicable laws – in particular the guaranty fund’s right to reimbursement by high-net-worth employers under the pay-and-recover clause – do we need express language clarifying that the aggregate reimbursement can’t exceed the amount paid? (So that you can’t, for example, draw collateral to pay the worker and collect a high-net-worth reimbursement for the same claim)
Maine alternative proposal, January 6, 2020. I think that if we’re presenting an alternative to Section 712, without proposing amendments, we should avoid unnecessary inconsistencies between the two versions. In particular, I think it confuses the issue to have one version call these policies “large deductible” policies and the other version call them “loss reimbursement policies.” There are pros and cons to both approaches, and I don’t think they have anything to do with the substantive differences between existing IRMA § 712 and the Guideline alternative. Accordingly, the draft I’m proposing is marked up against the existing language (with explanatory balloon comments in the margin), except for the drafting note at the top, which is marked up against the exposure draft.

GUIDE LINE: ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555) “ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES”

Drafting Note: Having the necessary statutory authority specific to so-called “large deductible” workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation. Generally, both approaches provide for the collection of reimbursements, resolve disputes over who gets the reimbursements and ensure that the claimants are paid. The provisions in each of the two options are generally consistent with one another, 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. The issue is whether the guaranty funds, on behalf of the claimants, are entitled to any deductible reimbursements or whether they are a general estate asset that is shared pro rata by the guaranty funds and the uncovered claimants.

Alternative Section 712. Administration of Loss Reimbursement Policies

A. For purposes of this section:

(1) “Loss reimbursement policy” means any combination of one or more policies, endorsements, contracts or security agreements in which:

(a) The insured has agreed with the insurer to: (i) Pay directly any portion of a loss or loss adjustment expense owed by the insurer under the policy up to a specified dollar amount; or (ii) Reimburse the insurer for its payment of loss and loss adjustment expense under the policy up to a specified dollar amount; and

(b) Under which the insurer remains liable for payment of loss and loss adjustment expense under the policy regardless of whether the insured has met its obligations. A loss reimbursement policy may provide for a specific dollar amount of loss reimbursement applicable to each claim, an aggregate dollar amount applicable to all claims under the policy, or both.

Drafting Note: The primary purpose of a loss reimbursement policy is the shifting of a portion of the ultimate financial responsibility to pay claims from the insurer to the insured, even though the initial obligation to pay claims may remain with the insurer. Because the payment of the entire amount of each claim remains the unconditional obligation of the insurer, the insured’s loss reimbursement obligation should not be treated as a “deductible” for...
purposes of any applicable exclusion from guaranty association coverage, even though these policies are commonly referred to as “large deductible” policies.

(2) “Loss reimbursement” means any payment made by the insured to or on behalf of the insurer for loss or loss adjustment expense pursuant to the terms of a loss reimbursement policy, to the extent that the insurer is responsible for payment regardless of whether the insured has met its obligations. Loss reimbursement includes any voluntary or involuntary application of loss reimbursement collateral to the loss reimbursement obligations of the insured. Loss reimbursement does not include:

(a) Payments made by the insured pursuant to a deductible arrangement under which the insurer has no obligation to pay or advance the amount of the deductible on behalf of the insured or a self-insurance arrangement under which the insurer has no payment obligation for the obligation of the self-insured;

(b) Retrospectively rated premium payments; or

(c) Reinsurance claim payments made by a captive reinsurer or other reinsurer affiliated with or funded by the insured or affiliated with the insurer.

(3) “Loss reimbursement claim” means any claim on a loss reimbursement policy that has been made against the estate, or that was previously paid by the insurer, to the extent that it is subject to an insured’s loss reimbursement obligation. A loss reimbursement claim includes any loss adjustment expenses that are subject to reimbursement by the terms of the policy.

(4) “Loss reimbursement collateral” means any cash, letters of credit, surety bond or any other form of security provided by the insured to secure its loss reimbursement obligations, regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer, and regardless of whether the collateral also secures other obligations of the insured.

(5) “Uncovered loss reimbursement claim” means a loss reimbursement claim that is not defined as a covered claim under the relevant guaranty association statute.

(6) “Other secured obligations” means any obligations, such as reinsurance or retrospective premium obligations, that are payable by the insured to the insurer and which are secured by collateral that also secures a loss reimbursement obligation.

B. Administration of Loss Reimbursement Claims.

(1) Except as otherwise provided in this section, all loss reimbursement claims that are also “covered claims” under an applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for administration and payment as provided in the guaranty association law.
(2) Unless otherwise prohibited by law, the receiver, with notice to all affected guaranty associations, may enter into agreements allowing an insured to fund or pay loss reimbursement claims, directly or through a third-party administrator.

(a) If the insurer previously allowed the insured to fund or pay loss reimbursement claims directly or through a third-party administrator, the arrangement is subject to assumption or rejection by the receiver as an executory contract under Section 114.

(b) This paragraph does not preclude a guaranty association that is responsible for payment of a loss reimbursement claim from entering into an agreement with an insured, or a third-party administrator selected by an insured, to administer or pay loss reimbursement claims on behalf of the guaranty association.

(3) The insured’s payment of a loss reimbursement claim in whole or part, including any payment made by a third-party administrator on behalf of the insured, shall extinguish the obligation, if any, of the receiver or any guaranty association to pay that claim or that portion of the claim. Acceptance of the insured’s payment by a claimant in full or final settlement of a claim shall bar the assertion of that claim in the delinquency proceeding or the guaranty association claims process.

(4) An agreement entered into or reaffirmed under this subsection may be terminated in the manner specified in the agreement.

C. Any loss reimbursements owed by an insured shall be administered as follows:

(1) The receiver shall bill an insured for reimbursement of a loss reimbursement claim when:

(a) the insurer paid the claim prior to the commencement of delinquency proceedings;
(b) the receiver is notified that a guaranty association has paid a loss reimbursement claim;
(c) the receiver has paid a loss reimbursement claim; or
(d) a loss reimbursement claim is allowed in liquidation proceedings.

(2) If the receiver is reimbursed by or on behalf of the insured, or obtains reimbursement by drawing collateral, for all or part of a loss reimbursement claim that a guaranty association has paid or is obligated to pay, the receiver shall remit such funds to the guaranty association, net of any reasonable and actual collection costs the receiver was unable to recover from the insured, to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under Section 802 or early access payments under Section 803. To the extent that the guaranty association is not fully reimbursed for its claim payments and its

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reasonable and actual expenses, it shall be entitled to assert a claim for those amounts in the delinquency proceeding.

E. If the insured does not make payment within the time specified in the loss reimbursement policy, or within sixty (60) days after receipt of the billing if no time is specified, the receiver has the obligation to take all commercially reasonable actions necessary to collect any reimbursements owed.

D. Any collateral held under a loss reimbursement policy issued by an insurer subject to a guaranty association may, after notice to the receiver, seek to collect reimbursement due from the insured on the same basis as the receiver, and with the same rights and remedies including actions necessary to collect any reimbursements owed.

E. The insolvency of the insurer, the insurer’s or receiver’s inability to perform any of the insurer’s obligations under the loss reimbursement policy, or any allegation of improper handling or payment of a loss reimbursement claim by the receiver and/or any guaranty association shall not be a defense to the insured’s reimbursement obligation under the loss reimbursement policy.

Any collateral held under a loss reimbursement policy issued by an insurer subject to a delinquency proceeding under this Act shall be maintained and administered in accordance with the loss reimbursement policy except where the loss reimbursement policy conflicts with this section.

If the loss reimbursement collateral, when combined with loss reimbursement payments that have been made by the insured, is insufficient to reimburse loss reimbursement claims already paid by the insurer, the receiver and guaranty associations, and to discharge all currently and past due loss reimbursement claims and other secured obligations, the collateral shall be applied first to fully meet any uncovered loss reimbursement claims whose reimbursement is secured by the collateral, then to all reimbursements due to guaranty associations under paragraph (C)(2) or for covered claims that have been paid directly by the receiver, and finally to any other secured obligations.

Claims of the same type shall be paid in the order filed with the receiver.

Excess collateral may be returned to the insured only if the receiver determines, after a periodic review of claims paid, that the collateral is sufficient, with a confidence level of at least 95%, to discharge both outstanding case reserves and incurred but not reported claims.

If the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured for a loss reimbursement claim and there is no available collateral, a guaranty association may, after notice to the receiver, seek to collect reimbursement due from the insured on the same basis as the receiver, and with the same rights and remedies including without limitation the right to recover reasonable costs of collection from the insured. The guaranty association shall report any amounts so collected from each insured to the receiver. The receiver shall provide the guaranty association with available information needed to collect a reimbursement due from the insured. Whenever a guaranty association undertakes to collect reimbursements from an insured, it shall notify all other guaranty associations that have paid loss reimbursement claims on behalf of the same insured. Amounts collected by a guaranty association pursuant to this paragraph shall be treated in accordance with subparagraph C(2). The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at

Deleted: (3) Any loss reimbursement paid to the receiver that is allocable to a claim paid by a guaranty association shall be immediately distributed to that guaranty association as an early access payment in accordance with Section 803. provided, however, that notwithstanding the provisions of Section 803, receivership court approval shall not be required for early access distributions made pursuant to this section.

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Commented [RAW35]: Existing Section 712 says “recovery’s,” exposure draft says “insurer’s.” If I had to pick between the two, I’d go with “receiver’s,” because the insurer’s insolvency is already listed separately and other types of “inability” are more likely to be post-receivership issues.

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any priority, except as agreed by the receiver at or before the time the expenses are incurred; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

G. The receiver is entitled to recover through billings to the insured or from loss reimbursement 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 or guaranty associations.

H. Nothing in this section limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association’s related expenses, such as those provided for pursuant to [insert cite to guaranty association net worth provision], or existing under similar laws of other states, provided that the guaranty association’s aggregate reimbursement attributable to any claim or expense payment may not exceed the actual amount paid.

J. [OPTIONAL] The provisions of this section shall be applied in all receiverships pending at the time of enactment.

Drafting Note: Attention should be drawn to whether Section 712 is adopted with IRMA or as a stand-alone. If it is adopted with IRMA, then the provisions in Section 111 of IRMA may apply. States may wish for this particular section to not apply retroactively even if electing to have the rest of IRMA so applied, or may wish to apply Section 712 retroactively while having the rest of IRMA applying prospectively.
The first sentence is taken from the exposure draft, which has it in the body of the definition, but it seems more suitable to a drafting note. The exposure draft also says this is a “distinguishing characteristic” of large deductible policies, but contradicts this by explicitly enumerating three other types of policies that share this characteristic: smaller deductibles, retros, and captive reinsurance.

IRMA’s punctuation is inconsistent – when “third-party” is used as an adjective, IRMA hyphenates it 6 times and leaves out the hyphen 14 times. Even the three references to TPAs within Section 712 are inconsistent. So I went with what I consider the correct form.

Existing Section 712, as written, seems to require the receiver to keep any pre-receivership self-pay arrangement in place, even if it’s unwritten and undesirable. This is even more problematic in the framework of the existing Model than it is for our Guideline, since under the existing Model, self-pay arrangements operate to diminish the estate.

Something to discuss – not sure whether it’s an appropriate addition. Global agreements are the receiver’s call, but maybe there’s a place for separate agreements with individual GAs if there’s no global agreement?

I think this is a helpful clarification, though it was omitted from the exposure draft. It avoids any ambiguity regarding a single workers’ compensation “claim” encompassing a series of periodic “claims” against the estate, and also addresses the situation where the money runs out in the middle of a single payment.

Exposure draft omits reference to TPAs. Not strictly necessary, but I think it’s a helpful clarification.

The exposure draft’s counterpart to this paragraph includes the sentence “No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.” Maybe I’m just burned out as I try to wrap this up, but I’m baffled by this sentence. What is the problem it’s trying to solve? What kind of charge might be made, in what circumstances, in the absence of this sentence?

The exposure draft is more forceful, but “shall have the obligation to” and “shall” actually mean the same thing, and the rights and duties of the receiver and GA seem to be a better fit in Paragraph (4) below.
The deleted half of this paragraph is one of the awkward features of existing Section 712 – what happens when the employer is required to reimburse the same claim under both a large deductible agreement and a net worth “pay and recover” law? It’s been deleted because the Guideline approach eliminates the conflict so there’s no need to resolve it – the guaranty association is entitled to the reimbursement either way.

Since the sentence that follows is deleted, these subparagraphs don’t need to be numbered inline.

A version of this clause appears in both the existing Model and the exposure draft, but how can the mere allowance of a claim trigger an obligation to “reimburse” a claim that hasn’t been paid? Should this be limited to cases where the insurer has the contractual right to bill the employer as soon as the claim is accepted? Are there such contracts?

The exposure draft phrases reimbursements by the insurer and draws on collateral as though they were two different things. But as far as we’re concerned, it all comes from the insured, one way or another. If a surety or guarantor has collection issues with the insured, that’s their problem, not ours.

This paragraph, and the deletion of existing paragraph (3), are the heart of the difference between the Guideline approach and the approach taken by the existing IRMA language. This draft is generally based on the first two paragraphs of Subsection C of the exposure draft, but I tried to clarify certain points. For example, the exposure draft says the GA “shall be entitled to recover” but doesn’t say from whom.

The exposure draft says “net amount of the reimbursement,” but doesn’t explain “net of what?” in this paragraph. That seems to be the point of the second Subsection E of the exposure draft, but I prefer existing Subsection G which makes those costs the responsibility of the insured if possible.

Note also that the exposure draft has two “Subsection E”s – if we keep the exposure draft’s organization, the second of those, “Administrative Fees,” should be F. It also consists in its entirety of a single numbered paragraph (1), with no paragraph (2), so the internal numbering seems superfluous.

The exposure draft has placeholder language, which would make sense in a stand-alone law, but I think it’s understood, when a state only adopts IRMA (or any other Model) in part, that internal cross-references might need to be changed to reference some other law. (For that matter, even when IRMA is adopted intact the internal cross-references might need to change to match the state’s own numbering scheme.)
The exposure draft makes an exception for gross negligence. This is worth discussing (we’re talking here about allegations that the insurer paid meritless claims because it wasn’t the insurer’s own money on the line), but is there a good reason for the two versions to be inconsistent here? If we agree to propose a gross negligence exception, consider doing it as a drafting note suggesting that states might want to consider such an exception, whichever version of Section 712 they adopt.

The exposure draft goes into more detail about the triggers for draws on collateral. Is that material necessary? I don’t see it as a substantive difference from the existing language, nor as a clarification that patches a hole that’s created any actual problems.

The applicable contractual provisions might not be in the policy itself, but I think that’s taken care of by the definition of “loss reimbursement policy.”

The exposure draft is broader, saying the entire policy applies unless there’s a conflict with this section. To the extent that it does more than restate the obvious, it doesn’t seem appropriate, since it seems to say the contract trumps all other sections of the receivership law, including all discretionary powers of the receiver therein, except Section 712. Seems particularly dangerous since the policy is defined to include all applicable side agreements.

Should there be any reference to Section 710 here, which addresses collateral more generally? Note that the race-to-file provision we’re proposing is different from the pro rata distribution called for by Subsection 710(B), but that ambiguously worded subsection seems to be intended to apply only to surety bond collateral.

This is a substantive difference between the exposure draft and the existing IRMA language where I strongly prefer the existing language. “Other secured obligations” that weaken the collateral should be disfavored and should not be entitled to compete on equal terms in the race to access the collateral.

I think we ought to consider giving uncovered secured claims – if they exist – priority over the Gas. If we don’t do this, however, we should as noted earlier delete the definition of “uncovered loss reimbursement claims because the term isn’t used.

The exposure draft says “no claim of the receiver, including those described in this Subsection, shall supersede any other claim against the collateral as described in Subsection (4) of this Section.” This seems wrong for three reasons. One is that it contradicts the other provisions in the exposure draft expressly allowing the receiver to net out actual and reasonable collection expenses. The other is that I don’t understand why claims of the same type should be treated differently depending on which responsible party happened to be on the spot to make the initial payment. Finally, if we keep the provision protecting uncovered loss reimbursement claimants, this is based on paying them out of the collateral and loss reimbursements as secured claimants, not paying them in full out of general estate assets and making the receiver go to the tail of the line for reimbursement.
This is in the exposure draft but not in the existing IRMA. Not sure why – is that because it doesn’t matter as much if they’re merely Early Access Distributions and not final payments?

This is an important addition made by the exposure draft, but I don’t think the exposure draft is strong enough. Even the 95th confidence level has, by definition, one chance in 20 of being inadequate. I omitted the reference to “a factor for” IBNR because I was afraid it might encourage reliance on rules of thumb which are often insufficient.

I’m surprised this has no counterpart in the exposure draft. The receiver has the obligation to pursue prompt and diligent collection of reimbursements, but what’s the remedy if the receiver doesn’t successfully get them?

Is this the only trigger, or should the receiver have the authority to delegate the authority to collect reimbursements and administer collateral to one or more Gas by agreement? (Or does that power already exist, to whatever extent it might be useful, when the law is silent?)

The phrase “as in accordance with” in existing IRMA looks like a typo. Should be either “in accordance with” or (but only in the existing version, not the Guideline alternative, of course!) “as early access payments in accordance with”
### Key Provisions Identified in Comments

<table>
<thead>
<tr>
<th>Section</th>
<th>Is critical to a multi-jurisdictional receivership? (Y/N)</th>
<th>Related Model</th>
<th>Should it be considered an accreditation standard? (Y/N)</th>
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<tbody>
<tr>
<td>#555 § 403</td>
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<td>#555 § 205</td>
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### Conflicts of Law:

**The receivership act and insurance guaranty association acts prevail if there is a conflict with other laws,** which ensures that these laws control over general laws.

**#555 § 102**

**Stays & Injunctions**

- Provides automatic stay of actions against receivership estate and insureds.
- Court may order that one judge hears all matters in a delinquency proceeding.
- Provides for the designation of a receiver and provides that they are available to the court.
- Other states' receivership laws and are given full faith and credit, which promotes the consistent application of laws and orders and avoids conflicting reciprocity standards.

**#555 § 108**

**Continuation of Coverage for life and health policies:**

- Governs the continuation of policies when a liquidation order is entered.
- Specifies that policies covered by a life and health insurance guaranty association continue in force after the entry of a liquidation order.

**#555 § 502**

**Priority of Distribution:**

- Provides for the disposition of assets in liquidation proceedings.
- Court must enter judgment on petition within 15 days of conclusion of the evidence.
- If grounds for receivership are established, the court must grant the petition.

**#555 § 205**

**#555 § 208**

**Ting of Proceedings:**

- Other states' receivership laws and are given full faith and credit, which promotes the consistent application of laws and orders and avoids conflicting reciprocity standards.
- Provides for the designation of a receiver and provides that they are available to the court.

**#555 § 105 K**

**Retained Model**

- Provides automatic stay of actions against receivership estate and insureds.
- Court may order that one judge hears all matters in a delinquency proceeding.
- Provides for the designation of a receiver and provides that they are available to the court.
- Other states' receivership laws and are given full faith and credit, which promotes the consistent application of laws and orders and avoids conflicting reciprocity standards.
<table>
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<tr>
<th>Other Comments Received</th>
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<tbody>
<tr>
<td>Create accreditation standard requiring adoption of Life and Health Insurance Guaranty Association Model Act in a &quot;functionally consistent&quot; manner.</td>
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<tr>
<td>Promote cost effective resolution in early stages of receivership proceedings.</td>
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<tr>
<td>Create accreditation standard requiring adoption of Property &amp; Casualty Guaranty Fund Limits.</td>
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<td>Strengthen the NAC’s Financial Analysis Working Group (F-AWG) and Receivership Financial Analysis Working Group (R-F-AWG).</td>
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<tr>
<td>Provide standardized judicial education on the receivership process.</td>
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<tr>
<td>Align receivership and life / health guaranty association laws regarding reinsurance.</td>
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<tr>
<td>Align the NAC’s “SWAT” (if necessary) and/or guidance such as the Receivers’ Handbook.</td>
</tr>
<tr>
<td>Review Section 7 of the insurance holding company system regulation act to ensure the continuity of inter-affiliate services in receiverships.</td>
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<tr>
<td>Create crisis management and consumer protection Act.</td>
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<tr>
<td>Address the implementation of a receivership in the event of a proceeding under Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act.</td>
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</table>

Question: If not an update to accreditation standards, what other options do you propose for encouraging states to adopt these provisions into law?

[Insufficient response]
Develop statutory changes to accommodate transactions under Insurance Business Transfer and corporate division statutes.

Develop statutory changes as needed to prevent “orphan claims” scenarios.

Costs that are not tied to the volume of insolvency activity.

Develop statutory changes (if needed) to permit guaranty funds to assess for administrative costs that are not tied to the volume of insolvency activity.

Develop statutory changes to accommodate transactions under Insurance Business Transfer and corporate division statutes.