The Receivership Model Law (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call on March 30, 2017. The following Working Group members participated: James Kennedy, Chair (TX); Doug Hartz, Vice Chair (WA); Steve Uhrynnowycz (AR); Jack Hom (CA); Jon Arsenault (CT); Toma Wilkerson (FL); Kevin Baldwin (IL); Kim Cross (IA); Christopher Joyce (MA); James Gerber (MI); Tamara Kopp (MO); Christy Neighbors (NE); Kristine Maurer (NJ); Laura Slaymaker (PA); and Brett Barratt (UT).

1. **Heard a Presentation on the LTC Insurance Marketplace**

The Working Group heard a presentation (Attachment xx-A1) on long-term care (LTC) insurance and the LTC insurance marketplace from Peter Gallanis (National Organization of Life and Health Guaranty Associations—NOLHGA), Bill O’Sullivan (NOLHGA), Paul Peterson (NOLHGA), Vince Bodnar (Long Term Care Group, Inc.—LTCG), Kevin Griffith (Faegre Baker Daniels LLP—FBD) and Patrick Hughes (FBD).

Mr. Bodnar provided background of the role of private LTC insurance compared to other funding of LTC expenses; traditional LTC products; hybrid LTC products; sales volume and premium trends; emerging product concepts; and, alternative products.

Mr. Hartz asked if Medicaid changes would change the insured market. Mr. Bodnar said if some of the loopholes were to change, it may force more planning for LTC needs.

Mr. Uhrynnowycz asked how the premium on hybrid products is reported. Mr. Bodnar said the LTC portion (i.e. the LTC rider) is reported on the LTC Experience Reporting Form and is reported as health premium on Schedule T.

Mr. Barratt asked for clarification on the role of Medicare and Medicaid. Mr. Bodnar said Medicare pays for post-acute care such as home care received when recovery is expected. Medicare also pays a limited amount of skilled nursing care costs. Medicaid pays for LTC when the person falls below a specified poverty level.

Mr. Gallanis said that in the 1990s, companies made earnings assumptions consistent with the capital market returns at that time. With subsequent financial market developments, return rates dropped dramatically. Companies’ early lapse assumptions were similar to disability insurance, which was high compared to how lapses on LTC insurance actually developed. Longevity was also higher than expected. Mr. Gallanis said the rate increases required to offset future losses when assumptions deviate, increases over time.

Mr. Bodnar summarized the key items to watch in regard to solvency implications: actuarial assumptions; financial metrics; ability to absorb an increase in LTC reserves; LTC spinoffs; diminishing LTC expertise; and suitability of emerging acquirers of LTC insurance blocks.

Mr. O’Sullivan summarized the guaranty association coverage and assessment structure. Mr. O’Sullivan said the *Life and Health Insurance Guaranty Association Model Act* (#520) guaranty associations cover policies by category; i.e., life, annuity or health. The LTC benefit coverage limit in Model #520 is $300,000. All states currently have this limit. Under Model #520 and the laws of the states, there are two assessment accounts for life/annuity and health. Health encompasses all forms of covered health insurance including covered LTC insurance. There are two factors to determine the category. First, is the type of policy to be covered. LTC would be assessed from the health insurance assessment account. All health premiums reported to the health account are used to determine the allocation. The second factor is the premium reported in the health account by each member in that state. The ratio of premium received by the member insurer in the account compared to premiums in the account by all members determines the proportion of the assessment. There is a three-year period used to look at assessable premium.

Mr. Griffith summarized the application of the guaranty association to both traditional LTC products and hybrid LTC products. Traditional LTC products have been regulated as health insurance. Three LTC insolvencies occurred prior to Penn Treaty Network America Ins. Co. (Penn Treaty) and its affiliate. Those include American Integrity Ins. Co. (1993), Life and
Health Ins. Co. of America (2004) and National States Ins. Co. (2010). Currently, Penn Treaty and its affiliate both have issued LTC products with many different optional benefit riders, including inflation riders. When the LTC guaranty association coverage limits are applied to Penn Treaty and its affiliate, assuming policies had been originally issued as of the effective issue date with coverage maximums at the guaranty association coverage limit, the policies would be underpriced today and there would be justification for premium rate increases on those policies. In addition to the need for premium rate increases, other issues have been raised by the liquidation of Penn Treaty and its affiliate. Most health insurers do not write LTC insurance, and most life and annuity insurers do not have significant LTC insurance policies. Many providers of major medical insurance are not members of the guaranty associations. Another issue is the applicability of the Moody’s interest rate limits to LTC insurance inflation benefits. Finally, the guaranty association manages the liability funding and timing of assessments given the magnitude of the obligations.

Mr. Griffith said there is no insolvency experience with hybrid LTC products, so there are questions about how hybrid LTC products should be categorized for coverage and assessment purposes as well as if clarifying amendments to Model #520 are needed to clearly address coverage and assessments of these products.

Mr. Peterson said the estimated annual national health account capacity is $5.2 billion, excluding three-year averaging. He said there are certain exclusions from assessable premium. He said NOLHGA has public assessment data on its website. He said a preliminary estimate, developed without detailed analysis, of the 760 health maintenance organizations’ (HMOs) capacity, excluding California HMOs managed by the California Department of Managed Health Care, is $4.7 billion.

Ms. Wilkinson asked if the information provided on slides 46 through slide 48 is commercial premium. Mr. Peterson said it is commercial premium and it excludes Medicare. Mr. Kennedy asked if this premium data included dual-licensed HMO products. Mr. Peterson said the information is from insurers with a “business type” of HMO. Mr. Kennedy asked if there was data comparing premiums written by stand-alone HMOs with premiums on HMO products issued by dual-licensed entities. Mr. Peterson said further research would be needed to address this question. Mr. Hartz said a referral to the Blanks (E) Working Group may be necessary to address reporting. Mr. Griffith said Model #520 includes an exclusion for HMO companies, not HMO products.

Having no further business, the Receivership Model Law (E) Working Group adjourned.
RECEIVERSHIP MODEL LAW (E) WORKING GROUP

2017 Charges:
The Receivership Model Law Working Group of the Receivership and Insolvency (E) Task Force will:

A. Continue to study the states' receivership laws and practices in comparison to the Financial Stability Board's (FSB) Key Attributes of Effective Resolution Regimes for Financial Institutions (Key Attributes) and its corresponding assessment methodology. Identify and provide recommendations for possible enhancements to the U.S. receivership regime based on the study, as well as recommendations to the FSB for possible future enhancements to either the Key Attributes or the assessment methodology.

B. Review and provide recommendations on any issues identified that may affect receivership model laws; for example, any issues that arise as a result of federal rulemaking and studies, international resolution initiatives or as a result of the work performed by other NAIC committees, task forces and/or working groups.

C. Evaluate and consider the changing marketplace of long-term care insurance products and the potential impact on guaranty funds.

D. Evaluate the need for amendments to the Life and Health Insurance Guaranty Association Model Act (#520) to address issues arising in connection with the insolvency of long-term care insurers.
To: Judy Weaver, Chair of the Financial Analysis Handbook (E) Working Group and Susan Bernard, Chair of the Financial Examiners Handbook (E) Technical Group

From: James Kennedy, Chair of the Receivership Model Law (E) Working Group

Date: [date]

Re: Receivership Provisions in Management, Service and Cost-sharing Agreements

The Receivership Model Law (E) Working Group (RMLWG) has identified that because of the increasing occurrence of holding company relationships, non-regulated entities that are operationally related to insurers frequently present a challenge when the insurer is in receivership. In many cases the issues may be resolved if certain language addressing receivership of the insurer is included in the affiliated agreements. Additionally, how the U.S. receivership regime handles nonregulated entities in receivership was an issue identified by the International Monetary Fund (IMF) during the Financial Sector Assessment Program (FSAP) review.

The NAIC adopted revisions to the Insurance Holding Company Model Regulation and Reporting Forms (Model #450) in 2010 to require specific language in management, service and cost-sharing agreements specific to when an insurer is placed into receivership, as follows. At this time, most states have adopted the following revision to their regulation, with few exceptions.

Section 19. Transactions Subject to Prior Notice - Notice Filing

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

(11) Specify that, if the insurer is placed in receivership or seized by the commissioner under the State Receivership Act:

a. all of the rights of the insurer under the agreement extend to the receiver or commissioner; and,

b. all books and records will immediately be made available to the receiver or the commissioner, and
   shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner’s request;

(12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the State Receivership Act; and

(13) Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the commissioner under the State Receivership Act, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered?


If there are any questions regarding this referral, please feel free to contact the Chair or NAIC staff support (Jane Koenigsman) to discuss.
IV. Supplemental Procedures – E.4. Form D Procedures

Special Notes:
The following procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.

Form D – Prior Notice of a Transaction

Form D is transaction specific and is not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ for Form D.

1. If a material transaction has occurred, did the insurer file a Form D with their domestic state? (Section 5 of the NAIC Insurance Holding Company System Regulatory Act (Model #440) requires each insurer to give prior notice of certain proposed transactions).

2. Did Form D include the following information for each party to the transaction:
   - Name
   - Home office address
   - Principal executive office address
   - The organizational structure
   - A description of the nature of the parties’ business operations
   - The relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties
   - The name(s) of the affiliate(s) that will receive, in whole or in substantial part, the proceeds of the transaction, when the transaction is with a non-affiliate

3. Does Form D include the following information for each transaction for which notice is being given:
   - A statement as to the section of the holding company regulation Form D filing is being made
   - A statement as to the nature of the transaction
   - A statement of how the transaction meets the ‘fair and reasonable’ standard of the state’s insurance holding company law or regulation Section 5A(1)(a) of the Act; and
   - The proposed effective date of the transaction

4. Does Form D provide a brief description of the following?
   - Amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment
   - Whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice
   - A description of the terms of any securities being received, if any
IV. Supplemental Procedures – E.4. Form D Procedures

- A description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like

5. If the transaction involves consideration other than cash, does the Form D provide a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation?

6. If the transaction involves a loan, extension of credit or a guarantee, does the Form D provide a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest?

7. If the transaction involves an investment, guarantee or other arrangement, has the time period been stated during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements? Does the Form D provide a brief statement as to the effect of the transaction upon the insurer’s surplus?

8. If the transaction involves a loan or extension of credit to any person who is not an affiliate, does the Form D include the following:
   - A description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extension of credit
   - A specification regarding what manner the proceeds are to be used to loan to, extend credit to, purchase assets of, or make investments in any affiliate
   - A description of the amount and source of funds, securities, property or other consideration for the loan or extension of credit
   - For transactions involving consideration other than cash, a description of its cost and its fair value and basis for evaluation
   - A brief statement as to the effect of the transaction upon the insurer’s surplus

9. If the transaction is a reinsurance agreement or modification thereto or a reinsurance pooling agreement or modification, does Form D include the following?
   - A description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year
   - The period of time during which the agreement will be in effect
   - A statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more affiliates
   - A brief description of the consideration involved in the transaction
   - A brief statement as to the effect of the transaction upon the insurer’s surplus
IV. Supplemental Procedures – E.4. Form D Procedures

10. Determine if the reinsurance agreement complies with the requirements for credit for reinsurance.

11. Determine whether the reinsurance agreement’s right of offset limits the offset specifically to the reinsurance agreement(s) and not other balances that may accrue as a result of other transactions.

12. For management and service agreements, does Form D include the following:
   - A brief description of the managerial responsibilities, or services to be performed
   - A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made (compensation bases other than actual cost should be closely evaluated)

13. For cost-sharing arrangements, determine whether the Form D includes the following:
   - A brief description of the purpose of the agreement
   - A description of the period of time during which the agreement is to be in effect
   - A brief description of each party’s expenses or costs covered by the agreement
   - A brief description of the accounting basis to be used in calculating each party’s costs under the agreement
   - A brief statement as to the effect of the transaction upon the insurer’s surplus
   - A statement regarding the cost allocation methods that specifies whether proposed charges are based on ‘cost or market.’ If market based, include rationale for using market instead of cost, including justification for the company’s determination that amounts are fair and reasonable
   - A statement regarding compliance with the NAIC Accounting Practices and Procedures Manual (AP&P Manual) regarding expense allocation
   - A description of when amounts are settled and a provision for interest in the event that settlements are not made timely

13. For management, service and cost-sharing agreements, in accordance with the holding company regulation of the state, does the agreement:
   - Identify the person providing services and the nature of such services;
   - Set forth the methods to allocate costs;
   - Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
   - Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
   - State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
IV. Supplemental Procedures – E.4. Form D Procedures

☐ Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;

☐ Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;

☐ State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

☐ Include standards for termination of the agreement with and without cause;

☐ Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;

☐ Specify that, if the insurer is placed in receivership or seized by the commissioner under the State Receivership Act:
  o all of the rights of the insurer under the agreement extend to the receiver or commissioner; and,
  o all books and records will immediately be made available to the receiver or the commissioner, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner’s request;

☐ Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the State Receivership Act; and

☐ Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the commissioner under the State Receivership Act, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered?

Assessment of Form D – Prior Notice of a Transaction

14. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction appears fair and reasonable in relation to the following:
   a. For reinsurance agreements, are the general terms, settlement provision and pricing consistent with those of non-affiliated agreements?
   b. For management, service or cost-sharing agreement are the fees to be paid by/to the insurer reasonable in relation to the cost of such services?
   c. Are fees paid for related party transactions consistent with the applicable section of the state’s Insurance Holding Company Act? (Note: Insurers should not use related-party transactions as a method for transferring profits of the insurance company to an affiliate or related party).
   d. Will the insurer have adequate surplus upon completion of the transaction?
   e. Does the transaction comply with the NAIC AP&P Manual?
   f. Do unusual circumstances, risks or concerns exist?
IV. Supplemental Procedures – E.4. Form D Procedures

15. Determine whether the transaction was accounted for properly, based on statutory accounting principles, with the NAIC AP&P Manual.

Assessment of Form D – Captive Reinsurance Transactions

16. For all transactions proposed to be entered into on or after Jan. 1, 2015, perform the following (either directly or by reviewing the work of the captive state) initially upon being presented the transaction for approval:

a. Require the insurer to submit a statement as to whether some or all of the risks ceded under the transaction qualify for an exemption from Actuarial Guideline 48 (AG48). If so, require the insurer to identify with specificity the basis for claiming the exemption.

b. Require the insurer to submit five years of pro forma financial statements of the affiliated captive reinsurance entity (assets, liabilities, equity and income) including specifically projected statutorily required reserves.

c. Require the insurer to list and value (in accordance with the valuations used in AG 48) all funds to be held by or on behalf of the insurer as security under the reinsurance contract. The insurer should identify any funds so listed that are (a) Primary Security (as that term is defined in AG 48) and/or (b) held by or on behalf of the insurer on a funds withheld, trust, or modified coinsurance basis.

d. If no exemption under Actuarial Guideline 48 applies, require the insurer to submit current and five year projected calculations, and support therefor, of (a) the statutory reserves with respect to the XXX/AXXX business being ceded; and (b) the Required Level of Primary Security, as defined in AG 48.

e. If no exemption under AG 48 applies, require the insurer to state whether, both at the inception of the transaction and thereafter: (i) funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, will be held by or on behalf of the insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis; and (ii) funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (i) above, will be held by or on behalf of the insurer as security under the reinsurance contract.

f. Consider the following in determining if the transaction should be approved:

i. If no exemption under AG 48 applies, consider (1) whether funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, will be held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis; and (2) whether funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, will be held by or on behalf of the ceding insurer as security under the reinsurance contract.

ii. The extent of refinancing risk present within the transaction given they may involve financing of long duration reserve liabilities with short or medium duration assets. If the financing transaction is scheduled to mature when the best
IV. Supplemental Procedures – E.4. Form D Procedures

- Estimate amount that would need to be refinanced is a substantial percentage of statutory reserves, consider whether a) the terms of the transaction provide the insurer with flexibility to either refinance (with the same finance provider or a replacement finance provider) or to recapture without incurring a material reduction to the insurer’s Total Adjusted Capital, or b) the insurer otherwise has a contingency plan to manage its capital at transaction maturity.

iii. Conditions imposed by the financing provider that require the assets available to satisfy policyholder claims be used before payment is made by the financing provider. Request information from the insurer as to whether assets supporting reserves contain conditions or “priority of payment” provisions that could make the asset unavailable to satisfy general account liabilities. If so, consider if such provisions are consistent with existing law.

iv. Contact the lead state to determine the financial position of the group as a whole and the group’s ability to absorb material unexpected losses from the transaction given the specific terms of the financing transaction. In determining the ability to absorb material unexpected losses, consider either reviewing the group’s ORSA Summary Report or obtaining similar information which may demonstrate available capital above existing group capital.

v. Consider if there are high-quality assets supporting the surplus of the captive that provide additional cushion to absorb material unexpected losses.

vi. Determine if other provisions are in place within the captive transaction that may help to limit exposure to the group. This may include specific capital requirements on the captive, limitations on the ability of the captive to pay dividends to the parent, additional reinsurance to a third-party reinsurer or other risk-reduction strategies.

vii. Contact the lead state and every domiciliary state regulator within the group to determine if they have any input in approving the transaction, although ultimately the decision must be made by the state of domicile.

viii. Consider if the captive will be retroceding business to other affiliates or non-affiliates.

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding the holding company Form D. In developing a conclusion, consider the above procedures as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the holding company Form D under the specific circumstances involved.

**Recommendations for further action, if any, based on the overall conclusion above:**

- Contact the insurer seeking explanations or additional information
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to the examination section for targeted examination
IV. Supplemental Procedures – E.4. Form D Procedures

- Engage an independent actuary or other reinsurance expert to review specific reinsurance contracts
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)

Analyst _______________  Date________

Comments as a result of supervisory review.

Reviewer _______________  Date________
III. GENERAL EXAMINATION CONSIDERATIONS

This section covers procedures and considerations that are important when conducting financial condition examinations. The discussion here is divided as follows:

A. General Information Technology Review
B. Materiality
C. Examination Sampling
D. Business Continuity
E. Using the Work of a Specialist
F. Outsourcing of Critical Functions
G. Use of Independent Contractors on Multi-State Examinations
H. Comments and Grievance Procedures Regarding Compliance with Examination Standards

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Detail Eliminated to Conserve Space--------------------------------------------

F. Outsourcing of Critical Functions

The examiner is faced with additional challenges when the insurer under examination outsources critical business functions to third-parties. It is the responsibility of management to determine whether processes which have been outsourced are being effectively and efficiently performed and controlled. This oversight may be performed through a number of methods including performing site visits to the third-party or through a review of SSAE 16 work that has been performed. In some cases, performance of site visits may even be mandated by state law. However, regardless of where the business process occurs or who performs it, the examination must conclude whether financial solvency risks to the insurer have been effectively mitigated. Therefore, if the insurer has failed to determine whether a significant outsourced business process is functioning appropriately, the examiner may have to perform testing of the outsourced functions to ensure that all material risks relating to the business process have been appropriately mitigated. The guidance below provides examiners additional information about the outsourcing of critical functions a typical insurance company may utilize. The guidance does not create additional requirements for insurers to comply with beyond what is included in state law, but may assist in outlining existing requirements that may be included in state law and should be used by examiners to assess the appropriateness of the company’s outsourced functions. Within the guidance, references to relevant NAIC Model Laws have been included to provide examiners with guidance as to whether compliance in certain areas is required by law. To assist in determining whether an individual state has adopted the provisions contained within the referenced NAIC models, examiners may want to review the state pages provided within the NAIC’s Model Laws, Regulations and Guidelines publication to understand related legislative or regulatory activity undertaken in their state.

Types of Third-Party Administrators

Insurance companies have been known to outsource a wide range of business activities including sales & marketing, underwriting & policy service, premium billing & collections, claims handling, investment management, reinsurance and information technology functions. There are a number of different types of entities that accept outsourced business from insurers including the following:

- Managing General Agent – Person who acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with the following activity related to the business produced adjusts or pays claims in excess of $10,000 per claim or negotiates reinsurance on behalf of the insurer.
• **Producer** – An insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, the person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of an insurance contract on behalf of an insured other than the person, firm, association or corporation.

• **Controlling Producer** – A producer who, directly or indirectly, controls an insurer.

• **Custodian** – A national bank, state bank, trust company or broker/dealer which participates in a clearing corporation.

• **Investment Adviser** – A person or firm that, for compensation, is engaged in the act of providing advice, making recommendations, issuing reports or furnishing analyses on securities. In addition to providing investment advice, some investment advisers also manage investment portfolios or segments of portfolios. Other common names for investment advisers include asset managers, investment managers and portfolio managers.

• **Affiliated Service Provider** – An affiliated person or firm to which the insurer outsources ongoing business services, including cost sharing services and management services.

• **Other Third-Party Administrators** – Other third-party entities that perform business functions of the insurer.

Additional information on each of the above types of entities has been provided below to assist examiners in reviewing business activities outsourced.

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**Affiliated Service Providers**

Specific requirements related to an insurance company’s utilization of cost sharing services and management services with affiliates are included in the NAIC’s *Insurance Holding Company System Model Regulation* (Model # 450). Prior to entering into one of these agreements, an insurer must first give notice to the State Insurance Department of the proposed transaction via the Form D filing. As the receipt and review of the Form D filing is typically the responsibility of the Department Analyst, the examiner should leverage that review to the extent possible. If the agreement has not been obtained and reviewed by the analyst, or if significant agreements have not been modified since 12/31/14 (date that new provisions were effective in Model #450), the examiner should obtain and evaluate whether the agreement includes the provisions listed below:

Agreements for cost sharing services and management services shall at a minimum and as applicable:

1. **Identify the person providing services and the nature of such services;**

2. **Set forth the methods to allocate costs;**

3. **Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;**

4. **Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;**

5. **State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;**

6. **Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;**
7. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;

8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

9. Include standards for termination of the agreement with and without cause;

10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;

11. Specify that, if the insurer is placed in receivership or seized by the commissioner under the State Receivership Act:
   
   a. all of the rights of the insurer under the agreement extend to the receiver or commissioner; and,
   
   b. all books and records will immediately be made available to the receiver or the commissioner, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner’s request;

12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the State Receivership Act; and

13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the commissioner under the State Receivership Act, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered.

If certain provisions are missing from affiliate service agreements, the examination team should encourage/require revisions to include all appropriate provisions, depending upon the date of the agreement and provisions required by Model #450 at that date. In addition, in accordance with the risk-focused examination process and utilizing guidance from the Related Party Repository, the examiner should consider whether terms of significant affiliated agreements are fair and equitable. Examiners should also note that additional guidance for reviewing individual affiliated transactions is located in Section 1, Part IV D in this Handbook.
### PRIORITY ISSUES / TOPICS

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### RATE INCREASES AND BENEFIT MODIFICATIONS

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<td>7  - Approval of Rate Increases</td>
<td>IAIR</td>
<td></td>
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<tr>
<td>8  - Clarify GA's ability &amp; obligation to ensure adequacy of LTCI rates</td>
<td>UnitedHealth Group</td>
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<tr>
<td>9  - GAs should offer options/alternative policies to the policyholders that would allow them to take reduced benefits in lieu of premium increases; Lack of non-forfeiture provisions in the long term care policies.</td>
<td>MI, UnitedHealth Group</td>
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### OTHER

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<tr>
<td>10  - Offer to present an educational session on background of LTC products and marketplace</td>
<td>NOLHGA</td>
<td>03/30/17 Conference Call</td>
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### LONG-TERM ISSUES / TOPICS

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<td>11  - Need clarity on how maximum GA benefits are applied to policyholders already on claim</td>
<td>MI</td>
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<td>12  - Consider the impact of changes in LTCI policies and new products</td>
<td>NE, IAIR</td>
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<td>13  - Consistency between states on GA LTC benefit limits</td>
<td>MI, IAIR</td>
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<tr>
<td>14  - LTCI policyholders that collect GA benefits should be made partnership eligible so that they can collect Medicaid no matter their asset level once the GA funds run out</td>
<td>Romeo Raabe -- TheLongTermCareGuy</td>
<td></td>
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### OTHER MODEL 520 CONSIDERATIONS

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<td>15  - Regarding Model 520 Premium Allocation, clarify that the premiums that belong to the guaranty association under Section 8.D. are those portions of the total premiums for relevant policies that correspond to the portions of the policies for which coverage is provided under Section 3.B.</td>
<td>Cantilo &amp; Bennett LLP</td>
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<tr>
<td>16  - Coordination of NAIC efforts with other Working Groups, GA, Industry</td>
<td>NE</td>
<td>Address any impact to Receivership as other NAIC groups complete work</td>
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The original comment letters received are posted to the Working Group's webpage under "Related Documents": [http://www.naic.org/cmte_e_mlwg.htm](http://www.naic.org/cmte_e_mlwg.htm)
Receivership Model Law (E) Working Group
Guidance Regarding Recognition of Receivership Stays and Injunctions

Introduction

Most state receivership laws provide for a stay of actions in which the insurer is or may become a defendant. Stays are a critical tool in a receivership. They can prevent the cost and uncertainty involved with litigating claims in multiple forums, and safeguard the assets of the insurer against preferences. This ensures the fair and consistent treatment of all claims, and reduces the cost of litigation to the receivership.

A survey of states’ receivership laws revealed inconsistencies with respect to the scope of stays, and the recognition of stays issued in receiverships in other states. This guidance suggests clarifications to address deficiencies in receivership laws regarding stays.

Background

State insurance receivership laws are derived from one of the NAIC model acts. The original 1939 Uniform Insurers Liquidation Act was supplanted by NAIC Model 555 (the “Model”). The NAIC has adopted three versions of the Model: the Insurers Supervision, Rehabilitation, and Liquidation Model Act; the Insurers Rehabilitation and Liquidation Model Act (“IRLMA”); or the Insurer Receivership Model Act (“IRMA”). Every state has a law that is either derived from, or incorporates elements of, one of the Models.

A majority of receivership acts are based on a version of the Model that contained two stay provisions: Actions by and Against Rehabilitator (“Rehabilitation Stay”) and Attachment, Garnishment, and Levy of Execution (“Attachment Stay”).

The Rehabilitation Stay provides for a temporary stay of actions in which the insurer is a party, or is obligated to defend a party. Typically the stay is a period of 90 days, and can be extended by the court. This section also states that the rehabilitator shall petition the courts in other states for stays when necessary.

The Attachment Stay prohibits attachments, garnishments, or levies of execution during the pendency of an insolvency proceeding. In some states the stay applies to any delinquency proceeding, while in others it applies only to a liquidation proceeding. Also, some states apply the stay to insolvency proceedings in any other state, while others limit it to proceedings in a “reciprocal state”.

These provisions can force receivers to seek stays or defend lawsuits in multiple forums, particularly in a rehabilitation. The patchwork of differing stays can also result in inconsistent outcomes in different states. The NAIC attempted to address these problems in the 1999 version of IRLMA. Section 5 (C) provided a broad stay of actions against the insurer or the liquidator, and recognized liquidation stays in other states:

The courts of this state shall give full faith and credit to any stay of all new actions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are pursuant to an order to liquidate an insurer issued in accordance with corresponding provisions in other states.

In 2005, IRMA § 1002(A) extended the recognition of stays to all receivership proceedings:
The statutory provisions of another state and all orders entered by courts of competent jurisdiction in relation to the appointment of a domiciliary receiver of an insurer and any related proceedings in another state shall be given full faith and credit in this state. For purposes of this Act, another state means any state other than this state. This state will treat all foreign states as reciprocal states.

Recommendations

An effective stay provision promotes judicial economy and predictability, which benefits all participants in the receivership process. However, the significant improvements in the NAIC Model regarding stays have not been widely adopted. States should review their receivership laws, and consider the following:

1) States with no stay provisions, or provisions based on older NAIC models, should compare their laws to the more recent NAIC Models, and evaluate the benefits of a more comprehensive stay.

2) States with no reciprocity provisions, or provisions based on older NAIC models, should consider adopting a provision similar to IRLMA § 5 (C) (2) or IRMA § 1002 (A). In the alternative, a state could update its definition of a “reciprocal state” to include any state that has adopted an act that is substantially similar to any of the receivership model acts promulgated by the NAIC.